Meeting of the Board of Medical Assistance Services  
600 East Broad Street, Conference Rooms 7A/B  
Richmond, Virginia  

April 10, 2018  
DRAFT Minutes

**Present:**  
Michael H. Cook, Esq.  
Patricia T. Cook, M.D.  
Alexis Y. Edwards  
Rebecca E. Gwilt, Esq.  
Maureen Hollowell  
Peter R. Kongstvedt, M.D.  
Vice Chair  
McKinley L. Price, D.D.S.  
Karen S. Rheuban, M.D.  
Chair  
Kannan Srinivasan

**Absent:**  
Cara L. Coleman, JD, MPH  
Vilma T. Seymour

**DMAS Staff:**  
Karen Kimsey, Chief Deputy  
Cheryl Roberts, Deputy Director for Programs  
Abrar Azamuddin, Legal Counsel  
Craig Markva, Manager, Office of Communications, Legislation & Administration  
Nancy Malczewski, Public Information Officer, Office of Communications, Legislation & Administration  
Mamie White, Public Relations Specialist, Office of Communications, Legislation & Administration

**Speakers:**  
Jennifer S. Lee, M.D., Director  
Scott Crawford, Deputy Director for Finance  
Brian McCormick, Acting Deputy Director for Administration  
Tammy Whitlock, Acting Deputy Director for Complex Care & Services  
Mukundan Srinivasan, Information Management Division Director  
Kate Neuhausen, MD, Chief Medical Officer

**Guests:**  
Tyler Cox, MSV  
Kenneth McCabe, DPB  
Chris Whyte, VECTRE  
Jenness Vaccarella, Conduent  
W. Scott Johnson, First Choice Consulting  
N. Pugar, Williams Mullen  
Kassie Schloth, McGuire Woods Consulting  
Chris Nolen, McGuire Woods Consulting  
Steve Ford, VHCA  
Jennifer Wicker, VHHA  
Patrick Finnerty, Myers & Stauffer  
Don Parr, Deloitte  
Paul LaRoche, Deloitte  
Robert Bohemn, Hunton & Williams  
Molly MacBar, VanGo
CALL TO ORDER

Dr. Karen S. Rheuban called the meeting to order at 10:00 a.m., and other members introduced themselves and introductions continued around the room. Dr. Rheuban recognized Dr. Jennifer S. Lee appointed in January to serve as the DMAS Director by Governor Northam. Dr. Lee shared opening remarks and thanked the Board for their dedication and service to the Commonwealth and to the Board.

Dr. Rheuban noted the entrance of Board Member Alexis Edwards and Deputy Director for Programs, Cheryl Roberts.

APPROVAL OF MINUTES FROM December 12, 2017 MEETING

Dr. Rheuban asked that the Board review and approve the Minutes from the December 12, 2017 meeting. Dr. Kongstvedt made a motion to accept the minutes and Dr. Price seconded. The vote was 8-yes (M. Cook, P. Cook, Gwilt, Hollowell, Kongstvedt, Price, Rheuban, and Srinivasan); and 0-no.

Election of Chairman/Vice Chairman

Dr. Rheuban turned the meeting over to Dr. Lee for the election process. Dr. Lee noted that the Board bylaws require the election of officers for the Board the first meeting after March 1st of each year and opened the floor to accept nominations for Chair.

Ms. Gwilt made a motion to nominate Dr. Rheuban to continue to serve as Chair and Mr. Cook seconded. Hearing no further nominations, the nominations were closed. The vote to elect Dr. Rheuban as Chair was 8-yes (M. Cook, P. Cook, Gwilt, Hollowell, Kongstvedt, Price, Rheuban, and Srinivasan); and 0-no.

Dr. Lee opened the floor to accept nominations for Vice Chair. Dr. Rheuban made a motion to nominate Dr. Kongstvedt for Vice Chair. Dr. Price seconded. Hearing no other nomination, the nominations were closed. The vote to elect Dr. Kongstvedt as Vice Chair was 8-yes (M. Cook, P. Cook, Gwilt, Hollowell, Kongstvedt, Price, Rheuban, and Srinivasan); and 0-no.

