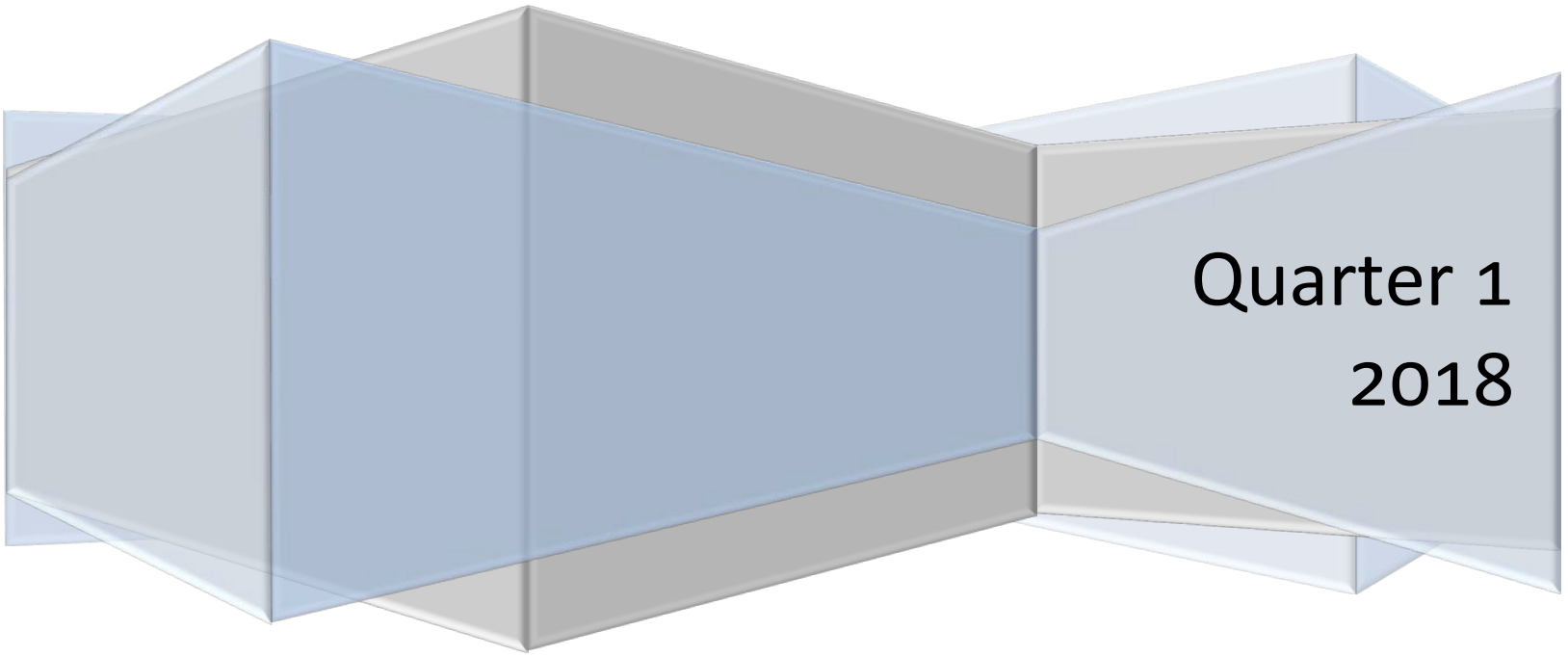
Virginia Department of Medical Assistance Services

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

Section 1115 Quarterly Report

Demonstration Waiver 1115
Project 11 – W- 00297/3

Demonstration Year: 4 (01/01/2018 – 12/31/2018)
Quarter 1 (01/01/2018-03/31/2018)
Approval Period (1/12/2015-12/31/2019)



Governor's Access Plan

INTRODUCTION

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

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

In May 2017, DMAS submitted an amendment to the GAP Demonstration Waiver to request approval to provide Medicaid coverage to former foster care youth (FFCY) who were enrolled in Medicaid and foster care in another state and who are now living in Virginia and are applying for Virginia Medicaid. Approval of the waiver amendment was received on September 22, 2017. Virginia's overall goal for the FFCY benefit is to serve foster care youth with the access to health services they need, with full Medicaid coverage.

This report highlights progress made during Quarter 1 of the fourth year of the GAP Demonstration. This report is organized to reflect the GAP, ARTS, and FFCY components of the waiver.

BACKGROUND

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

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

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

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

GOALS

The three key goals of the GAP Demonstration are to:

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

ELIGIBILITY AND BENEFIT INFORMATION

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

Figure 1: GAP Eligibility Requirements

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

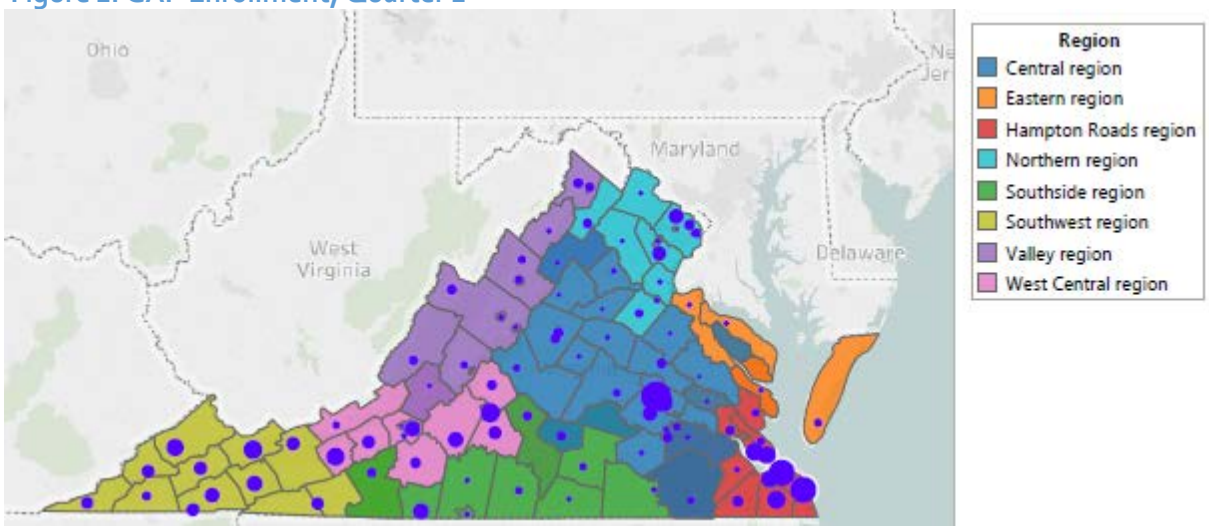
DMAS has continued to see increased enrollment with the Demonstration continuing during Quarter 1. Individuals are receiving information about the program and applying through their relationships with local entities. The partnerships, which DMAS has with the local Community Services Boards (CSBs) and Magellan, in addition to a growing relationship with the FQHCs, are attributable to the continued success.

ENROLLMENT COUNTS FOR YEAR TO DATE

GAP MEMBER POPULATION

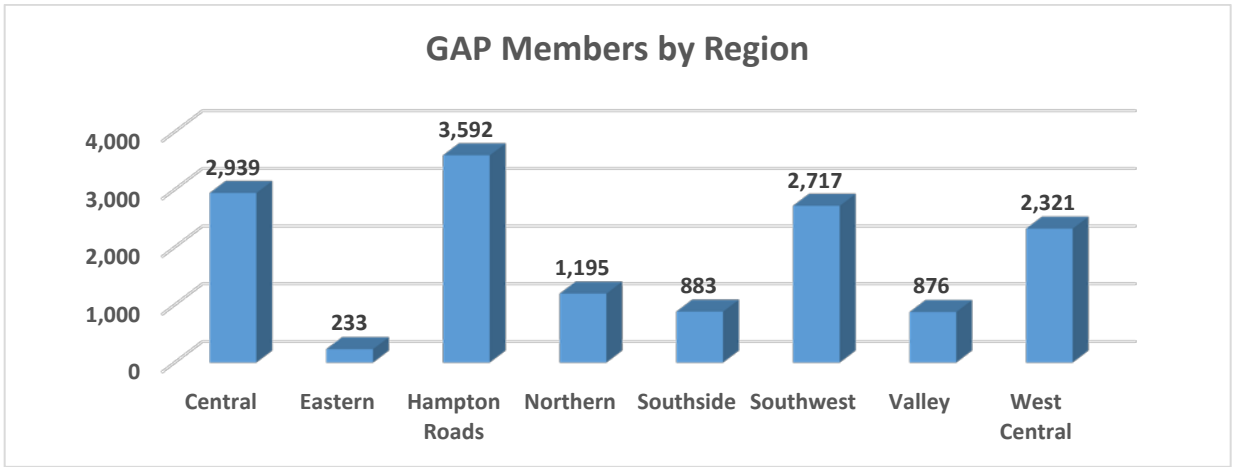
DMAS currently provides coverage to approximately 1,236,518 enrolled in Medicaid. Approximately 1.12% of these beneficiaries are enrolled in GAP. In the following Figures and Tables, the population displayed includes GAP members categorized by location, race/ethnicity, gender, age group and primary diagnosis.

