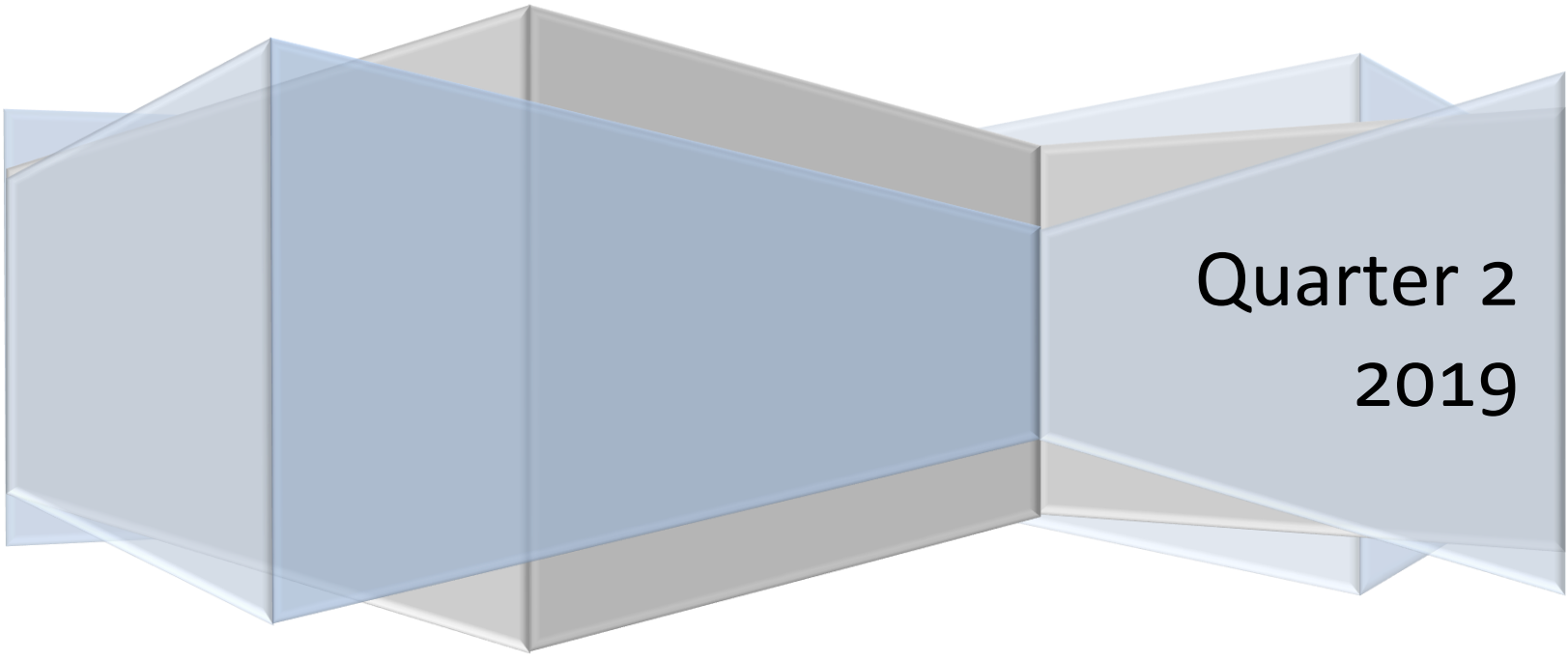
Virginia Department of Medical Assistance Services

The Virginia Addiction and Recovery Treatment Services (ARTS), and Former Foster Care Youth (FFCY) Delivery System Transformation

Section 1115 Quarterly Report
Demonstration Waiver 1115
Project 11-W-00297/3

Demonstration Year: 5 (01/01/2019 – 12/31/2019)
Quarter 2 (04/01/2019-06/30/2019)
Approval Period (1/12/2015-12/31/2019)



Addiction and Recovery Treatment Services

INTRODUCTION

In September 2014, to address the prescription drug and heroin overdoses taking the lives of thousands of Virginians, Governor McAuliffe signed Executive Order 29 creating the Governor's Task Force on Prescription Drug and Heroin Abuse. Dovetailing with Virginia's concern, in July 2015, CMS issued the CMS State Medicaid Director letter, #15-003 to Medicaid Directors that highlighted new service delivery and funding opportunities for Medicaid members experiencing a Substance Use Disorder (SUD). The CMS opportunities significantly aligned with the Governor's Task Force conclusions. In 2016, the Virginia General Assembly and Governor McAuliffe authorized the Department of Medical Assistance Services (DMAS) to make changes to its existing substance use disorder treatment services. Under this authority, DMAS and the Department of Behavioral Health and Disability Services (DBHDS) worked with stakeholders (Virginia Department of Health, Department of Health Professions, the managed care organizations and others) to develop an enhanced and comprehensive benefit package to cover addiction and recovery treatment services. DMAS also submitted an application for and received CMS 1115 Demonstration waiver authority to waive the limits for using Medicaid federal dollars to fund individuals seeking treatment in Institutions for Mental Diseases (IMDs) for SUD related residential services. Virginia continued efforts to address the number of opioid fatalities and in November 2016, the State Health Commissioner declared a Public Health Emergency for Virginia as a result of the opioid addiction epidemic. Efforts to continue the momentum to combat the epidemic in the Commonwealth continued. In December 2017, Governor McAuliffe established an Executive Leadership Team on Opioids and Addiction to implement recommendations of the Task Force. In September 2018, Governor Northam established the Governor's Commission on Opioids and Addiction.

This report highlights progress made with the State's implementation of the system transformation of the SUD treatment services: Addiction and Recovery Treatment Services (ARTS).