Selection of Secretary

Dr. Lee then opened the floor to accept nominations for Board Secretary. Dr. Kongstvedt made a motion to accept Mamie White as Board Secretary and Dr. Rheuban seconded. The vote to elect Ms. White as Board Secretary was 8-yes (M. Cook, P. Cook, Gwilt, Hollowell, Kongstvedt, Price, Rheuban, and Srinivasan); and 0-no.
DIRECTOR’S REPORT

Dr. Lee introduced her Executive Management Team and asked them to share remarks: New Staff: Chief Deputy Karen Kimsey (replacing Linda Nablo) appointed by Governor Northam. Brian McCormick (replacing Suzanne Gore), Acting Deputy Director for Administration and Tammy Whitlock (replacing Karen Kimsey), Acting Deputy Director for Complex Care Services. Current Staff: Dr. Kate Neuhausen, Chief Medical Officer; Scott Crawford, Deputy Director for Finance; and Cheryl Roberts, Deputy Director for Operations.

Dr. Lee shared information about her background, her interest in health policy and the life experiences that shaped her commitment to systemic changes that improve access to care for low-income individuals across Virginia. She described her vision for the agency, including the opportunity to provide coverage to an additional 400,000 adults through Medicaid expansion.

Dr. Lee concluded her comments by sharing a slide entitled “Who Qualifies for Virginia Medicaid” to demonstrate the impact and importance of expanded eligibility for individual Virginians and for the Commonwealth’s Medicaid program. Dr. Rheuban offered the support of the Board to assist Dr. Lee and participate in the activities of the agency in achieving these goals. (see attached handout).

2018 GENERAL ASSEMBLY LEGISLATIVE OVERVIEW

Brian McCormick, Acting Deputy Director for Administration, provided highlights of some of the 2018 enrolled bills (Senate Bills 310, 536, 735 and 943) which had an impact on DMAS during the 2018 General Assembly Session (see attached handout).

Ms. Kimsey recognized BMAS Member Maureen Hollowell for her contributions with Senate Bill 310, which directed DMAS to make recommendations regarding changes that provide flexibility to an individual enrolled in a home and community-based waiver to choose their place of residence in the Commonwealth during the Session.

2018 BUDGET OVERVIEW

Scott Crawford, Deputy Director for Finance, provided highlights of some of the budget actions which had an impact on DMAS during the 2018 General Assembly Session. At the current time, there are three budgets: the Governor’s Introduced Budget, a House Budget and a Senate Budget. As the General Assembly did not come to a budget agreement during the regular Session, Mr. Crawford stated the Governor announced a Special Session to convene on April 11, 2018. (see attached handout).

SUMMARY OF HOUSE-PASSED MEDICAID BUDGET LANGUAGE
Dr. Kate Neuhausen, Chief Medical Officer, provided a brief Medicaid Expansion summary of the House’s budget language pertaining to Medicaid Expansion. She explained how the provider assessment could fund the state’s fiscal obligations, the coupling of potential work requirements for eligibility and the reforms required under the 1115 Waiver. (see attached handout).

**CCC PLUS UPDATE**

Tammy Whitlock, Acting Deputy Director for Complex Care Services, provided a recap of the Commonwealth Coordinated Care (CCC) Plus program which completed their statewide rollout in January 2018. Ms. Whitlock provided the current enrollment statistics, discussed some of the implementation challenges, and explained their approach to monitoring CCC Plus activities going forward (see attached handout).

**MEDICAID ENTERPRISE SYSTEM (MES) UPDATE**

Mukundan Srinivasan, Director of Information Management, gave an update on the recently implemented MES program which affects every division in the agency and shared how effective the modular approach has been to moving to this platform. He also highlighted accomplishments, plans and target dates for future projects including a Board software members will be able to access. (see attached handout).

**ADDITION AND RECOVERY TREATMENT SERVICES (ARTS) EVALUATION**

Dr. Neuhausen provided an update on progress of the Addiction and Recovery Treatment Services Benefit implemented statewide on April 1, 2017, including improvements in access to and utilization of addiction treatment services during the first nine months of ARTS published in an independent evaluation by VCU (see attached handouts).

Ms. Edwards left the meeting.

**REGULATORY ACTIVITY SUMMARY**

The Regulatory Activity Summary is included in the Members’ books to review at their convenience (see attached).