Figure 2: GAP Enrollment, Quarter 1



GAP membership continues to steadily grow. In the quarter ending March 31, 2018, there were 14,756 individuals enrolled from 266 unique localities across the Commonwealth. The map shown in Figure 2 shows the location of members enrolled across the Commonwealth of Virginia.

Figure 3: GAP Members of the Commonwealth by Region, Quarter 1



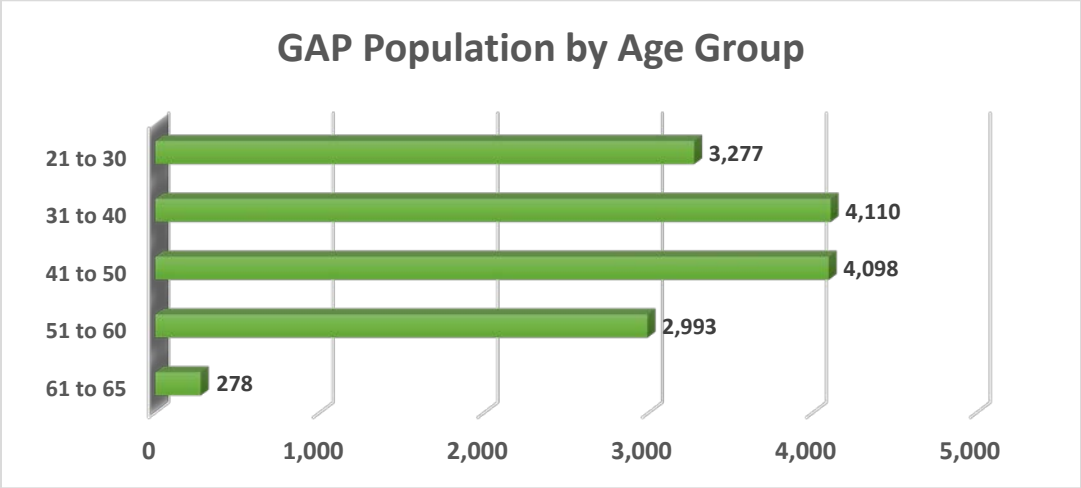
The figure above displays the geographic distribution of the GAP population, broken down by regions in Quarter 1. As highlighted in the figure, the Hampton Roads region continues to house the largest concentration of GAP members at 3,592 with the Central (2,939 members) and Southwest (2,717 members) regions closely following. These regions have remained the top 3 enrollment by region since the beginning of GAP.

Figure 4: GAP Enrollment, Quarter 1

Demonstration Population	Total Number of members Quarter Ending 3/31/2018	Members Enrolled Since 01/12/2015
GAP Members Enrolled	14,756	21,059

There have been 21,059 unique members enrolled since the implementation of the Demonstration. The difference between the unique members' number and the currently enrolled number may be associated those that did not successfully complete the eligibility renewal/re-enrollment process or those that have moved to full Medicaid, or gained other insurance coverage.

Figure 5: GAP Members by Age Group, Quarter 1



The age demographics of GAP members remain relatively equal across all eligible age groups with the exception of members over the age of 61. Figure 6 displays the distribution of GAP members by age group, details age demographics among the GAP member population. The 31-40 age group remains the largest population of GAP members at 28%.

Figure 6: Cover Virginia Renewals, Quarter 1

Of the **4,063** GAP renewals due to Cover Virginia in Quarter 1:	**3,773** were approved
	115 were cancelled due to ineligibity
	146 were cancelled due to member inaction

In November 2015, Cover Virginia began the exparte renewal process, which allowed for electronic systematic verification of information (such as income) to determine eligibility for members approaching their renewal. Figure 7 highlights the number of renewal approvals and cancellations completed in Quarter 1. Overall, in Quarter 1, 92.9% of the renewals were approved.

OPERATIONAL UPDATES

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

Effective 7/1/2017, GAP members became eligible to receive Mental Health Peer Supports and ARTS Peer Supports. During Quarter 1, there have been no service authorizations for GAP members receiving Peer Supports services. There are a total of 14 credentialed providers for this level of care in Magellan's network. DMAS anticipated a slow start up for this level of care. During Quarter 1, DMAS spoke with providers and Magellan regarding barriers to GAP members accessing Peer Recovery Services for mental health and substance abuse. DMAS is planning to work with Magellan during Quarter 2 to ensure that members and providers are aware that GAP members are eligible to receive these services in their communities and continue to partner with the provider network to decrease any barriers.

PERFORMANCE METRICS

DMAS continues to see an increase in enrollment for the GAP population. In Quarter 1, Magellan received 2,861 SMI screenings for review and Cover Virginia processed 1,050 financial applications for coverage. In Quarter 1, 6,371 GAP members accessed physical health care, 899 accessed behavioral health care, and 154 accessed both physical and mental health care. In Quarter 1, 7,682 GAP members accessed preventive medical care services. It is noteworthy that in Quarter 1, 3,517 GAP members are utilizing GAP case management services, which focused on assisting individuals with accessing needed medical, behavioral health (psychiatric and substance abuse treatment), social, education, vocational, and other support services. This is an increase in utilization over previous quarters.

OUTREACH/ INNOVATION ACTIVITIES TO ASSURE ACCESS

DMAS continues to implement a multi-faceted approach to educate potential members, families, advocates, providers and other stakeholders about GAP. During Quarter 1, DMAS continued Phase II of the GAP outreach plan focusing on ongoing awareness.

In an effort to increase the completion of applications and care coordination with this transient population, DMAS and Magellan focused on efforts to ensure members and providers are aware that GAP members have access to receive free cell phone service through the SafeLink program. Through Magellan, GAP members receive a free mobile phone, cellular minutes, and health messaging services. Members also receive additional access to care and support as well as health and reminder tips. This special version of the program is specifically for members of Virginia's Medicaid behavioral health program. In 2017, less than 1% of the GAP population is receiving the benefits associated with the SafeLink Program.

During Quarter 1, Magellan and DMAS met and discussed barriers and plan to increase access and usage of Safelink. Barriers to GAP member utilization of this program: limit to one Safelink phone per household address, the transient and homeless population, and those residing in other homes where a Safelink phone is registered therefore prohibiting a successful application. GAP Staff will continue to meet with Magellan to discuss the details related to the SafeLink program and how to increase availability and usage in Quarter 2.

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

Since January 2015, Magellan hosted conference calls for GAP providers and members. As the volume of questions from GAP providers decreased, providers were invited to join the general Magellan provider call, GAP was added to that agenda to allow for any GAP specific questions, comments or concerns. DMAS and Magellan staff host these calls and answer questions from the provider network as well as provide updates and announcements as needed. A low number of GAP issues continue to be identified on these monthly calls. GAP questions and responses are monitored by DMAS staff to ensure accurate information is disseminated.

Another avenue for outreach has been the email address for the public to make inquiries about GAP: BridgetheGAP@dmas.virginia.gov . This email inbox is monitored daily by DMAS GAP staff. Designed to address general information about the GAP plan and its policies, DMAS staff has been successful with supplying providers and members with electronic materials (such as the GAP supplemental manual and Medicaid memos) via email to increase awareness about GAP. This quarter, the majority of the emails received came from providers; most inquires involved questions regarding covered medical services and procedure codes. Additionally, providers are utilizing the email to request presentations and print materials.