BACKGROUND

Virginia's Medicaid members are disproportionately impacted by the substance use epidemic. Nationally, Medicaid members are four times more likely than people with private insurance to have ever used heroin or had pain reliever dependence[1]. Medicaid members are also prescribed opioids at twice the rate of non-Medicaid members and are at three-to-six times the risk of prescription opioid overdose. In 2014, Virginia spent $44 million on Medicaid members with a primary or secondary diagnosis of SUD who were admitted to hospitals or Emergency Departments. Due to the overwhelming impact of SUD for Medicaid members, the Governor's Task Force on Prescription Drug and Heroin Addiction made a recommendation to increase access to treatment for opioid addiction by increasing Medicaid reimbursement rates for SUD treatment services. As part of the Governor's Task Force recommendations, DMAS initiated a large stakeholder workgroup to develop the comprehensive benefit for SUD treatment services, resulting in the ARTS benefit, which implemented on April 1, 2017. As of June 1, 2019, Virginia Medicaid has

[1] *MACPAC (June 2017), Report to Congress on Medicaid & CHIP, Chapter 2: Medicaid and the Opioid Epidemic.*

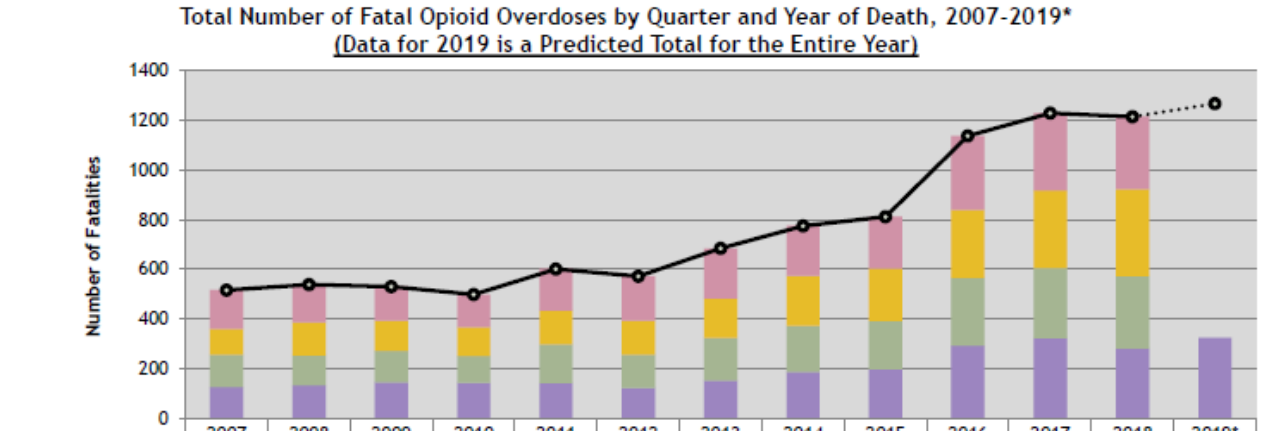
over 1.38 million individuals enrolled in its program who have access to the ARTS benefit. This includes members eligible for Medicaid Expansion which implemented January 2019.

In 2013, fatal drug overdose became the leading method of unnatural death in the Commonwealth. This trend has continued to worsen at a greater magnitude due mainly to illicit opioids (heroin, illicit fentanyl, and fentanyl analogs). From 2007-2015, opioids (fentanyl, heroin, U-47700, and/or one or more prescription opioids) made up approximately 75% of all fatal drug overdoses annually in Virginia. However, this percentage is increasing each year due to the significant increase in fatal fentanyl and/or heroin overdoses that began in late 2013 and early 2014. Fatal opioid overdoses increased by 8.0% in 2017 when compared to 2016.

The Virginia Department of Health (VDH) reported that 1,215 Virginians died from opioid overdoses in 2018, nearly doubling since 2011 (see Figure 1). Projected estimates for 2019 (entire year) are calculated based upon initial counts by quarter, average toxicology turnaround time at the time of the report, the date of data analysis, and previous quarter fatality trend review.

Even after the initiation of the ARTS benefit, Virginia continues to feel the impact of the opioid epidemic. As Figure 1 shows below, the trend for opioid fatalities statewide had begun to level off. However, estimates for 2019 show an increase compared to 2018. Fentanyl (prescription, illicit, and/or analogs) caused or contributed to death in nearly 55% of all fatal overdoses in 2018.

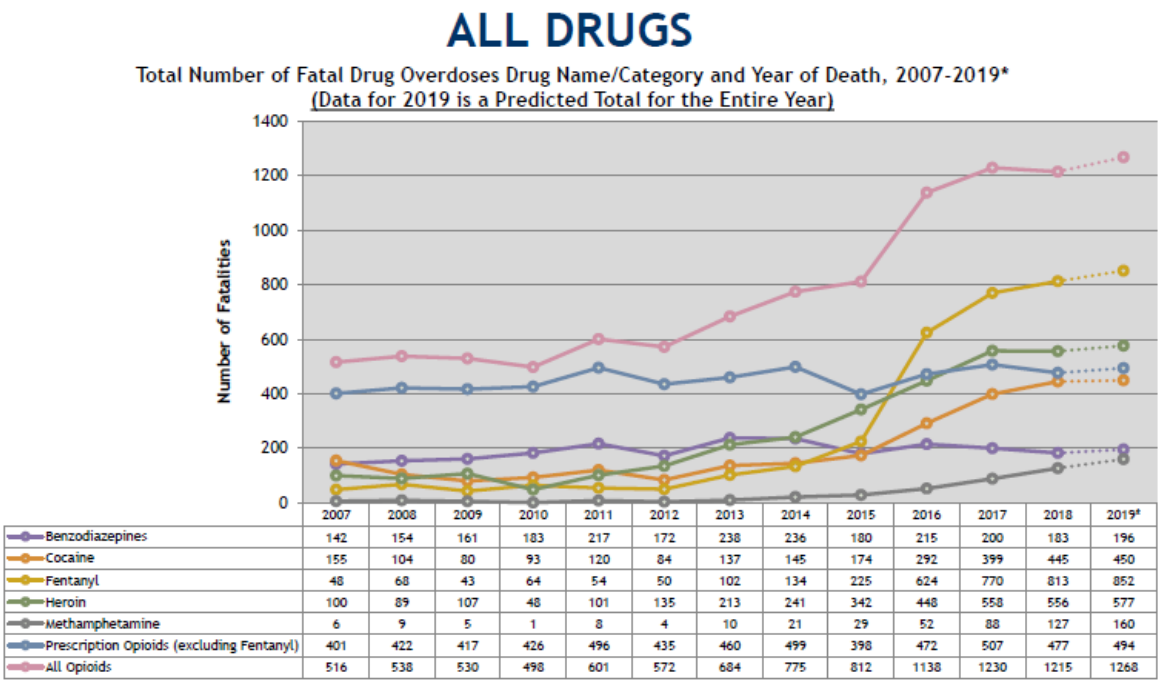
Figure 1: Total Number of Fatal Opioid Overdoses in Virginia as of June 2019



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*
Q4	156	151	136	131	168	179	202	201	208	298	312	292	
Q3	104	134	122	116	136	137	158	202	213	275	312	351	
Q2	130	120	128	109	156	134	173	185	195	272	284	292	
Q1	126	133	144	142	141	122	151	187	196	293	322	280	324
Total Fatalities	516	538	530	498	601	572	684	775	812	1138	1230	1215	1268

Further, there are variances in substance use patterns depending on the community in comparison to overall statewide numbers regarding all drug-related fatalities. There have been many efforts directed at opioids both nationally and within the state, however, Virginia is experiencing increases in fatal overdoses of non-opioid substances such as cocaine and methamphetamine. VDH reports that fatal non-opioid illicit drug overdoses are on the rise. In 2018 compared to 2017, fatal cocaine overdoses increased 11.5% and fatal methamphetamine overdoses increased 44.3% (Figure 2). This reinforces the fact that Virginia is experiencing a crisis of addiction and not just one of opioids.