**OLD BUSINESS**

Dr. Rheuban announced the June meeting will be scheduled for a different date due to scheduling conflicts. Dr. Rheuban asked members to send their suggested agenda items to the Board Secretary and offered the topic of ‘Social Determinants’ for discussion at the June meeting.
ADJOURNMENT

Mr. Cook made a motion to adjourn the meeting at 12:23 p.m. Dr. Price seconded. The vote was 7-yes (M. Cook, P. Cook, Hollowell, Kongstvedt, Price, Rheuban, and Srinivasan); and 0-no.
Who Qualifies for Virginia Medicaid

Not all low-income Virginians are eligible

- Children 0-18: 148% FPL ($17,967)
- Pregnant Women: 148% FPL ($17,967)
- Elderly & Disabled: 80% FPL ($9,712)
- Working Parents: 52% FPL ($6,313)
- Childless Adults: Not Eligible
**Senate Bill 310 – DeSteph:** Effective 7/1/18

In its final form, this bill requires DMAS to make recommendations to the General Assembly as to how the Agency can provide greater flexibility for waiver-enrolled individuals to choose their preferred housing. The original bill would have required DMAS to pay for Medicaid services to some waiver-enrolled individuals whose residential settings may have disqualified them for federal Medicaid payment. Following concerted efforts by both DMAS and concerned stakeholders, the bill was amended from a requirement for the Agency to pay, to simply the provision of DMAS recommendations. This was a significant victory for the Agency.

**Senate Bill 536 – Obenshain:** Awaiting Governor’s Action

This bill requires Medicaid-enrolled health care providers to submit Medicaid claims to their MCOs within a specified time period. It also prohibits the practice of Medicaid MCO network providers attempting to bill Medicaid patients for claims that were denied for late filing. Both of these protections already exist in federal law; therefore this bill has no impact on DMAS.

**Senate Bill 735 – Dunnavant:** Effective 7/1/18

Authorizes the Department of Health Professions to disclose Medicaid patient information to Medicaid providers as part of the Prescription Monitoring Program. The bill ensures that DMAS providers have access to critical prescription information.

**Senate Bill 943 – McPike:** Effective 7/1/18

Requires DMAS to provide quarterly reports to each Medicaid MCO that specifies the renewal date for each Medicaid recipient enrolled with that MCO. This bill enhances the ability of MCOs to provide additional notice to their enrollees about upcoming eligibility renewals.
OVERVIEW OF 2018 GENERAL ASSEMBLY BUDGET ACTIONS

Presentation to:
Board of Medical Assistance Services

Scott Crawford
Deputy Director, Finance

April 10, 2018
Governor’s Introduced Budget included Medicaid Expansion and a provider assessment on hospitals – resulted in $421.6M in GF savings and new revenue over the 2019/2020 Biennium

House Budget retained Medicaid Expansion and the provider assessment, coupled with work requirements and some other reforms

Senate Budget eliminated Medicaid Expansion and the provider assessment – resulting in a need for a $421.6M GF reduction throughout the budget

General Assembly did not come to a budget agreement during regular session
## Comparison of Budgets Introduced During Regular Session

<table>
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<th>Major Budget Items</th>
<th>GIB</th>
<th>House</th>
<th>Senate</th>
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<td>Work Requirements</td>
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<td>✔️</td>
<td></td>
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<tr>
<td>Other Reforms (cost sharing, premium assistance)</td>
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<td>✔️</td>
<td></td>
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<tr>
<td>Provider Assessment on Hospitals</td>
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<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Fully funds forecasted growth</td>
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<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Hospital Inflation</td>
<td>Full</td>
<td>Half</td>
<td>Full</td>
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<tr>
<td>Overtime for Consumer Directed (CD) Attendants</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>CSB Same Day Access (STEP VA)</td>
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<td>✔️</td>
<td>✔️</td>
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<td>Rate Increase for CD Attendants</td>
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<tr>
<td>Rate Increase for CD and Agency Attendants</td>
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<td></td>
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<tr>
<td>Merge CoverVA Call Center with DSS Call Center</td>
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<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Funds Federally Required Evaluations</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
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Special Session Begins April 11

• Governor has called for a Special Session to convene on April 11 to adopt a budget

• Governor re-introduced Governor McAuliffe’s original Governor’s Introduced Budget (GIB)

• Unclear how negotiations will unfold or what the timeline will look like

• Eventual budget could look like one of the budgets introduced during regular session, or it may look different from any of them
SUMMARY OF MEDICAID EXPANSION
BUDGET LANGUAGE PASSED BY HOUSE

APRIL 10, 2018 PRIOR TO SPECIAL SESSION

Katherine Neuhausen, MD, MPH
Chief Medical Officer
Virginia Department of Medical Assistance Services
Expansion Population – Eligibility