DMAS' also maintains a GAP webpage on the DMAS website: http://www.dmas.virginia.gov/Content_pgs/gap.aspx. The webpage includes sections for individuals, providers and other stakeholders. The webpage has links to Cover Virginia and Magellan as well as other helpful information for individuals who may be interested in applying for GAP, current GAP members and providers. The GAP webpage received 8879 page views during Quarter 1, of which 6,648 were unique page views between January 1, 2018 and March 31, 2018. The GAP webpage is averaging approximately 550 views per week. This number has remained consistent throughout the demonstration.

Cover Virginia's website (http://www.coverva.org/gap.cfm) includes a webpage dedicated to GAP and outlines the financial eligibility criteria and application process. It also includes a picture of the GAP ID card. During Quarter 1, the GAP Information Flyer was updated and posted in Spanish.

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

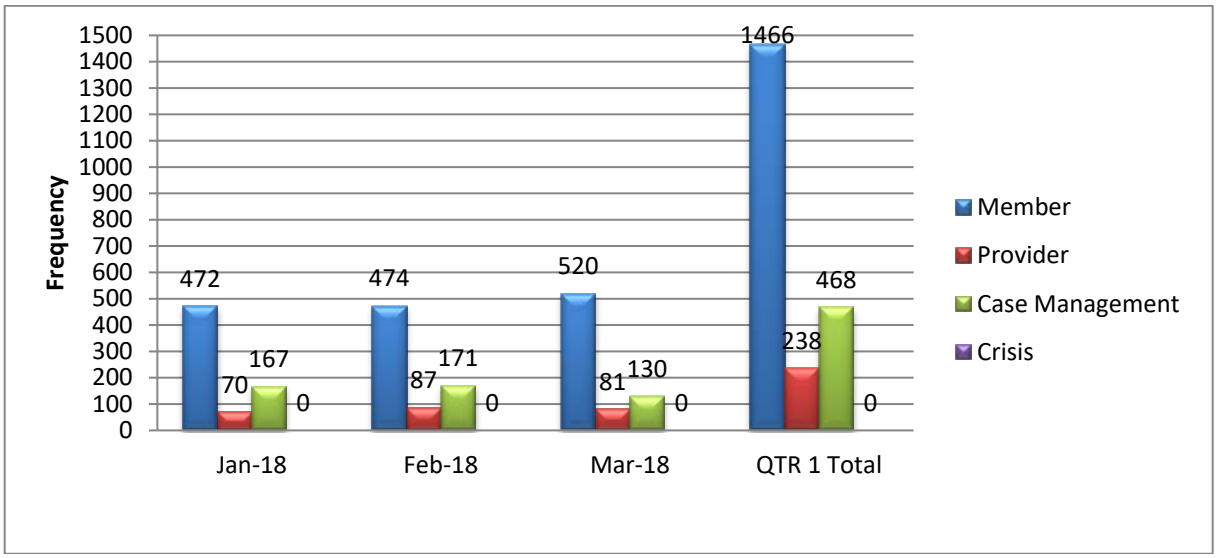
See additional outreach efforts located in Appendix A.

COLLECTION & VERIFICATION OF UTILIZATION & ENROLLMENT DATA

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

The Magellan Call Center provides monthly data to DMAS about calls received related to GAP. Figure 12 below reflects the types of calls they receive:

Figure 7: BHSA Call Center Data, Quarter 1



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

BUDGET NEUTRALITY AND FINANCIAL REPORTING

The state provides, as Appendix D of this Report, an updated budget neutrality workbook for Quarter 1 that includes established baseline and member month's data that meets all the reporting requirements for monitoring budget neutrality.

CONSUMER ISSUES

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

CONTRACTOR REPORTING REQUIREMENTS

DMAS receives reports from Magellan regarding care coordination, Peer Supports/Recovery Navigator Services, warm line and routine utilization. DMAS receives weekly reports from Cover VA regarding number of eligibility applications being processed. During Quarter One 2018, DMAS continued to receive all necessary reports from contractors. When additional clarification is needed regarding reporting requirements, Magellan and DMAS hold conference calls and provide details to ensure data received is accurate and timely.

During Quarter 1, DMAS changed a reporting requirement regarding the SMI component of the screening process from quarterly to monthly. Having access to this data monthly will allow DMAS to more closely monitor Magellan's screening process to ensure the individuals that are deemed clinically eligible are reviewed appropriately. DMAS will begin receiving the monthly file in Quarter 2.

DMAS is exploring using predicative modeling tools to assist in identifying GAP members with the highest level of need. GAP staff were introduced to the Pharmacy Based Risk Adjustment Model. The model can be used to capture high and low risk GAP members from pharmacy data (medication management and adherence) based on cost of the medications. Pharmaceutical cost data offers a detailed, longitudinal record of utilization, diagnoses, procedures, and prescriptions across the full range of health care settings. Results of analyses could potentially give insight to and suggest higher levels of medical vulnerability and need for coordination of health and mental health services in the GAP population. DMAS continues to consider whether this model will relate appropriately to the goals of the waiver.

RECOVERY NAVIGATORS

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

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

In Quarter 1, there were 337 total referrals to Recovery Navigation. There was an average of 143 members enrolled in Recovery Navigation. There is an average of 38 new members per month to Recovery Navigation. The average number of days in Recovery Navigation is 118. There was a total of 48 calls in Quarter 1 to the "Warmline", an evening and weekend support line each month, staffed by the Recovery Navigators. Of the supports delivered to GAP members by Recovery Navigation, emotional support, empathy, caring, concern, was the primary delivery type followed by informational, providing knowledge and information about skills and training.

DMAS gathers success stories and experiences of these navigators; below is one account narrated by a Recovery Navigator from Quarter 1:

A 58 year old female GAP member with a history of multiple psychiatric hospitalizations and a previous suicide attempt was referred for Recovery Navigation following a Crisis Stabilization admission for depressive symptoms. As the Recovery Navigator and the member worked on her Wellness Recovery Action Plan, a goal was for her to pursue a wellness tool of advocating for herself and educating herself about her mental illness. To meet this goal, she started attending a local consumer advocacy group monthly. Since the Recovery Navigator also attends this group, they are able to see each other regularly. She also began calling the Recovery Navigator to give her updates about her progress or if she needs extra support.

The member decided that she would like to be a Peer Recovery Specialist and has successfully completed training in Quarter 1. She has also accepted an offer to be on the board at Southwest Virginia Mental Health Institute. She has also co-presented a workshop at the Virginia Psychiatric Association conference.

Figure 8: 8 Dimensions of Wellness

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

Recovery Navigators offer support framed around the eight dimensions of wellness. Wellness means overall well-being. It includes the mental, emotional, physical, occupational, intellectual, and spiritual aspects of a person's life. The Eight Dimensions of Wellness, as defined by Substance Abuse, Mental Health Services Administration (SAMHSA) may also help people better manage their condition and experience recovery. Figure 15 describes each dimension.

PEER SUPPORTS: MENTAL HEALTH AND ARTS

During Quarter 1, there were no service authorizations for GAP members receiving Peer Supports services. There are 14 credentialed providers for this level of care in Magellan's network.

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

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

LESSONS LEARNED

DMAS continues to evaluate how processes and procedures can be refined and strengthened. At this stage of GAP, significant progress has been made to increase the awareness and outreach of the benefit plan since implementation. Working with all stakeholder groups has been critical to the success of the program and DMAS believes the unified approach allowed for the program to have continued growth. Since implementation, DMAS has seen a low number of grievances or reconsiderations. Data exhibits high utilization of non-mental health medications among members. This shows that members are continuing to access both medical and behavioral health services, which is one of the three GAP Demonstration goals.

EVALUATION ACTIVITIES AND INTERIM FINDINGS

DMAS has a part time data analyst dedicated to GAP who has statistical/epidemiological background and a strong understanding of the GAP waiver. Robust data and analysis of service utilization, trends, and noteworthy data are provided for review by clinical staff and for further collaboration with contractors. The evaluation design draft is on hold due to the Virginia General Assembly has not passed a budget and the CMS required independent evaluation requires additional funding for DMAS to complete. In the interim, DMAS continues to review data and objectives related to the initial evaluation design.