Figure 2: Total Number of Fatal Overdoses in Virginia as of June 2019



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*
Benzodiazepines	142	154	161	183	217	172	238	236	180	215	200	183	196
Cocaine	155	104	80	93	120	84	137	145	174	292	399	445	450
Fentanyl	48	68	43	64	54	50	102	134	225	624	770	813	852
Heroin	100	89	107	48	101	135	213	241	342	448	558	556	577
Methamphetamine	6	9	5	1	8	4	10	21	29	52	88	127	160
Prescription Opioids (excluding Fentanyl)	401	422	417	426	496	435	460	499	398	472	507	477	494
All Opioids	516	538	530	498	601	572	684	775	812	1138	1230	1215	1268

GOALS

Virginia's overall goal for the ARTS benefit is to improve quality of care, to offer a continuum of care across the benefit plan, improved population health, and decreased costs for the Medicaid population with SUD. DMAS' specific objectives for this benefit are outlined below in Figure 3:

Figure 3: DMAS's Objectives of the ARTS Benefit

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

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

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

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

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

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

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

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

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

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

ELIGIBILITY AND BENEFIT INFORMATION

The ARTS benefit expands access to a comprehensive continuum of addiction treatment services for all enrolled members in Medicaid, in Virginia's CHIP-Family Access to Medical Insurance Security (FAMIS) and FAMIS MOMS. (Note: FAMIS and FAMIS MOMS are programs covered by the Child Health Insurance Program (CHIP) benefit).) The Governor's Access Plan (GAP) sunsetted in March 2019 and the majority of members are eligible for Medicaid Expansion. The ARTS benefit is covered through the fee for service, Medallion 4.0 Managed Care, and Commonwealth Coordinated Care Plus (CCC Plus) Medicare/Medicaid Programs. All MCOs and Magellan of Virginia are covering the full range of ARTS services. The full continuum of the ARTS benefit is listed in Figure 4:

Figure 4: ARTS Continuum of Care

Expansion of the administration of community-based addiction and recovery treatment services

- Transition through the DMAS contracted MCOs including Medallion 4.0, Commonwealth Coordinated Care (CCC) Plus.
- The DMAS contracted Behavioral Health Services Administrator (BHSA), Magellan of Virginia, covers the ARTS benefit for those members who are enrolled in the full coverage Fee-For-Service (FFS).

Expansion of Community-based addiction and recovery treatment services for all members

- Residential Treatment,
- Partial Hospitalization,
- Intensive Outpatient Treatment,
- Medication Assisted Treatment/Opioid Treatment Services (includes individual, group counseling and family therapy and medication administration), and
- Substance Use Case Management.

Allowing for coverage of inpatient detoxification and inpatient substance use disorder treatment for all members

- For all full-benefit Medicaid and FAMIS enrolled members.
- DMAS expanded coverage of residential detoxification and residential SUD treatment for all full-benefit Medicaid enrolled members.

ENROLLMENT COUNTS FOR YEAR TO DATE

DMAS provides SUD treatment services and co-occurring substance use and mental health disorder treatment services to all 1.38 million members enrolled in Medicaid, Medicaid Expansion, FAMIS and FAMIS MOMS. Virginia expanded Medicaid effective January 1, 2019. As a result, adults with incomes ≤ 138% federal poverty limit (FPL) could now be eligible for Medicaid. Virginia has enrolled over 292,972 newly eligible adults as of June 28, 2019. Medicaid Expansion could enable as many as an estimated 60,000 uninsured Virginians to gain access to SUD treatment services, including an estimated 18,000 with opioid use disorder (OUD).

DMAS contracted with Virginia Commonwealth University (VCU) to conduct an independent evaluation of the ARTS program. Highlights of the first fifteen months of evaluation outcomes covering April 1, 2017 to June 1, 2018 were provided in the previous quarterly report. The next evaluation for the second year post ARTS implementation is targeted to be completed in September 2019. Preliminary data for Medicaid (non-expansion) versus Medicaid Expansion population who have diagnosis of SUD, OUD or alcohol use disorder (AUD) compared to those in treatment is show in Figure 5 and 6.

Figure 5: Substance Use Disorder Prevalence and Treatment Rates among Non-Expansion Population – April 2018 to March 2019.

	SUD	OUD	AUD
Number of members	52,020	22,155	17,987
Total number and percent receiving treatment	**48%** 25,007	**63%** 13,937	**43%** 7,747

Figure 6: Substance Use Disorder Prevalence and Treatment Rates among Medicaid Expansion Population – January 2019 to March 2019.

6% (16,518) of members have **SUD**

3% (7,125) of members have **OUD**

2% (5,620) of members have **AUD**

OPERATIONAL UPDATES

During Quarter 2 of year three post ARTS implementation, DMAS continued to monitor activity with the MCOs and Magellan of Virginia to determine if there were any significant operational, policy, systems, or fiscal developmental issues. DMAS tracks all emails and calls related to the ARTS benefit to ensure any concerns or issues are addressed.

DMAS has identified low claims activity for care coordination within the Opioid Treatment Program and the Preferred Office Based Opioid Treatment (OBOT) levels of care. To increase provider activity and claims, DMAS is currently developing a training on Substance Use Care Coordination for providers in order to encourage the use of ARTS Care Coordination.

During the second quarter of 2019, DMAS continued to monitor the MCOs and Magellan of Virginia to ensure contractual compliance with operations, system readiness, provider network adequacy

and claims processing. MCOs and Magellan of Virginia continue to show compliance with all areas; although there are some claims issues that present themselves. Each claim issue is handled on a case by case basis and DMAS works closely with the provider and MCO to track and follow up with all claims issues to resolution.