- Adults ages 19 – 64
- Not Medicare eligible
- Income from 0% to 138% Federal Poverty Level
  - Single adult earning up to $16,753,20
  - Parent in family of 3 earning up to $28,676,40
- Likely characteristics of expansion population based on other states’ experience:
  - 30-50% have mental illness and/or substance use disorder in similar states (Ohio, West Virginia)
  - High prevalence of chronic medical disease
State Plan and Medicaid Waivers

Medicaid is a joint federal and state benefits program established by Title XIX amendments to the Social Security Act

**State Plan for Medical Assistance**

- Virginia’s agreement with the federal government for administering the Medicaid program
- 25 state plan amendments (SPAs) on average annually
- Regulations in Virginia Administrative Code (12 VAC 30 Chapters 5-110)
- 90-day approval period

**Medicaid Waivers**

- Waive parts of the Social Security Act
- Different waiver types
  - § 1915(b) establishes a managed care service delivery system
  - § 1915(c) establishes home and community based services
  - § 1115 tests new research and demonstration projects
- Approval timeline uncertain
Expansion: Two Track Process in House Budget

- Track 1:
  - Expansion through State Plan Amendments
  - Early reforms for newly eligible
- Track 2:
  - 1115 Demonstration Waiver
  - Required reforms that transform the Medicaid program for newly eligible individuals
- DMAS would work in parallel to begin the process of applying for a 1115 waiver at the same time as submission of the State Plan Amendments to CMS
Early Reforms with Track 1

- **Referrals** to job training, education, and job placement assistance for all unemployed, able-bodied adults
- Premium Support for Employer-Sponsored Insurance
- Health Savings Accounts
- Appropriate Utilization of ED Services
- Healthy Behavior Incentives
- Enhanced Fraud Prevention Efforts
Reforms Required with Track 2 – 1115 Waiver

- Population earning 100-138% Federal Poverty Level
  - Monthly Premiums
  - Deductible Accounts
  - Waiting period prior to re-enrollment if premium not paid
  - Cost-sharing to promote healthy behaviors and appropriate ED use
  - Cost-sharing reductions for compliance with healthy behaviors
Expansion: Two Track Process in House Budget

Reforms Required with Track 2 – 1115 Waiver

- Training, Enrollment, Education, Employment and Opportunity Program (TEEOP)
  - Escalating participation in community engagement increases to at least 80 hours per month
  - Community engagement includes employment, job skills training, job search activities, education, volunteering, and caregiving
  - Exemptions – medically frail, children < 18 y/o, individuals > 55 y/o, primary caregivers with a dependent child < 18 y/o, Serious Mental Illness, etc.
Provider Assessment in House Budget to Fund the Costs of Medicaid Expansion

Total state costs of expansion to be financed by a provider assessment on private acute care hospitals

Estimated Cost of Coverage: FY 2019 = $80.8M (assessment is 0.5%) and FY 2020 = $226.1M (assessment is 1.4%)

Assessment will **cover the full cost of expanded Medicaid coverage** – meaning it will be calculated to equal the amount estimated in the official Medicaid forecast

**Excluded** from the assessment are: public hospitals, freestanding psychiatric and rehab hospitals, children’s hospitals, long-stay hospitals, long-term acute care hospitals, and critical access hospitals

DMAS will be responsible for assessing and collecting the assessment which will be **calculated as a percentage of net patient revenue**
CCC Plus Implementation Recap

CCC Plus phased in regionally August 2017 – January 2018

<table>
<thead>
<tr>
<th>Tidewater</th>
<th>Central</th>
<th>Charlottesville</th>
<th>Roanoke Alleghany &amp; Southwest</th>
<th>Northern &amp; Winchester</th>
<th>CCC &amp; Remaining ABD</th>
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</thead>
<tbody>
<tr>
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<td>✔</td>
<td>✔</td>
<td>✔</td>
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</table>

August | September | October | November | December | January

CCC Plus Implementation Highlights:

- Planning and design phase included Stakeholder input – Began March 2015
- Plans were selected via competitive procurement (April 2016 – December 2016)
- CMS waiver authority 1915(b) and 1915(c) – Approved April 2017
- MCO readiness activities - December 2016 – July 2017
- Regional member and provider town halls – June 2017 – November 2017
- Regional implementation - Aug 2017 – Jan 2018
- August 2017 Contracts and Rates - approved by CMS December 2017
- January 2018 Contracts and Rates – submitted to CMS for approval December 2017

DMAS has worked with stakeholders on every phase of the project including to resolve implementation concerns such as provider payments, coordination with Medicare, and continuity of care.
## CCC Plus Enrollment by Plan by Region