CONCLUSION

During Quarter 1, DMAS continued to focus on increasing access to healthcare for the population in Virginia with significant behavioral health and medical needs and is committed to recognizing how access to care impacts the members ability to live, work, and function successfully. DMAS has seen increased enrollment in Quarter 1 and growth in the GAP program, which allows more individuals to gain access to health care in Virginia. DMAS is also committed to continued collaboration with its contractors and stakeholders to develop higher confidence in the data process as well as identify additional opportunities to better serve our members throughout the remainder of 2018.

Addiction and Recovery Treatment Services

INTRODUCTION

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

This report highlights progress made with the State's implementation of the system transformation of the SUD treatment services: ARTS.

BACKGROUND

Virginia's 1.1 million members enrolled in Medicaid are disproportionately impacted by the substance use epidemic. Over 1,100 Virginians died from opioid overdoses in 2016, nearly doubling since 2011. Nationally, Medicaid members are four times more likely than people with private insurance to have ever used heroin or had pain reliever dependence. Medicaid members are also prescribed opioids at twice the rate of non-Medicaid members and are at three-to-six times the risk of prescription opioid overdose. The financial impact is nearly as great as the human cost. Virginia spent $44 million on Medicaid members with a primary or secondary diagnosis of SUD who were admitted to hospitals or Emergency Departments in 2014. The Governor's Task Force on Prescription Drug and Heroin Addiction, due to the overwhelming impact of substance use disorders for member's enrolled in Medicaid, made a recommendation to increase access to treatment for opioid addiction for Virginia's Medicaid members by increasing Medicaid reimbursement rates. Thus DMAS developed a large stakeholder and provider workgroup to work in collaboration to develop the comprehensive benefit for substance use disorder treatment services: ARTS, which implemented on April 1, 2017. Even after ARTS implementation, Virginia continues to be impacted by the opioid epidemic. In 2017, VDH estimated that over 1,500 individuals died as a result of drug overdoses; nearly 80% involved prescription opioids, heroin, or fentanyl.

GOALS

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

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, FAMIS, FAMIS MOMS and GAP (Note: FAMIS and FAMIS MOMS are programs covered by the Child Health Insurance Program (CHIP) benefit). The ARTS benefit is covered through the fee for service, Medallion 3.0 Managed Care, and Commonwealth Coordinated Care Plus (CCC Plus) Medicare/Medicaid Programs. All MCOs and Magellan of Virginia are covering the full range of ARTS services.

Expansion of the administration of community-based addiction and recovery treatment services	•Transition through the DMAS contracted managed care organizations (MCOs) including Medallion 3.0, Commonwealth Coordinated Care (CCC) and CCC Plus. •The DMAS contracted Behavioral Health Services Administrator (BHSA), Magellan of Virginia, will cover ARTS for those members who are enrolled in the full coverage Fee-For-Service (FFS) and members enrolled in the GAP benefit thus providers will continue to bill Magellan for these FFS enrolled members only.
Expansion of Community-based addiction and recovery treatment services for all members	•Residential Treatment, •Partial Hospitalization, •Intensive Outpatient Treatment, •Medication Assisted Treatment/Opioid Treatment Services (includes individual, group counseling and family therapy and medication administration), and •Substance Use Case Management.
Allowing for coverage of inpatient detoxification and inpatient substance use disorder treatment for all members	•For all full-benefit Medicaid and FAMIS enrolled members. •DMAS expanded coverage of residential detoxification and residential substance use disorder 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 1.3 million members enrolled in Medicaid, FAMIS, FAMIS MOMS and GAP.

DMAS contracted with Virginia Commonwealth University (VCU) to conduct an independent evaluation of the ARTS program. Highlights of the first nine months of evaluation outcomes covering April 1, 2017 to January 1, 2018.

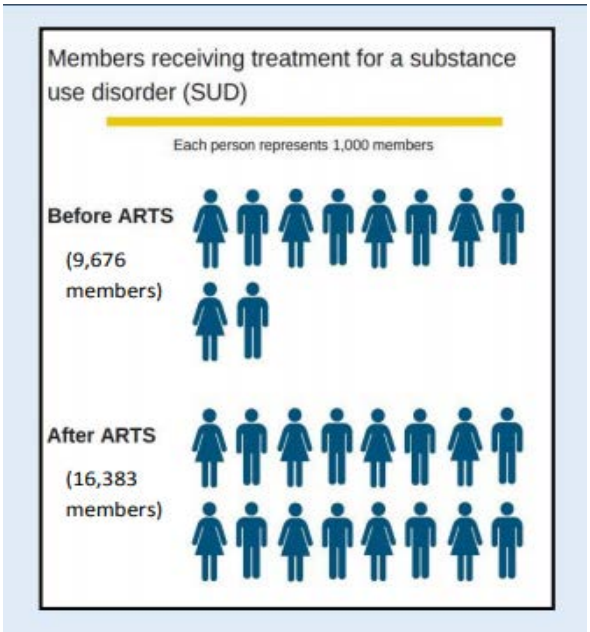
Key Findings

• Treatment rates among Medicaid members with SUD increased by 60% in the first 9 months of ARTS program being implemented.

• The number of emergency department visits related to opioid use disorders (OUD) decreased by 31% during the first 9 months of ARTS program. This is compared with a 15% decrease in emergency department visits for all Medicaid members.

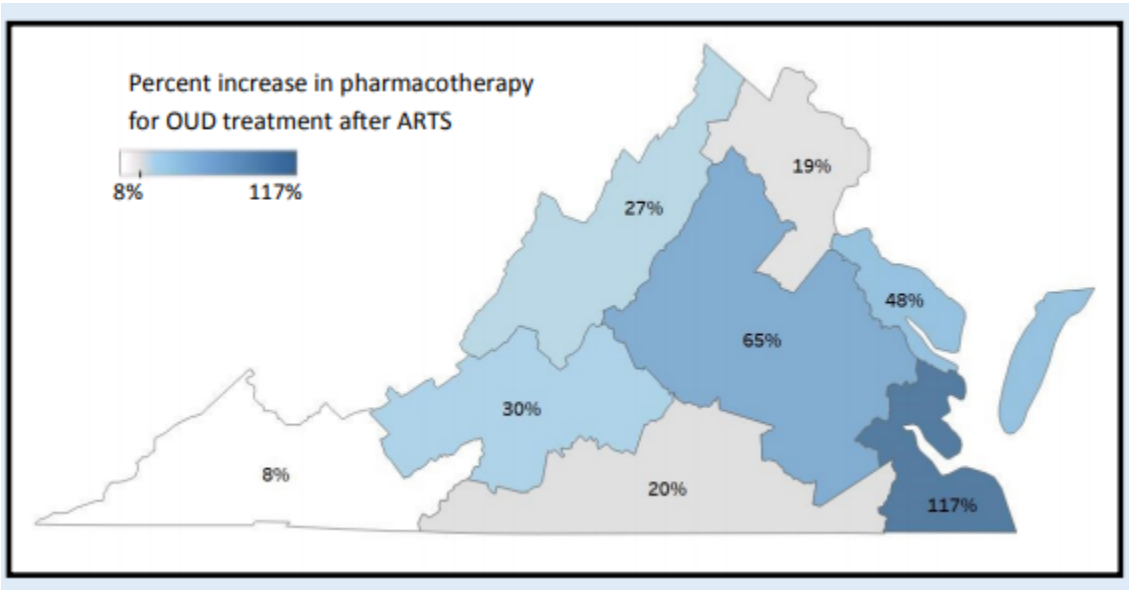
• The number of prescriptions for opioid pain medications among Medicaid members decreased by 29% during the first 9 months of ARTS.

Figure 9: Members Receiving Treatment Services



Pharmacotherapy for OUD treatment increased in all regions of Virginia after ARTS implementation. The largest increase in numbers of members receiving pharmacotherapy for OUD was 117% in the Eastern region. Rates of receiving any treatment among members has increased approximately 3% to 24% prior to ARTS, to 38% after ARTS implementation.

Figure 10: Member Receiving Pharmacotherapy for OUD



DMAS continues to work to increase member use and access of the Peer Services benefit which includes Peer and Family Support Services.

OPERATIONAL UPDATES

During Quarter 1 of year two 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. There continued to be claim issues identified by providers and reported to DMAS. DMAS worked with the MCOs and Magellan of Virginia extensively to update systems to ensure appropriate claims processing as well as providing technical assistance to providers if billing incorrectly. DMAS continued to promote the MCOs ARTS Care Coordinators, who are licensed practitioners and Registered Nurses, to help field clinical concerns, assist with member transition and discharge and field questions. DMAS continued to present on the ARTS program and provide training to various provider association and committee groups.