DMAS continues to work to update ARTS regulations, provider manuals and increase access to ARTS services. The current DMAS regulations for ARTS are still under review and once final, DMAS will follow with an update to the ARTS provider manual to reflect changes and clarifications to policies. DMAS' goal is to minimize treatment barriers for members who have a SUD, while ensuring these members with OUD obtain access to high quality Medication Assisted Treatment (MAT) and other proven therapies.

DMAS staff completed two OBOT Quality Reviews in which staff from Program Integrity worked with staff who oversee the ARTS benefit to perform onsite reviews. The purpose of the provider reviews is to gain an understanding of how the Preferred OBOT model is being applied across providers within the community. DMAS provided letters to providers outlining the findings on the review as well as providing an opportunity for providers to receive technical assistance to help further enhance the OBOT model across providers.

PERFORMANCE METRICS

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

DMAS has begun conversations with the external quality review organization (EQRO) contract to focus on ARTS quality metrics to evaluate the outcomes of the program as well as analyze outcomes of individual MCOs.

DMAS has submitted the final version of the new monitoring protocol to CMS and awaits final approval.

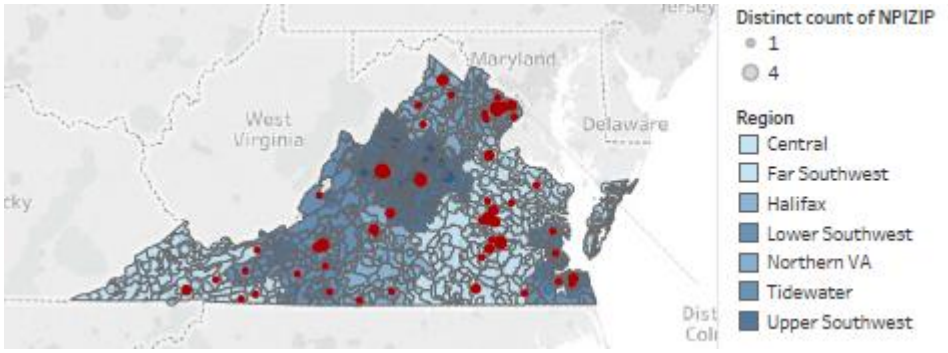
COLLECTION & VERIFICATION OF UTILIZATION & ENROLLMENT DATA

DMAS has collected data submitted from the MCOs and Magellan of Virginia on network and service authorizations for ARTS services. The Special Terms and Conditions (STCs) require the state to report on residential levels of care, at least one sublevel level of care is required to be available to members upon implementation within each MCO and Magellan of Virginia network. The STCs also require access standards and timeliness requirements, including number of days to first ARTS service at appropriate level of care after referral. This is specified in the ARTS Network Development Plans and the ARTS Network Readiness Plans and referenced in the relevant contracts.

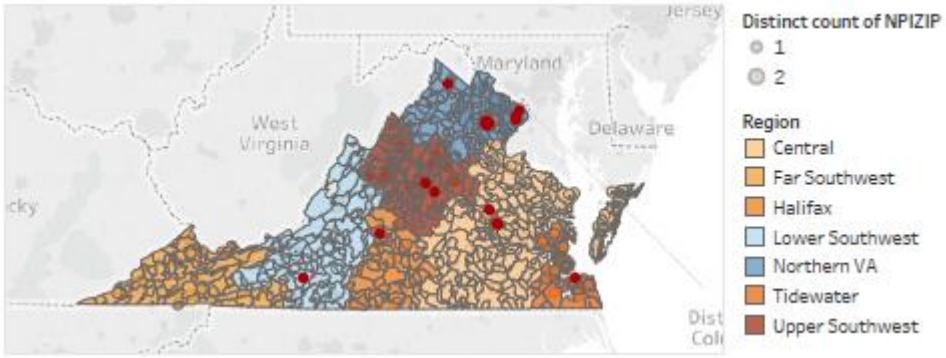
The following maps show network adequacy for this quarter. The orange shaded areas of the map are areas in which provider needs are the greatest. Currently network adequacy is based on a 30 mile radius in urban areas and 60 mile radius in rural areas.

Figures 11: ARTS Network Adequacy Maps[2]

ASAM Level 2.1: Intensive Outpatient

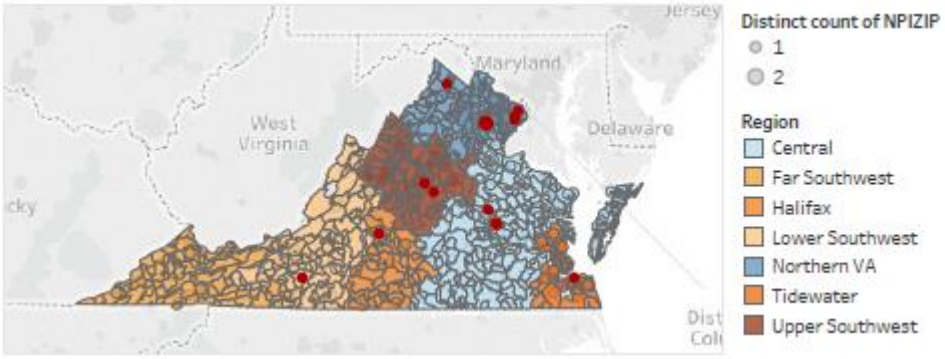


ASAM Level 2.5: Partial Hospitalization

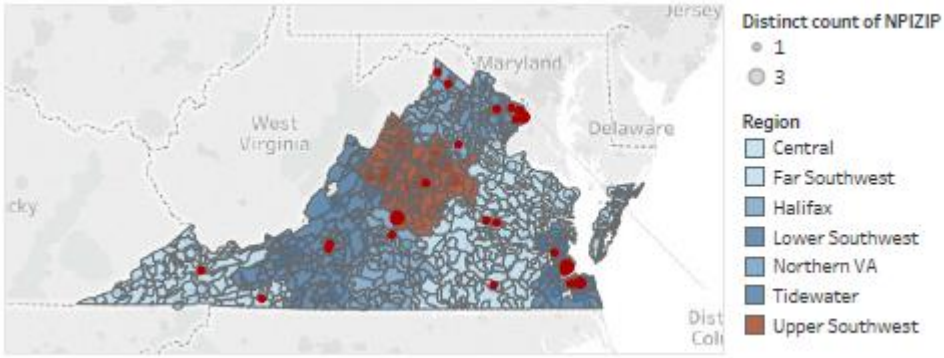


[2] Map based on Longitude (generated) and Latitude (generated) and Latitude (generated) broken down by ASAM Level of Care. For pane Latitude (generated): Color shows details about Color and Region. Details are shown for Member Zip Code. For pane Latitude (generated) (2): Size shows distinct count of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