### As of 3/5/2018

<table>
<thead>
<tr>
<th>MCO</th>
<th>Tidewater</th>
<th>Central</th>
<th>Charlottesville</th>
<th>Roanoke Alleghany</th>
<th>Southwest</th>
<th>Northern VA/Winchester</th>
<th>Total</th>
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<tbody>
<tr>
<td>Aetna</td>
<td>5,379</td>
<td>8,862</td>
<td>3,908</td>
<td>3,578</td>
<td>3,931</td>
<td>4,695</td>
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<tr>
<td>Anthem</td>
<td>13,329</td>
<td>16,057</td>
<td>5,446</td>
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<td>3,532</td>
<td>16,105</td>
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<tr>
<td>Magellan</td>
<td>6,486</td>
<td>4,783</td>
<td>2,872</td>
<td>2,432</td>
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<td>Optima</td>
<td>10,531</td>
<td>7,383</td>
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<td>2,447</td>
<td>2,612</td>
<td>3,088</td>
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<td>4,619</td>
<td>2,201</td>
<td>3,143</td>
<td>2,262</td>
<td>6,995</td>
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<td>VA Premier</td>
<td>5,106</td>
<td>9,588</td>
<td>7,126</td>
<td>8,787</td>
<td>6,613</td>
<td>3,870</td>
<td>41,090</td>
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<td><strong>Total</strong></td>
<td><strong>45,120</strong></td>
<td><strong>51,292</strong></td>
<td><strong>29,097</strong></td>
<td><strong>25,274</strong></td>
<td><strong>21,107</strong></td>
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<td><strong>210,041</strong></td>
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CCC Plus Enrollment by LTSS Benefit

Source: VAMMIS. March 5, 2018
Implementation Challenges

• Transportation
• Claim payment delays
  ▪ Nursing Centers
• Coordination with Medicare
• Community MH Services – January 1, 2018
Implementation Monitoring

Two Pronged Approach

Standard Monitoring Activities

• Host weekly Implementation Monitoring Calls with each Health Plan
• Review and discuss weekly dashboards
• Track and discuss progress of items on Issues log
• Review and discuss weekly missed trip log

Dynamic Monitoring Activities

• Respond to concerns from members, advocates and providers
  – Resolution of specific concern
  – Research root cause of the concern and take necessary action
• Examples:
  – Nursing facility accounts receivables beyond 30 day tracking
  – Chart reviews to address quality of care concerns
# Encounter Status

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<tr>
<th>MCO</th>
<th>Passed</th>
<th>Failed</th>
<th>Total</th>
<th>% Passed</th>
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<td>702</td>
<td>325,054</td>
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<td>35,920</td>
<td>500,950</td>
<td>92.8%</td>
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<td><strong>Total</strong></td>
<td>2,824,422</td>
<td>300,708</td>
<td>3,125,130</td>
<td>90.4%</td>
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As of March 9, 2018
Virginia took a collaborative, hands-on approach with MCOs to establish clear expectations for care coordinators

Customized Training On-Site – DMAS Tech Waiver SMEs met with ALL health plans
- Education
- Clinical Case Reviews
- Joint Home Visits

Timely Information Sharing, Communication, & Training
- Weekly Training Calls on services, success stories, case reviews and scope of Care Coordinator role
- Coffee Talk Tuesdays dedicated to Live Q&A
- Specialized training based on identified learning needs – 2-part training on EPSDT

Questions Answered Directly from Care Coordinators
- Dedicated Email box for their questions, concerns and requests for training
- Direct communication with DMAS Care Management Staff
- Email notices to growing group of registered Care Coordinators

Direct Issue Resolution Process with Care Coordinator Management and Clinical Leads
Male member in mid-80s with Dementia living in an Assisted Living Facility (ALF). The member had been living at this ALF since July 2017 following an inpatient stay for altered mental status. His son is the Power of Attorney and lives in Hawaii.

The only medical history the current ALF Manager had was the member’s discharge paperwork from summer 2017. The only confirmed diagnosis was HTN. He was not on any medication for the reported Dementia. The son reported the member was diagnosed with Prostate Cancer in early 2017.

An Interdisciplinary Care Team meeting was held with the member, the new PCP and the ALF Manager who provided updates. The PCP confirmed the diagnosis of Dementia. The member had stopped taking prescribed Aricept for at least 8 months. The CC consolidated the pharmacy history for the PCP office.