During this reporting period, DMAS worked with the MCOs and Magellan of Virginia to assign members receiving buprenorphine to a Preferred Office Based Opioid Treatment (OBOT) Provider or any other in-network provider if a Preferred OBOT Provider is not available and accessible. The MCOs and Magellan of Virginia cover all the members' addiction treatment services (e.g., physician visit, lab tests, counseling, medication, etc.) instead of members needing to pay out of pocket at out-of-network providers. This increased access to Preferred OBOT Providers will ensure that the member receives the counseling and "high touch" care coordination that will result in the best outcomes.

PERFORMANCE METRICS

Each MCO and Magellan of Virginia will 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 substance use disorder services. Monitoring of performance will include determining and analyzing the root causes for performance issues.

This quarter DMAS has been working to ensure that we have one standardized way across all the MCOs and Magellan of Virginia to report on the following metrics:

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge
- Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
- Timely Transmission of Transition Record
- Use of Opioids at High Dosage in Persons Without Cancer (PQA)
- Use of Opioids from Multiple Providers in Persons Without Cancer (PQA)

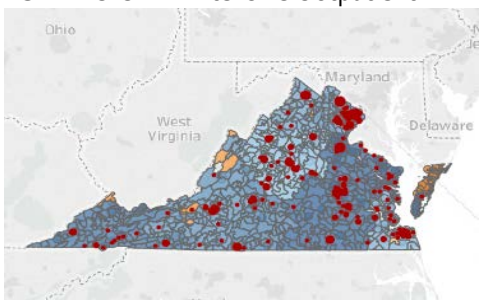
- Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (PQA)
- 180 day readmission rate for residential treatment for SUDs
- Fourteen day readmission rate among Medicaid beneficiaries for inpatient treatment for SUDs
- Alcohol Screening and Follow-up for People with Serious Mental Illness
- Continuity of Pharmacotherapy for Opioid Use Disorder

COLLECTION & VERIFICATION OF UTILIZATION & ENROLLMENT DATA

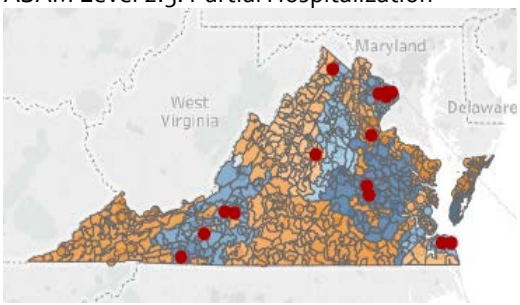
DMAS has collected data submitted from the MCOs and Magellan of Virginia on network and service authorizations for ARTS services. The Special Terms and Conditions (STCs) require the state to report for residential levels of care, at least one sublevel level of care is required to be available to recipients upon implementation within each MCO and 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. DMAS continues to work on identifying Network Adequacy across all MCOs and Magellan of Virginia.

Figures 11: ARTS Network Adequacy Maps

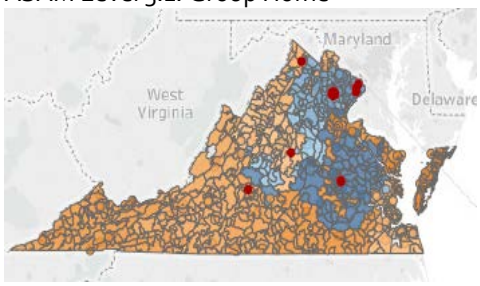
ASAM Level 2.1: Intensive Outpatient



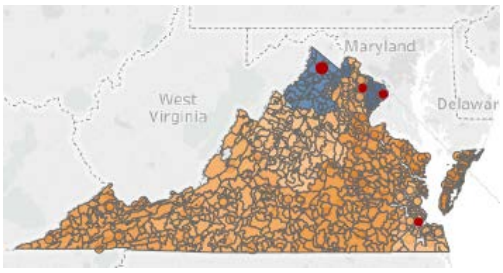
ASAM Level 2.5: Partial Hospitalization



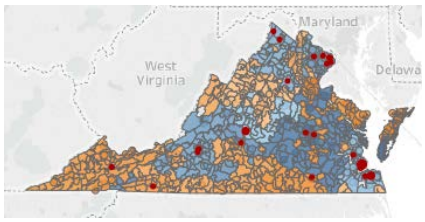
ASAM Level 3.1: Group Home



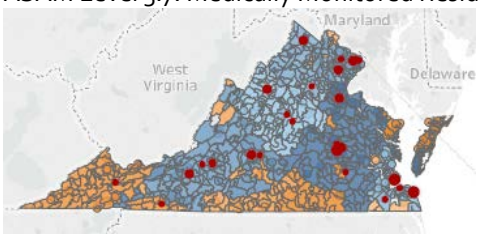
ASAM Level 3.3: Clinically Managed Residential



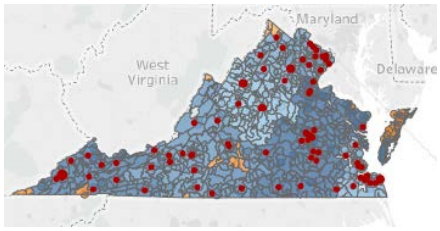
ASAM Level 3.5: Clinically Managed Residential



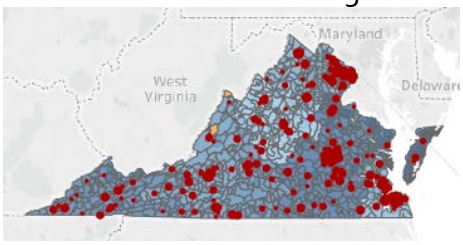
ASAM Level 3.7: Medically Monitored Residential



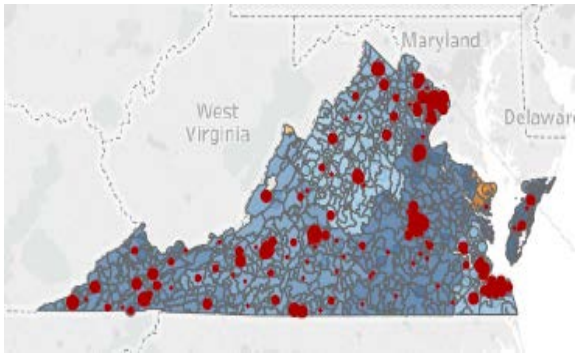
ASAM Level 4: Inpatient Detox

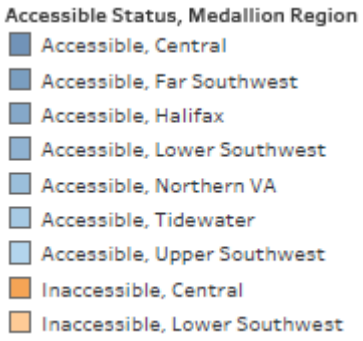


Substance use Case Management



Opioid Treatment Programs (OBOT & OTP)

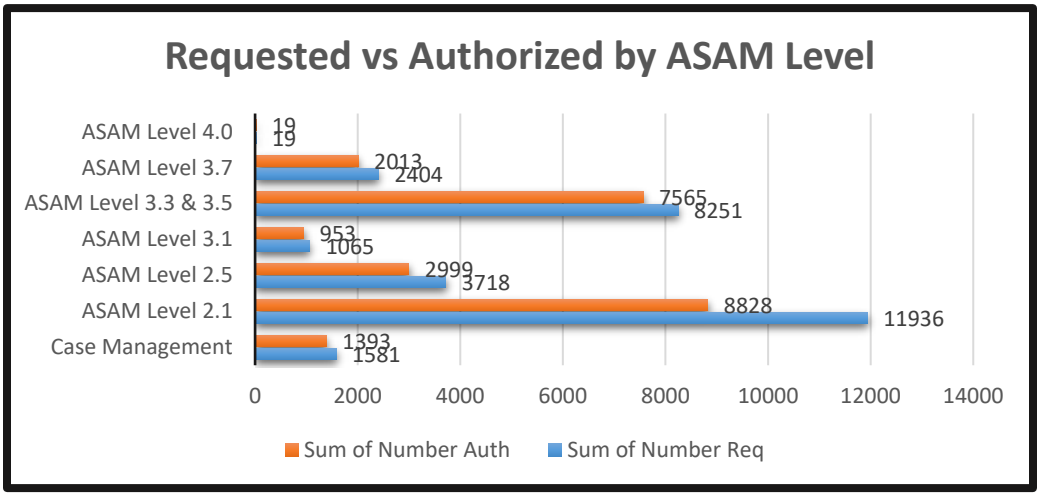




Map based on Longitude (generated) and Latitude (generated) and Latitude (generated) broken down by ASAM Level of Care. For pane Latitude (generated): Color shows details about Color and Region. Details are shown for Member Zip Code. For pane Latitude (generated) (2): Size shows distinct count of providers.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