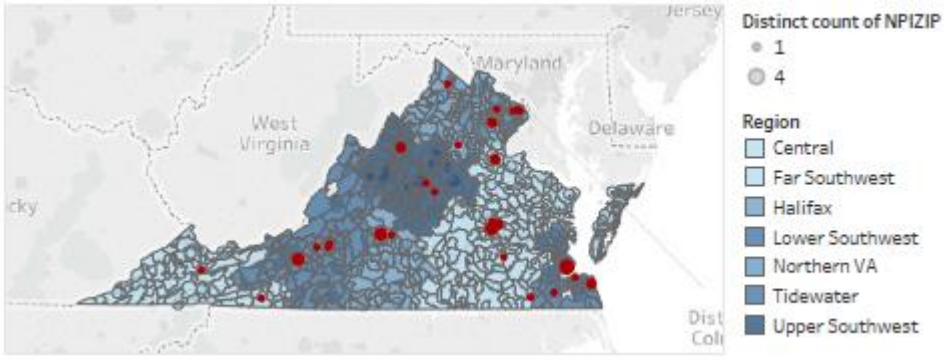
ASAM Level 3.1: Group Home



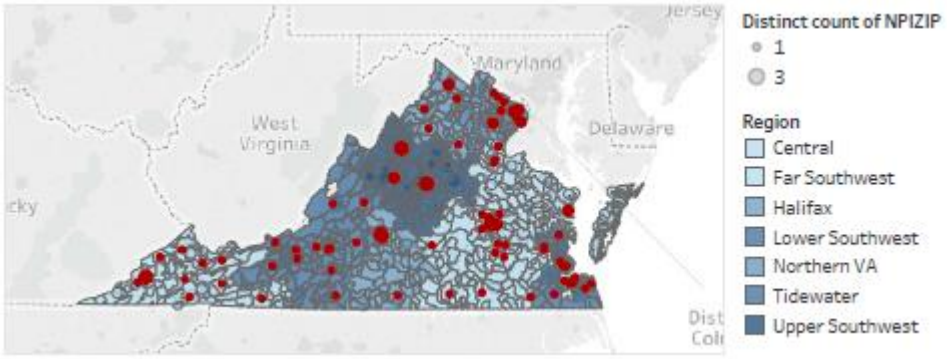
ASAM Level 3.3: Clinically Managed Residential (RTS) / ASAM Level 3.5: Clinically Managed RTS