Upon the next visit with the PCP, the member vaccinations were updated and follow up with other potential medical conditions was completed. A pre-screening was requested due to several self-care deficits. A comprehensive plan of care is now in place.

After approximately six weeks on the Aricept, the member had a noticeable difference in interactions, engaging more in conversation and enjoying music again. The son has expressed his appreciation of the CC helping his dad through care coordination.
Prior to enrolling in CCC Plus, Member had difficulty leaving his home using his wheelchair. In order to help him, the Member’s family constructed their own makeshift ramp. While this enabled him to leave the home, it was not safe.

When the Member met with his CCC Plus Care Coordinator face to face, he shared his safety concerns about the steep incline of the ramp. He noted there were two occasions when the wheelchair overturned due to the incline. The Member said he had to “hold on with my chin on the rail until someone could help me.”

The CCC Plus Care Coordinator educated the Member about the Environmental Modification service available to him through CCC Plus to help him obtain a safe and secure means of exiting his home in his electric wheelchair. The Care Coordinator arranged for the installation of a professionally constructed ramp built to local building codes. After installation, the Member has a new sense of freedom and security to be able to come in and out of his home whenever he chooses. When the Member recently met with the Care Coordinator 6 months later, he continued to express his gratitude for the ramp that increased his safety and quality of life.
Next Steps

• Partnering with VCU to evaluate initial Care Coordination efforts
• Dual Special Needs Plan contract
• Including members on the Health Insurance Premium Payment program
• Carving in Residential Services
MEDICAID ENTERPRISE SYSTEM

April 10, 2018
Projects Updates

- Systems Integration
- Enterprise Data Warehouse
- Encounter Processing
- Operations Services and Plan Management
- Pharmacy Benefit Management System
Deloitte’s HealthInteractive Platform High-level Conceptual Diagram
Accomplishments

- **Systems Integration (ISS)**
  - Kickoff held on 3/15/18
  - 4 Tracks: Single Sign On, Functional, Technical, and Governance

- **Encounter Processing Solution (EPS)**
  - Release I on target for April 2018 implementation.
  - IV&V Operational Readiness Review (R2) complete. EY and CMS Progress Report pending.
  - A Certification Final Review (R3) is targeting April/May 2018.

- **Pharmacy Benefit Management Solution (PBMS)**
  - Phase II is in process for integration of clinical lab data. A July 2018 Implementation is targeted.
  - IV&V Operational Readiness Review (R2) complete. EY and CMS Progress Report pending.
  - A Certification Final Review (R3) is targeting April/May 2018.
Accomplishments

- **Financial Management Solution (FMS)**
  - Oracle “Move and Improve” SOW being reviewed.
  - Budget and Cost Allocation solutions being assessed.

- **Enterprise Data Warehouse Solution (EDWS)**
  - Data evaluation effort yielded favorable results for conversion. On Track.
  - UAT Planning is beginning for Phase 1.
  - June 30, 2018 Phase I target completion for Historical Data Conversion to production.

- **Operations Services (OPSS) and Plan Management (PLMS)**
  - Conference Room pilots for design and configurations being conducted.
Integration Services Solution or Systems Integrator (SI)

Integration Track
The module integration approach

Security Track
An overview of the ISS security solution

Governance Track
The approach to governance

Technical Track
The technology behind ISS
## Flight Plan Overview

**24 Months DDI: Mar, 2018 to Feb 2020**

### Deployment Targets
- Development – 6/1/2018
- Move IT – 7/1/2018
- ICAM/SSO – 8/20/2018
- ISS Platform (Build 1) – 12/10/2018

### Master Integration Plan Development & Execution

#### Design, Build and Deploy ISS Platform

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<th>3...n</th>
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</tbody>
</table>

#### Release Plan Execution

- **Build 1**: Month 18 to 21 (4 Months)
- **Build 2**: Month 22 to 25 (3.5 Months)

### Optional DDI - 6 Months

- Stabilize and transition to O&M - Month 22

### Close
- 3/16/2020

---

<table>
<thead>
<tr>
<th>Module</th>
<th>Implementation Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDWS</td>
<td></td>
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<tr>
<td>BFS</td>
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<tr>
<td>FFMS</td>
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<tr>
<td>Appeals</td>
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<td>CRMG</td>
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<td>Oracle</td>
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<td>TPL</td>
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<tr>
<td>Plan</td>
<td></td>
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<tr>
<td>PMIS</td>
<td></td>
</tr>
</tbody>
</table>

**Step 1**: Live with Conduct Data

**Step 2**: Integrate with new data sources

**Modules with a 2 step implementation plan:**

- EDWS PH - II
- Modules with single step implementation plan:
  - Go Live as a integrated solution with new data sources sources.