The data below shows an increase in service authorizations for Intensive Outpatient Services (ASAM Level 2.1) compared to approved services supported through medical necessity utilizing ASAM Criteria. This service did not require a service authorization prior to ARTS. 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



BUDGET NEUTRALITY AND FINANCIAL REPORTING

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

CONSUMER ISSUES

The only concern continues to be timely access to in-network providers for buprenorphine prescriptions. The MCOs and Magellan of Virginia will continue to work with members if there are no in-network providers to ensure that members still have access to needed buprenorphine prescriptions through out of network prescribers. DMAS is working with the MCOs and Magellan of Virginia to ensure that any issues that may surface are documented and resolved.

CONTRACTOR REPORTING REQUIREMENTS

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

The MCOs and Magellan of Virginia contracts were modified to incorporate ASAM requirements into provider credentialing and networking, utilization management and service coordination processes; ensuring that service provision reviews are based on ASAM Criteria and that care coordination structures match the ASAM Criteria. The MCOs and Magellan of Virginia contracts also added the requirement for monthly dashboard reporting.

This reporting continued to focus on finalizing the credentialing process with ARTS providers licensed within the scope of practice as defined by Virginia state licensure authorities. The MCOs and Magellan of Virginia continued to utilize, as required by contract, a standardized provider credentialing checklist developed by DMAS for OTPs and Preferred OBOT providers, Intensive Outpatient Programs (ASAM Level 2.1), Partial Hospitalization Programs (ASAM Level 2.5) and Residential Treatment Services (ASAM Level 3.1, 3.3, 3.5, and 3.7) that align with the ASAM Criteria. State licensure requirements for Outpatient Services (ASAM Level 1.0), OTP, Intensive Outpatient (ASAM Level 2.1), and Partial Hospitalization (ASAM Level 2.5) currently align with ASAM Criteria.

DMAS completed the Request for Proposal (RFP) process to secure a new vendor to perform the ASAM site visits for residential treatment providers. The new vendor completed 4 provider applications for ASAM level of care certification.

DMAS's physician review panel continues to review the applications for Preferred OBOT Providers to ensure they meet the ASAM Criteria. There are now a total of 79 Preferred OBOT Providers approved. During this reporting period there were 8 newly recognized Preferred OBOTs .

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

Addiction Provider Type	# of Providers before ARTS	# of Providers after ARTS
Inpatient Detox (ASAM 4.0)	Unknown	75
Residential Treatment (ASAM 3.1, 3.3, 3.5, 3.7)	4	76
Partial Hospitalization Program (ASAM 2.5)	0	14
Intensive Outpatient Program (ASAM 2.1)	49	90
Opioid Treatment Program	2	40
Office-Based Opioid Treatment Provider	0	78

DMAS worked with VDH to gather needed data for the google maps. The map was successfully completed and added to the ARTS webpage. DMAS continues to work to update the google map on a monthly basis. The map may be located:
https://www.google.com/maps/d/viewer?mid=1px9XvltnM7rXZ6vrTgXgPGIHTew&hl=en&usp=sharing

LESSONS LEARNED

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

During this reporting period, DMAS continued to receive several claims and networking issues reported by providers. DMAS worked with individual providers, MCOs and Magellan of Virginia to ensure all claims issues where addressed timely.

DMAS no longer holds the weekly technical assistance calls for providers, but continues to monitor the DMAS SUD mailbox daily for provider's issues. DMAS plans to move to having a quarterly ARTS provider stakeholder meeting later this year to allow opportunities for providers, stakeholders and MCOs to have opportunities to identify issues and strategize for program improvements.

DMAS values working with stakeholders and various providers in order to get a first-hand knowledge of how the services are utilized in the community and how the regulations and requirements are operationalized from the provider's purview. This has allowed DMAS to review the manual to ensure that services requirements not only meet regulatory standards but also can be appropriately operationalized in the community.

EVALUATION ACTIVITIES AND INTERIM FINDINGS

DMAS continues to meet regularly with the VCU research team and finalized the first quarterly report. This analysis shows the increase in provider access for members with OUD as well as any SUD. DMAS worked with VCU to gather information regarding Medication Assisted Treatment (MAT) access to members within ARTS residential treatment. Data shows a low number of members are discharged with aftercare from residential treatment.

VCU completed its 9 month evaluation. The evaluation results are available in the Appendix of this report.

DMAS worked to implement a Learning Collaborative for our Preferred OBOT providers through Project ECHO in collaboration with the VDH. Project ECHO will be used as the platform to hold ongoing Learning Collaborative with clinical staff of Preferred OBOT providers and OTP providers. DMAS plans to Project Echo live by early summer. The sessions will be targeted to the Medicaid Preferred OBOT providers for didactic session and case studies. A second series of trainings will be offered for prescribers needing the trainings to obtain their buprenorphine waiver as required by the Drug Addiction Treatment Act (DATA) 2000 and defined in the

Controlled Substances Act. These trainings will be targeted to prescribers in Federally Qualified Health Centers, Rural Health Clinics, Residential Treatment Settings and health systems.

DMAS is working on a provider memo to communicate CMS requirements for providing or coordinating MAT within residential settings (ASAM Level 3s), Intensive Outpatient (ASAM Level 2.1) and Partial Hospitalization (ASAM Level 2.5). DMAS coordinated a webinar for Residential Treatment Providers and MAT on Thursday, January 18, 2018. This webinar discussed improving the quality of addiction treatment by expanding access to MAT in residential addiction treatment programs. DMAS staff participated in the MAT Regional Expansion Summit on January 24, 2018. Discussions included best practices in reporting the impact of MAT in treatment of individuals experiencing opioid use disorder.

DMAS staff participated in the first Annual InterProfessional Summit for Addition Education, this summit addressed efforts to increase access to evidenced based practices with substance use disorder treatment including MAT, Peer Recovery Services and screenings.

CONCLUSION

DMAS successfully implemented the ARTS program. DMAS continues to work with providers, MCOs and Magellan of Virginia to identify issues and foster the lines of communication between the providers, MCOs and Magellan of Virginia. DMAS is also committed to finalizing the review of the ARTS Network and working with stakeholders to increase access to needed areas.

Former Foster Care Youth

INTRODUCTION

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

BACKGROUND

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

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

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

GOALS

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

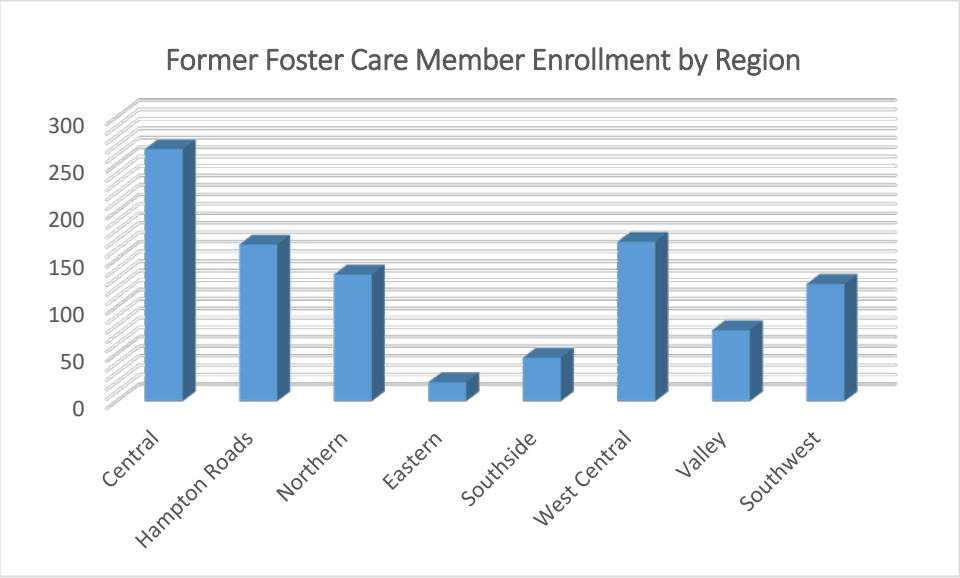
The goals of the FFCY demonstration are: (1) to increase and strengthen coverage of former foster care youth who were in Medicaid and foster care in a different state and (2) to improve or maintain health outcomes for these youth.