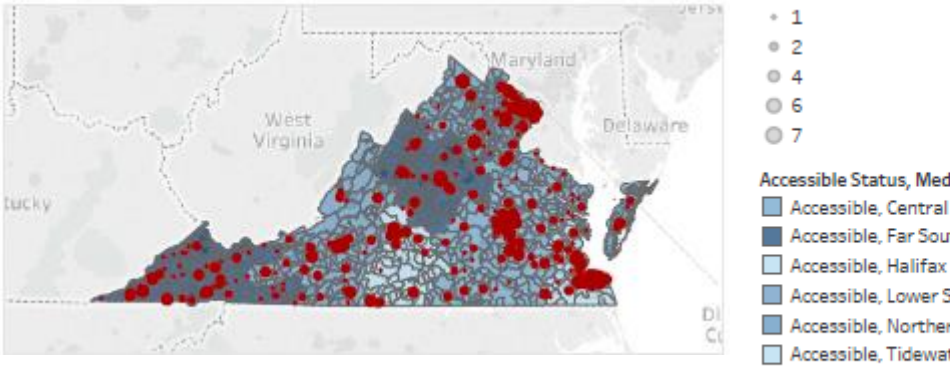
ASAM Level 3.7: Medically Monitored RTS



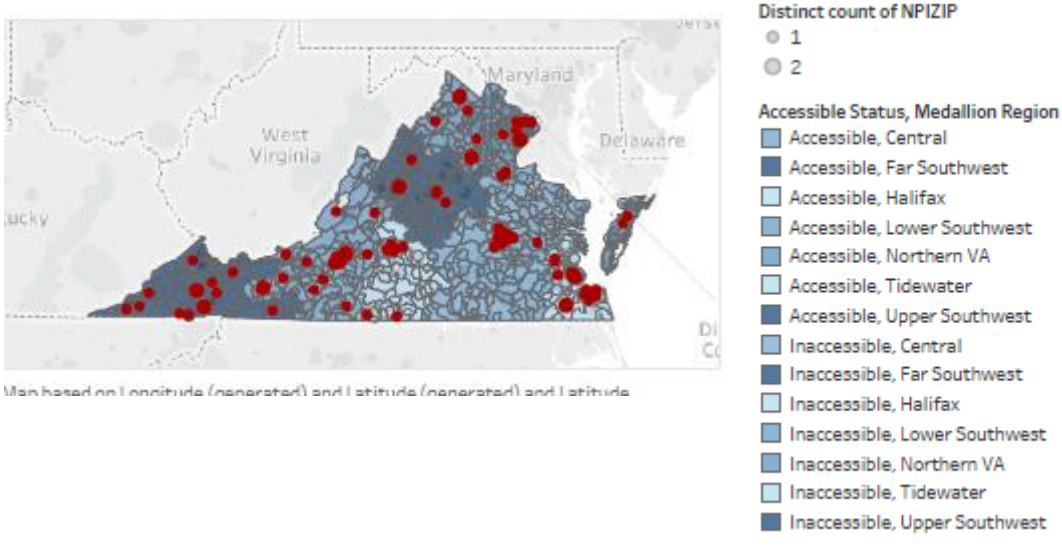
ASAM Level 4: Inpatient Detox



Substance use Case Management

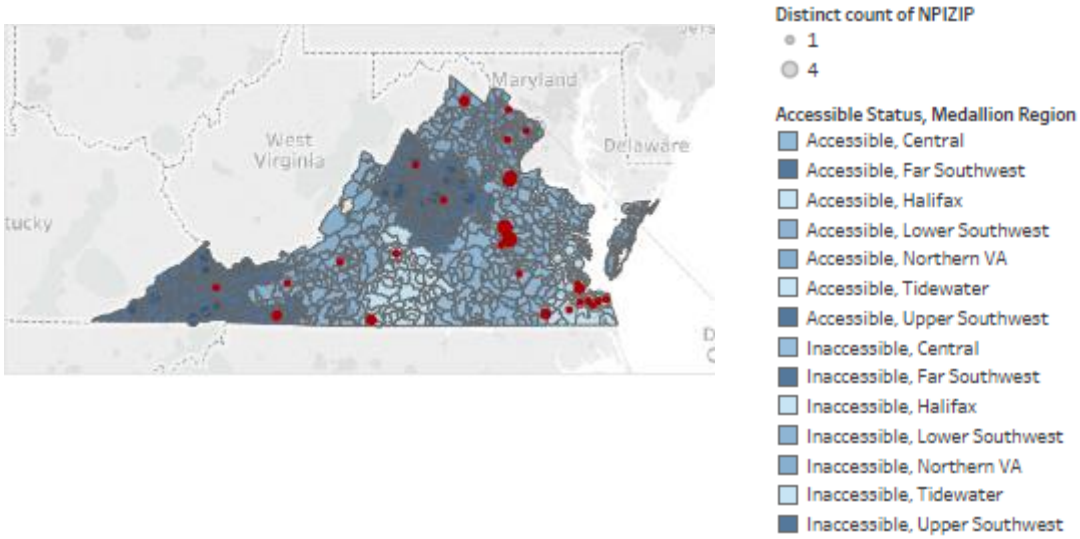


Office Based Opioid Treatment (OBOT)



Map based on Longitude (generated) and Latitude (generated) and Latitude

Opioid Treatment Providers (OTP)



The American Society of Addiction Medicine (ASAM) levels of care and service authorization requirements are as follows:

ASAM Level of Care	ASAM Description	Service Authorization Required?
4.0	Medically Managed Intensive Inpatient	Yes
3.7	Medically Monitored Intensive Inpatient Services (Adult) Medically Monitored High-Intensity Inpatient Services (Adolescent)	Yes
3.5	Clinically Managed High-Intensity Residential Services (Adults)/Medium Intensity (Adolescent)	Yes
3.3	Clinically Managed Population-Specific High-Intensity Residential Services (Adults)	Yes
3.1	Clinically Managed Low-Intensity Residential Services	Yes
2.5	Partial Hospitalization Services	Yes
2.1	Intensive Outpatient Services	Yes
1.0	Outpatient Services	No
OTS	Opioid Treatment Program (OTP)	No
OTS	Office-Based Opioid Treatment (OBOT)	No
0.5	Early Intervention/Screening Brief Intervention and Referral to Treatment (SBIRT)	No
n/a	Substance Use Case Management	Yes (or Registration)
n/a	Peer Recovery Support Services	Yes (or Registration)

The data below (Figure 12) shows an increase in service authorizations for Intensive Outpatient Services compared to services approved based on medical necessity utilizing ASAM) Criteria.

This Intensive Outpatient Program did not require a service authorization prior to ARTS. Peer Recovery Support Services require registration or service authorization and are shown in Figure 13. The MCOs and Magellan of Virginia are providing outreach and training to providers regarding ASAM Criteria to further improve appropriateness of authorization requests.

Figure 12: Service Authorization for ASAM Level 2.1 to 4.0

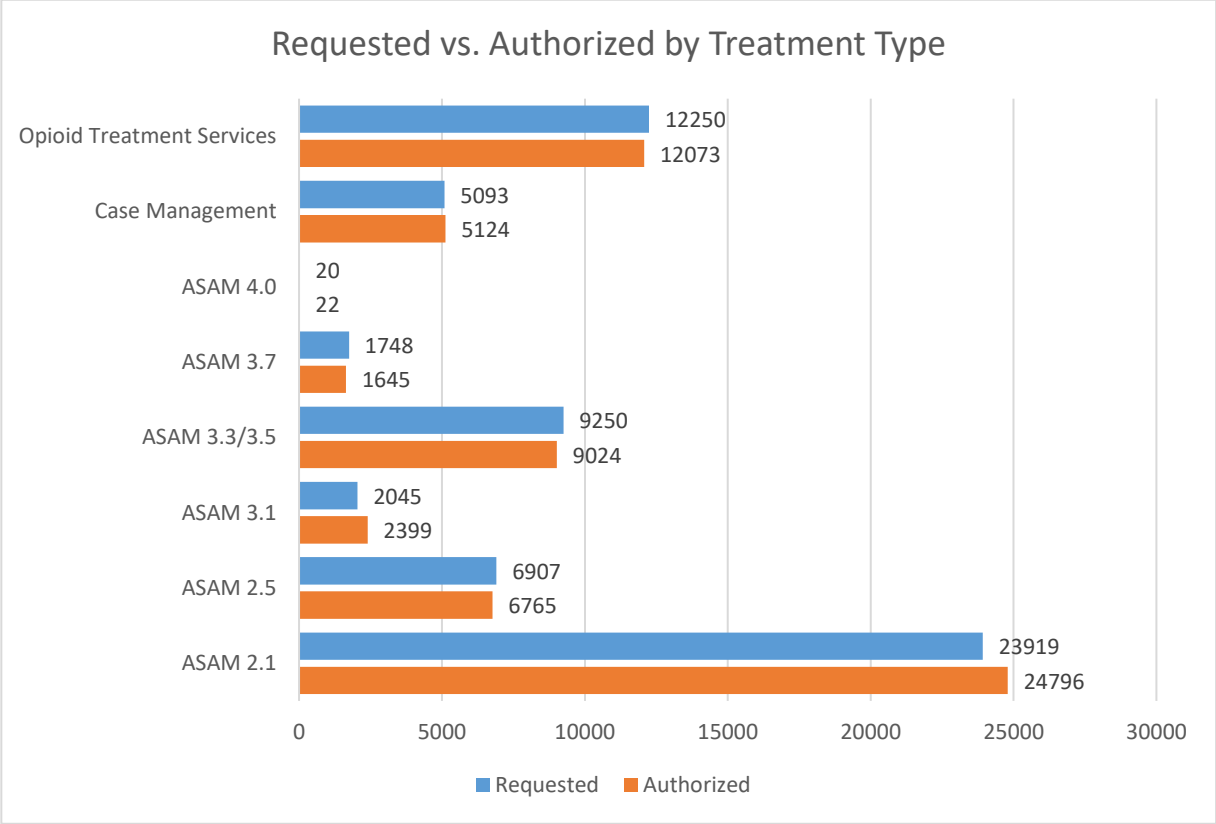
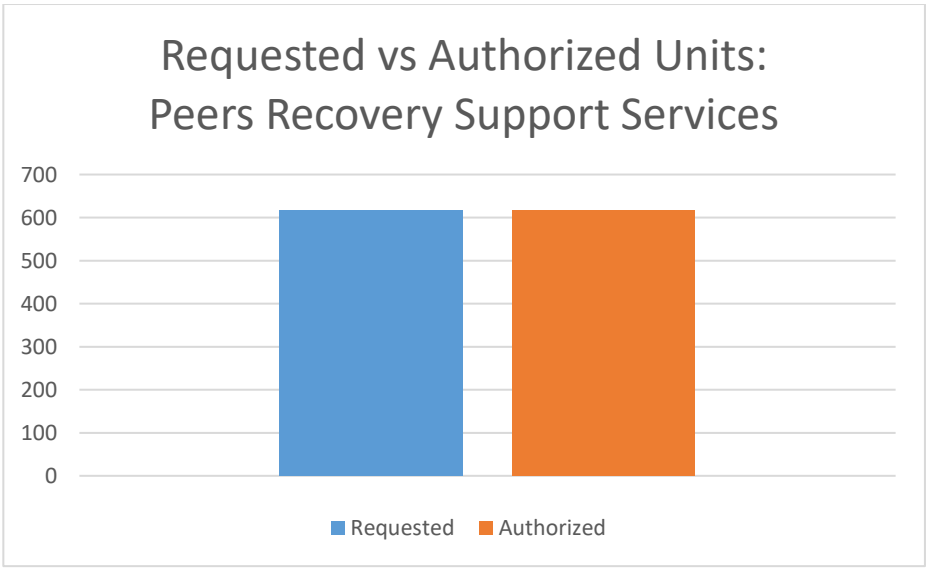