**Kick Off 3/15/18**

**Initiation & Planning**

- Technical
- Functional
- Security
- Governance

---

**Reference**

- [Link to Flight Plan](#)
## MES PROJECT IMPLEMENTATION FLIGHTPLAN

<table>
<thead>
<tr>
<th>Track 1: Integration Services</th>
<th>Track 2: Enterprise Data Warehouse</th>
<th>Track 3: Encounter Processing</th>
<th>Track 4: Pharmacy Benefit Management</th>
<th>Track 5: Financial</th>
<th>Track 6: Modular Core Services</th>
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<td><strong>2018</strong></td>
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<td><strong>2019</strong></td>
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<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Original Planned Start</td>
<td>Fiscal Agent Contract Ends</td>
<td>MES Full Operations</td>
<td>Fiscal Agent Contract Ends</td>
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<td>Revised Starts</td>
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<tr>
<td>RFP and Vendor Selection</td>
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<td><strong>2016</strong></td>
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<td>DDI Phase I</td>
<td>O&amp;M</td>
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<td>Track 1 Start</td>
<td>Track 3 Start</td>
<td></td>
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<td>Track 2 Start</td>
<td>Track 3 Start</td>
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<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>DDI Phase I</td>
<td>O&amp;M</td>
<td>DDI Phase II</td>
<td>O&amp;M</td>
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<td>DDI Phase I</td>
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<td>Track 6 Start</td>
<td>Track 6 Start</td>
<td></td>
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**Key Events:**
- Fiscal Agent Contract Ends
- MES Full Operations
- Fiscal Agent Contract Extended
- Revised Starts
- Original Planned Start
- DDI Tracks 3 through 6
- DDI Phase I
- DDI Phase II

**Timeline:**
- 7/1
- 4/1/16
- 11/1/16
- 11/30/19

**Additional Details:**
- EPS Phase 1
- PBMS Phase 1
- MCSS Phase 1
- FMS Phase 1
- DDI Phase I
- DDI Phase II
- O&M
- DDI Tracks 3 through 6

**Extended Details:**
- DDI Phase II
- Fiscal Agent Contract Extended
- EPSS Phase 1
- PBMS Phase 1
- EPS Phase 1
- DDI Phase I

**Certification:**
- MES Certification
- O&M
- Original Planned Start
- Revised Starts
- DDI Tracks 3 through 6
<table>
<thead>
<tr>
<th>Task</th>
<th>2016</th>
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<th>2019</th>
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<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td><strong>RFP and Vendor Selection</strong></td>
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<tr>
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<tr>
<td><strong>Track 2: Enterprise Data Warehouse</strong></td>
<td>7/1</td>
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<tr>
<td><strong>Track 4: Pharmacy Benefit Management</strong></td>
<td>7/1</td>
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<tr>
<td><strong>Track 5: Financial</strong></td>
<td>7/1</td>
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<tr>
<td><strong>Track 6: Modular Core Services</strong></td>
<td>7/1</td>
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</tbody>
</table>

**DDI Phase I**

**Mainframe**

**DDI Phase II**

**VITA Takeover In Place (TIP):**
- Managed Security
- Server Storage Data Center
- End User Services
- Voice + Data Network Services
- MSI
UPDATE ON MEDICAID ADDICTION
AND RECOVERY TREATMENT SERVICES
(ARTS) PROGRAM

9 MONTH OUTCOMES FROM VCU EVALUATION

Katherine Neuhausen, MD, MPH
Chief Medical Officer
Virginia Department of Medical Assistance Services

www.dmas.virginia.gov
Addiction and Recovery Treatment Services (ARTS) Benefit

Changes to DMAS’s Substance Use Disorder (SUD) Services for Medicaid and FAMIS Members approved in Spring 2016

1. Expand short-term SUD inpatient detox to all Medicaid/FAMIS members
2. Expand short-term SUD residential treatment to all Medicaid members
3. Increase reimbursement for existing Medicaid/FAMIS SUD treatment services
4. Add Peer Support services for individuals with SUD and/or mental health conditions
5. Require SUD Care Coordinators at DMAS contracted Managed Care Plans
6. Organize Provider Education, Training, and Recruitment Activities
ARTS Program: Transforming the Delivery System of Medicaid SUD Services