ELIGIBILITY AND BENEFIT INFORMATION

Individuals eligible in this demonstration group are those former foster care youth who: (1) were in the custody of another state or American Indian tribe, (2) were receiving foster care and Medicaid services until discharge from foster care upon turning age 18 or older, (3) are not eligible in a mandatory Medicaid coverage group, and (4) are under the age of 26. All individuals in the Former Foster Care Child Under Age 26 covered group receive the full Medicaid benefit package, including long-term supports and services, if medically necessary.

ENROLLMENT COUNTS FOR YEAR TO DATE

Figure 13: Member Enrollment by Region



The figure above displays the geographic distribution of the Former Foster Care population, broken down by regions in the first quarter. As highlighted in the figure, the Central region continues to house the largest concentration at 266 with the West Central (168 members) and Hampton Roads (165 members) regions closely following.

OPERATIONAL UPDATES

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

PERFORMANCE METRICS

By implementing the demonstration, Virginia anticipates increasing healthcare coverage for former foster care youth, while improving health outcomes. The evaluation design for the

Demonstration (See Appendix B) has been drafted and is pending review by CMS. The evaluation addresses three questions:

1. Does the demonstration provide Medicaid coverage to former foster care individuals?

2. How did former foster care individuals in the demonstration use Medicaid-covered healthcare services?

3. What do health outcomes look like for individuals in the demonstration?

COLLECTION & VERIFICATION OF UTILIZATION & ENROLLMENT DATA

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

BUDGET NEUTRALITY AND FINANCIAL REPORTING

The state provides, as Appendix D of this Report, an updated budget neutrality workbook for Quarter 1 Demonstration Year 2018 year that includes established baseline and member month's data that meets all the reporting requirements for monitoring budget neutrality.

CONSUMER ISSUES

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

CONTRACTOR REPORTING REQUIREMENTS

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

RECOVERY NAVIGATORS

The FFCY demonstration does not utilize Recovery Navigators.

LESSONS LEARNED

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

EVALUATION ACTIVITIES

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

CONCLUSION

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

ENCLOSURES

- Appendix A GAP Outreach Chart – Quarter One 2018
- Appendix B- Draft Evaluation Design
- Appendix C - Summary of Evaluation Questions, Hypotheses, Data Sources, and Analytic Approaches to Evaluate Medicaid Coverage for Former Foster Care Youth 1115 Demonstration
- Appendix D - ARTS VCU Evaluation
- Appendix E- GAP, ARTS, and FFCY Budget Neutrality Reports

STATE CONTACT(S)

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Appendix A GAP Outreach Chart – Quarter 1 2018

DATE	EVENT	AUDIENCE	ITEM	FOCUS: GAP	FOCUS: Peer Support	#ATTENDED	COMMENTS	PRESENTER
2/8/2018	Jail Outreach	Returning citizens in re-entry program	Approved Flyers	Yes	Yes	12	Spoke to a group of inmates in a re-entry program who are about to be released. I offered information about applying for GAP and covered Recovery Navigation & Warmline.	Magellan
2/15/2018	Cornerstone CSU	Met with new staff and explained Recovery Navigation	Approved flyers	Yes	Yes	3	Spoke with new staff members and explained what recovery navigation is and what recovery navigators offers members	Magellan
2/19/2018	VCU Psychology Class Presentation	VCU Psychology Class	GAP	x	X	35	Presented on GAP Basics, eligibility, benefit package, and recovery navigation	DMAS
3/5/2018	Jail Outreach - Danville	Returning citizens in re-entry program	Approved Flyers	Yes	Yes	5	Spoke to a group of inmates in a re-entry	Magellan

							program who are about to be released. I offered information about applying for GAP and covered Recovery Navigation, Warmline & SafeLink Wireless.	
3/29/2018	Dept. of Corrections Resource Fair - Green Rock Correctional Unit	Returning citizens in Correctional Facility	Approved Flyers	Yes	Yes	130 +	Presented to 2 groups of inmates about GAP and then staffed a table and fielded questions and handed out flyers to those interested in applying for GAP. We were able to educate many guys on how to apply, and offered them the CSB name to connect to upon discharge. Also handed out SafeLink Wireless flyers.	Magellan

Medicaid Coverage for Former Foster Care Youth who were in Foster Care and Medicaid in a Different State: Section 1115 Demonstration
Draft Evaluation Design
March 21, 2018

Demonstration Objectives and Goals

The purpose of the demonstration is to provide Medicaid coverage to former foster care youth who were covered by Medicaid when they aged out of foster care while under the responsibility of another state, and are now applying for coverage in Virginia. By implementing the demonstration, Virginia anticipates increasing healthcare coverage for former foster care youth, while improving health outcomes. The demonstration will test two goals:

1. Ensure access to Virginia Medicaid-covered services for former foster care individuals between the ages of 18 and 26 who previously resided in other states and were receiving Medicaid coverage until their discharge from foster care upon turning 18 years or older (target population), and
2. Improve or maintain health outcomes for individuals in the target population.

Evaluation Questions and Hypotheses

Based on the above information, several evaluation questions and hypotheses are required to determine whether the demonstration is achieving its goals.

Goal 1. Ensure access to Virginia Medicaid-covered services for former foster care individuals between the ages of 18 and 26 who previously aged out of foster care when residing in another state and receiving Medicaid.

Evaluation Question 1. Does the demonstration provide Medicaid coverage to former foster care individuals?

Hypothesis 1a: Individuals eligible for the demonstration will receive Medicaid coverage.

Evaluation Question 2. How did former foster care individuals in the demonstration use Medicaid-covered healthcare services?

Hypothesis 2a: Individuals in the demonstration will use Medicaid-covered healthcare services.

Goal 2. Improve or maintain health outcomes for individuals in the target population.

Evaluation Question 3. What do health outcomes look like for individuals in the demonstration?

> **Hypothesis 3a:** Individuals in the demonstration will have positive health outcomes [as defined by NQF measures].

The specific outcome measures that will be examined to answer the evaluation questions are presented in Appendix A. (Information in the appendix comes from CMS technical guidance, dated March 16, 2017.)

Methodology

a. Evaluation design: The evaluation will be conducted by staff in the Policy and Research Division at the Department of Medical Assistance Services (DMAS) using a descriptive post-test only design. The evaluation will cover the September 2017 to December 2019 time period, representing the start and end dates of the demonstration. The design will not include a comparison group (see Appendix B for additional information).

b. Data Collection and Sources: The evaluation will use administrative data (enrollment, claims, and encounters) available through the Virginia Medicaid Management Information System (MMIS). MMIS data will be provided by staff in the agency's Office of Data Analytics (ODA) at the end of the first (fall 2018) and second (winter 2020) demonstration years. The evaluation will only be conducted using existing administrative data and no prospective data (e.g., beneficiairy surveys, interviews, focus groups, or other quantitative or qualitative data) will be collected due to resource limitations. Moreover, the evaluation will not include pretest (or baseline) data because DMAS will only have access to data on individuals in the demonstration after they receive Medicaid coverage

c. Data Analysis Strategy: The outcome measures will be analyzed using descriptive statistical methods (e.g., tables, graphs, numerical summaries, frequencies, percentages, proportions, and/or rates as appropriate). For example, policy staff may calculate the average number of emergency department (ED) visits and standard deviation of individuals enrolled in the demonstration as well as the rate at which they visited the ED during both years of the demonstration.

References

Centers for Medicare and Medicaid Services. *Technical Assistance Former Foster Care Youth: Modified Evaluation Design*, March 16, 2017.