Figure 13: Service Authorizations or Registrations for Peer Recovery Support Services, April – June 2019



BUDGET NEUTRALITY AND FINANCIAL REPORTING

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

CONSUMER ISSUES

There were no significant consumer issues reported during the second quarter.

CONTRACTOR REPORTING REQUIREMENTS

DMAS recently updated its reporting requirements for August data to ensure reporting is streamlined and consistent among all the MCOs.

DMAS requires monthly reporting from the MCOs on service authorization, provider network, appeal and grievances and patient utilization management (PUMS) related to ARTS. The MCOs and Magellan of Virginia continue to utilize standardize service authorization form to ensure align with ASAM Criteria. DMAS has developed a new PUMS report that is sent out to the MCOs that report all members who participate in PUMS to ensure smooth transition among MCOs.

The DMAS vendor contracted to perform the ASAM site visits for residential treatment providers performed one new site visit and approval for a level 3.1 provider. DMAS continues to work with providers and MCOs to develop means to recruit more SUD residential in-network providers.

DMAS's physician review panel continues to review the applications for Preferred OBOT Providers to ensure they meet the ASAM Criteria. As of this reporting period, there are a total of 115 Preferred OBOT Providers approved. During this reporting period there were four newly recognized Preferred OBOTs.

The table (Figure 14) below represents the current network by ASAM Level of Care and change in numbers of Medicaid enrolled providers for this reporting period.

Figure 14: ARTS Provider Network Counts

Addiction Provider Type	# of Providers before ARTS	# of Providers after ARTS	% Increase in Providers
Inpatient Detox (ASAM 4.0)	Unknown	103	NEW
Residential Treatment (ASAM 3.1, 3.3, 3.5, 3.7)	4	87	↑ 2075%
Partial Hospitalization Program (ASAM 2.5)	0	22	NEW
Intensive Outpatient Program (ASAM 2.1)	49	137	↑180%
Opioid Treatment Program	6	38	↑ 533%
Preferred Office-Based Opioid Treatment Provider	0	108	NEW

DMAS continues to work to update the google map on a quarterly basis. The map may be located: https://www.google.com/maps/d/viewer?mid=1px9XvltnM7rXZ6vrTgXgPGIHTew&hl=en&usp=sharing

LESSONS LEARNED AND OUTREACH

DMAS continues to receive positive feedback from members, community leaders, providers, the MCOs and Magellan of Virginia on the transparency, outreach and willingness to engage feedback for a successful implementation, as well as the resolution of any concerns. DMAS has received positive feedback from community leaders and members who have received services.

DMAS is working with the Department of Health Professions to promote the utilization of telemedicine and medication assisted treatment. DMAS has drafted a provider bulletin and is currently in review internally at DMAS prior to posting publicly. DMAS consulted with the regional contact at the Drug Enforcement Agency (DEA) to review the bulletin to confirm it meets the policy requirements of the DEA.

DMAS staff met with Peer Recovery Support Services (PRSS) stakeholders to discuss some potential barriers that may be hindering the use of these services across providers. Stakeholders mentioned the requirements as major barriers: 1) the Peer Wellness and Resiliency Plan (treatment plan) is too cumbersome; 2) requirement of a licensed professional to provide supervision; and 3) reimbursement being too low to support all the requirements by DMAS. DMAS worked to address some of the barriers and provided further clarity to the PRSS Provider Manual Supplement which was finalized and posted during this reporting period. DMAS staff continue to work towards establishing a PRSS workgroup to address other barriers.

DMAS staff continues to attend and present at various conferences to discuss the ARTS benefit and how it can assist members in recovery. This included presentations at the 2019 Rx Drug Abuse and Heroin Summit, the National Association of State Health Policy (NASHP) Federally Qualified Health Center (FQHC) Summit, Medicaid Evidence-based Decisions Project (MED) conference, the 2019 Carilion Women's Health and Perinatal Conference, Opioid Use Disorders in Primary & Specialty Care Conference facilitated by a local FQHC, among other local events.

EVALUATION ACTIVITIES AND INTERIM FINDINGS

DMAS continues to meet regularly with the VCU research team. Currently VCU is working on the 24 month evaluation report for DMAS and is estimated to be finalized in August 2019. DMAS reported on the first 15 months evaluation in the last 1115 Demonstration Waiver annual report. DMAS is working with VCU on the current year agreement and looking at special populations to include re-entry and pregnant woman.

CONCLUSION

DMAS continues to work with providers, MCOs and Magellan of Virginia to identify issues and foster the lines of communication between these parties. DMAS is committed to finalizing the VCU evaluation and have the 24 month evaluation available for the next quarterly report.