Demonstration Goal 1: Ensure access to Virginia Medicaid-covered services for former foster care individuals between the ages of 18 and 26 who previously aged out of foster care when residing in another state and receiving Medicaid.					
Evaluation Component	**Evaluation Question**	**Evaluation Hypotheses**	**Measure [Reported for each Demonstration Year]**	**Data Source**	**Analytic Approach**
Process	1. Does the demonstration provide Medicaid coverage to former foster care individuals?	1a. Individuals eligible for the demonstration will receive Medicaid coverage.	Number of individuals in demonstration/Total number of applications from former foster care individuals	MMIS	Descriptive statistics (e.g., percentages, numerical summaries, proportions, and/or rates)
	2. How did former foster care individuals in the demonstration use Medicaid-covered healthcare services?	2a. Individuals in the demonstration will use Medicaid-covered healthcare services.	Number of individuals in demonstration with ambulatory care visit/Total number of individuals in Medicaid	MMIS	Descriptive statistics (e.g., percentages, numerical summaries, proportions, and/or rates)
			Number of individuals in demonstration who had an emergency department visit/Total number of individuals in Medicaid		
			Number of individuals in demonstration who had an inpatient visit/Total number of individuals in Medicaid		
			Number of individuals in demonstration who had a behavioral health encounter/Total number of individuals in Medicaid		
Demonstration Goal 2: Improve or maintain health outcomes for individuals in the target population.					

Outcomes/ Impact	3. What do health outcomes look like for individuals in the demonstration?	3a. Individuals in the demonstration will experience improved health outcomes.	Number of individuals in demonstration with appropriate follow-up care for hospitalizations (physical and/or mental illness)/Total number of individuals in Medicaid with hospitalizations	MMIS	Descriptive statistics (e.g., percentages, numerical summaries, proportions, and/or rates)

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
ADMINISTERING MEDICAID AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM IN VIRGINIA

Highlights from the First Nine Months of ARTS

The Department of Medical Assistance Services contracted with Virginia Commonwealth University (VCU) to conduct an evaluation of the Addiction and Recovery Treatment Services (ARTS) program. Below are the major findings from a report published by the VCU evaluation team about changes in access to and utilization of addiction treatment services during the first nine months of ARTS.

More Medicaid members with substance use disorders are receiving treatment

• The percent of Medicaid members with a substance use disorder who received any treatment increased from 24 percent before ARTS to 38 percent during the first nine months of ARTS.

	Before ARTS April-December 2016	After ARTS April- December 2017	Percent Change
Total number of members with a substance use disorder (SUD)	42,011	43,093	3%
Members with SUD receiving any SUD treatment	10,102	16,570	64%
Percent receiving SUD treatment	**24%**	**38%**	**60%**

More Medicaid members with opioid use disorders are receiving treatment

• The percent of Medicaid members with an opioid use disorder who received any treatment increased from 48 percent before ARTS to 62 percent during the first nine months of ARTS.

	Before ARTS April-December 2016	After ARTS April- December 2017	Percent Change
Total number of members with an opioid use disorder (OUD)	14,696	17,093	16%
Members with OUD receiving any OUD treatment	6,989	10,522	51%
Percent receiving OUD treatment	**48%**	**62%**	**29%**

Fewer emergency department visits related to opioid use disorders

• The number of emergency department visits related to opioid use disorders decreased by 31 percent during the first nine months of ARTS.

This compares with a 15 percent decrease in emergency department visits for all Medicaid members.

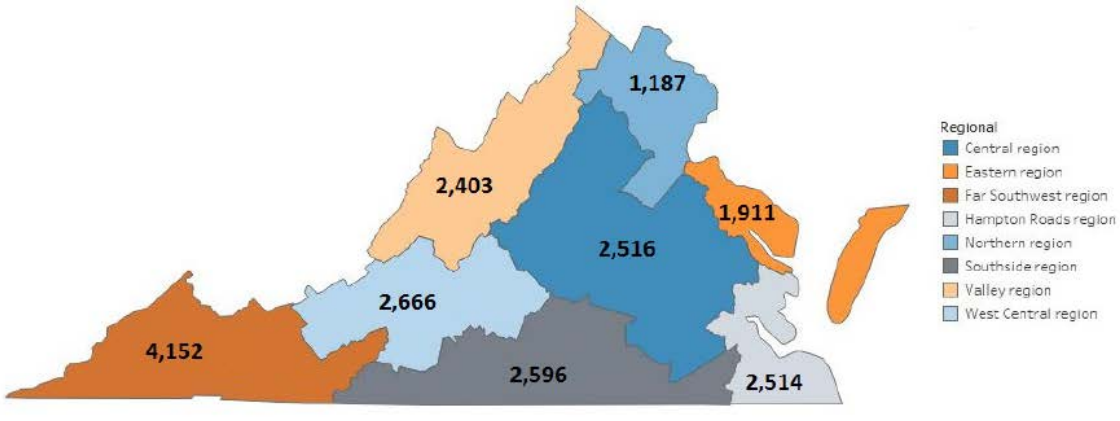
	Before ARTS April-December 2016	After ARTS April-December 2017	Percent Change
ED visits related to opioid use disorders	**4,484**	**3,101**	**-31%**
Total ED visits for all Medicaid members	706,325	601,586	-15%

Fewer prescriptions for opioid pain medications

• The number of prescriptions for opioid pain medications among Medicaid members decreased by 29 percent during the first 9 months of ARTS.

	Before ARTS April-December 2016	After ARTS April-December 2017	Percent Change
Total number of prescriptions for opioid pain medications	420,883	299,598	-29%
Number of prescriptions for opioid pain medications per 10,000 members	**3,045**	**2,152**	**-29%**

• The number of prescriptions for opioid pain medications per 10,000 Medicaid members varies widely across Virginia regions.



FFCY Former Foster Care Youth

ARTS Addiction and Recovery Treatment Services

GAP Bridging the Mental Health Coverage Gap in Virginia

Appendix E – GAP, ARTS, and FFCY Budget Neutrality Reports

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

ELIGIBILITY GROUP	Budget Neutrality DY 3 Full year estimate	1/4 of Full Year Estimate	DEMONSTRATION YEAR 4 (CALENDAR YEAR 2018) QUARTER 1 January 2018	February 2018	March 2018	TOTAL QUARTER	
Non-LTC Disabled Adults with SMI							
Pop Type:	**Medicaid**						
Eligible Member Months	971,771	242,943	79,394	79,060	78,826	237,280	With the proposed 1115 Demonstration waiver, individuals served through the GAP program are assumed to be diverted from obtaining a disability determination and thereby qualifying for full-Medicaid benefits under current Virginia eligibility levels.
PMPM Cost	$ 2,200.84	$ 2,200.84	$ 2,075.84	$ 2,128.62	$ 2,109.51	$ 2,104.61	
Total Expenditure	$ 2,138,712,488	$ 534,678,122	$ 164,809,169	$ 168,288,539	$ 166,284,433	**$ 499,382,141**	
GAP Population							
Pop Type:	**Expansion**						
Eligible Member Months	189,301	47,325	13,776	14,065	14,410	42,251	The 1115 Demonstration waiver initially provided a limited coverage benefit to individuals with severe mental illness at or below 60% FPL. It was expanded to include those at or below 80% FPL as of July 1, 2016 and has increased to 100% FPL as of October 1, 2017.
PMPM Cost	$ 417.82	$ 417.82	$ 326.23	$ 375.30	$ 465.67	$ 390.12	
Total Expenditure	$ 79,093,744	$ 19,773,436	$ 4,494,082	$ 5,278,620	$ 6,710,370	$ 16,483,072	
Former Foster Care Transfers from Out of State							
Pop Type:	**Expansion**						
Eligible Member Months	830	208	64	66	65	195	
PMPM Cost	$ 508.28	$ 508.28	$ 447.63	$ 410.07	$ 496.89	$ 451.34	
Total Expenditure	$ 421,869	$ 105,467	$ 28,648	$ 27,064	$ 32,298	$ 88,010	
SUD Waiver Services Recipients							
Pop Type:	**Expansion**						
Eligible Member Months	879	220	38	49	162	249	
PMPM Cost	$ 2,656.06	$ 2,656.06	$ 3,186.79	$ 3,325.64	$ 3,386.07	$ 3,343.77	
Total Expenditure	$ 2,334,675	$ 583,669	$ 121,098	$ 162,957	$ 548,544	$ 832,599	