DMAS continues to track outcomes for providers assessing members and facilitating access to MAT along the continuum of care. DMAS also is focusing efforts to further decrease overdose deaths across the state through encouraging MAT during and after release from institutional settings, including hospitals, emergency departments, jails, and inpatient rehabilitation.

STATE CONTACT(S)

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

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Former Foster Care Youth

INTRODUCTION

Individuals in foster care face a number of challenges upon the termination of their state custodianship, including access to health care. The "Former Foster Care Child Under Age 26 Years" Medicaid covered group provides an opportunity for this population to continue receiving Medicaid coverage until age 26, allowing these individuals time to transition into managing the responsibilities of living independently.

BACKGROUND

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

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

In May 2017, DMAS submitted an amendment to the GAP Demonstration Waiver to request approval to provide Medicaid coverage to former foster care youth who were enrolled in Medicaid and foster care in another state and who are now living in Virginia and are applying for Virginia Medicaid. Approval of the waiver amendment was received on September 22, 2017.

GOALS

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

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

ELIGIBILITY AND BENEFIT INFORMATION

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

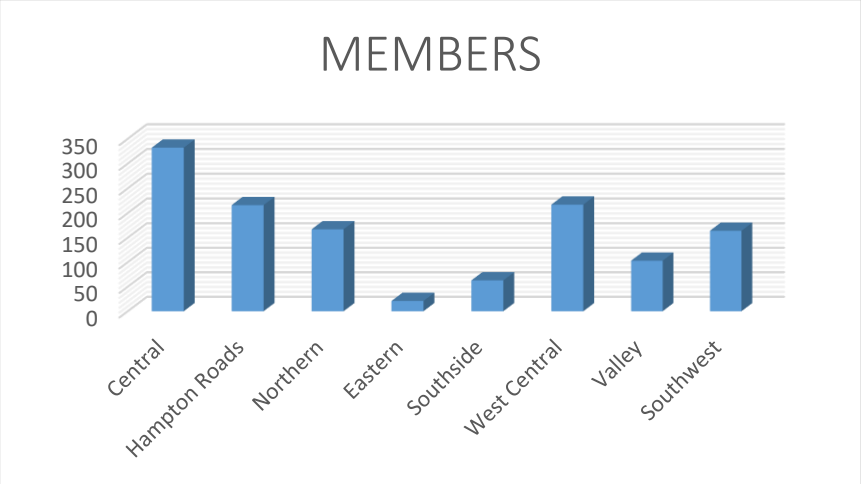
Foster Care Child Under Age 26 covered group receive the full Medicaid benefit package, including long-term supports and services, if medically necessary.

ENROLLMENT COUNTS FOR YEAR TO DATE

ELIGIBILITY GROUP	CALENDAR YEAR 2019 QUARTER 2			TOTAL QUARTER MEMBER MONTHS	TOTAL QUARTER UNIQUE MEMBERS
	April 2019	May 2019	June 2019		
Former Foster Care					
Eligible Member Months	1,260	1,286	1,283	3,829	1,354

AS OF DATE	6/30/2019
MEMBER AGE	MEMBER COUNT
18	38
19	189
20	248
21	232
22	194
23	152
24	121
25	109

REGION	MEMBERS
Central	332
Hampton Roads	216
Northern	167
Eastern	21
Southside	63
West Central	217
Valley	103
Southwest	164



OPERATIONAL UPDATES

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

PERFORMANCE METRICS

By implementing the demonstration, Virginia anticipated increasing healthcare coverage for former foster care youth, while improving health outcomes. The design for evaluating the first demonstration year was approved by CMS and covered the September 2017 to December 2019 time period, representing the start and end dates of the demonstration year. The evaluation addressed three questions:

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

DMAS has requested guidance on the continuation of the evaluation design from CMS. No changes to the evaluation design are planned pending the receipt of guidance from CMS. The approved evaluation design from 2018 is contained in Appendix A.

COLLECTION & VERIFICATION OF UTILIZATION & ENROLLMENT DATA

The first evaluation evaluated administrative data (enrollment, claims, and encounters) available in the MMIS at the end of the first (fall 2018) demonstration year. The evaluation was conducted using existing administrative data, and no prospective data (e.g., beneficiary surveys, interviews, focus groups, or other quantitative or qualitative data) was collected due to resource limitations. The evaluation did not include pretest (or baseline) data because DMAS only has access to data on individuals in the demonstration after they receive Medicaid coverage. The next evaluation will be completed at the end of the second demonstration year (winter 2020). DMAS has requested guidance on the continuation of the evaluation design from CMS. No changes to the evaluation design are planned pending the receipt of guidance from CMS.

BUDGET NEUTRALITY AND FINANCIAL REPORTING

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

ELIGIBILITY GROUP	Budget Neutrality DY 3 Full year estimate	1/4 of Full Year Estimate		DEMONSTRATION YEAR 5 (CALENDAR YEAR 2019) QUARTER 2 April 2019	May 2019	June 2019	TOTAL QUARTER
Pop Type:	Expansion			Former Foster Care Transfers from Out of State			
Eligible Member Months	830	208		77	74	72	223
PMPM Cost	$ 508.28	$ 508.28		$ 565.10	$ 762.07	$ 757.06	$ 692.44
Total Expenditure	$ 421,869	$ 105,467		$ 43,513	$ 56,393	$ 54,508	$ 154,414

CONSUMER ISSUES

Benefits are provided through the state's fee-for-service and managed-care delivery systems. No complaints or issues have been identified to date. There were no appeals filed related to this population during this reporting period.

CONTRACTOR REPORTING REQUIREMENTS

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

RECOVERY NAVIGATORS

The FFCY demonstration does not utilize Recovery Navigators.

LESSONS LEARNED

There is nothing to report at this time.

EVALUATION ACTIVITIES

The evaluation of the first demonstration year covered the September 2017 to December 2019 time period. The design for evaluating the demonstration was approved by CMS, and interim evaluation findings were submitted to CMS in March 2019 in a separate document. DMAS has requested guidance on the continuation of the evaluation design from CMS. No changes to the evaluation design are planned pending the receipt of guidance from CMS.

CONCLUSION

The demonstration was implemented as a measure to continue Medicaid coverage for former foster care youth who received their services in another state but who are now living in Virginia. This group was formerly covered in Virginia under the State Plan; the change in the authority mechanism did not necessitate any changes to the application process for these individuals or how they receive Medicaid coverage.

ENCLOSURES

- Appendix A- FFCY Draft Evaluation Design

STATE CONTACT(S)

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

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