All ARTS Services are Covered by Managed Care Plans
A fully integrated Physical and Behavioral Health Continuum of Care

Magellan will continue to cover community-based substance use disorder treatment services for fee-for-service members

Effective July 1, 2017

ARTS
4/1/17

Inpatient Detox

Residential Treatment

Partial Hospitalization

Intensive Outpatient Programs

Opioid Treatment Program

Office-Based Opioid Treatment

Case Management

Peer Recovery Supports
## Increases in Addiction Providers Due to ARTS

Over 350 new Addiction Treatment Provider Organizations in Medicaid

<table>
<thead>
<tr>
<th>Addiction Provider Type</th>
<th># of Providers before ARTS</th>
<th># of Providers after ARTS</th>
<th>% Increase in Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Detox (ASAM 4.0)</td>
<td>Unknown</td>
<td>103</td>
<td>NEW</td>
</tr>
<tr>
<td>Residential Treatment (ASAM 3.1, 3.3, 3.5, 3.7)</td>
<td>4</td>
<td>78</td>
<td>↑ 1850%</td>
</tr>
<tr>
<td>Partial Hospitalization Program (ASAM 2.5)</td>
<td>0</td>
<td>13</td>
<td>NEW</td>
</tr>
<tr>
<td>Intensive Outpatient Program (ASAM 2.1)</td>
<td>49</td>
<td>72</td>
<td>↑ 47%</td>
</tr>
<tr>
<td>Opioid Treatment Program</td>
<td>6</td>
<td>29</td>
<td>↑ 383%</td>
</tr>
<tr>
<td>Office-Based Opioid Treatment Provider</td>
<td>0</td>
<td>79</td>
<td>NEW</td>
</tr>
</tbody>
</table>
## Highlights From the First Nine Months of ARTS

### Increase in total number of Substance Use Disorder Outpatient Providers

<table>
<thead>
<tr>
<th>By Provider Type</th>
<th>Before ARTS (Apr-Dec 2016)</th>
<th>After ARTS (Apr-Dec 2017)</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of SUD Outpatient Providers</td>
<td>950</td>
<td>2,544</td>
<td>185%</td>
</tr>
<tr>
<td>Physicians</td>
<td>223</td>
<td>1359</td>
<td>518%</td>
</tr>
<tr>
<td>NP</td>
<td>16</td>
<td>155</td>
<td>869%</td>
</tr>
<tr>
<td>Counselors and SW</td>
<td>267</td>
<td>350</td>
<td>31%</td>
</tr>
<tr>
<td>Other</td>
<td>444</td>
<td>680</td>
<td>65%</td>
</tr>
</tbody>
</table>
# Highlights From the First Nine Months of ARTS

## Increase in total number of Opioid Use Disorder Outpatient Providers

<table>
<thead>
<tr>
<th>By Provider Type</th>
<th>Before ARTS (Apr-Dec 2016)</th>
<th>After ARTS (Apr-Dec 2017)</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of OUD Outpatient Providers</td>
<td>488</td>
<td>1,128</td>
<td>↑150%</td>
</tr>
<tr>
<td>Physicians</td>
<td>108</td>
<td>476</td>
<td>↑341%</td>
</tr>
<tr>
<td>NP</td>
<td>6</td>
<td>51</td>
<td>↑750%</td>
</tr>
<tr>
<td>Counselors and SW</td>
<td>122</td>
<td>199</td>
<td>↑63%</td>
</tr>
<tr>
<td>Other</td>
<td>252</td>
<td>402</td>
<td>↑80%</td>
</tr>
</tbody>
</table>
### Highlights From the First Nine Months of ARTS

More members are receiving treatment for all Substance Use Disorders (SUD) and Opioid Use Disorder (OUD)

<table>
<thead>
<tr>
<th></th>
<th>Before ARTS (Apr-Dec 2016)</th>
<th>After ARTS (Apr-Dec 2017)</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members with SUD receiving treatment</td>
<td>10,102</td>
<td>16,570</td>
<td>↑64%</td>
</tr>
<tr>
<td>Members with OUD receiving treatment</td>
<td>6,989</td>
<td>10,522</td>
<td>↑51%</td>
</tr>
</tbody>
</table>
### Highlights From the First Nine Months of ARTS

**Fewer Emergency Department (ED) visits and decreased costs related to Opioid Use Disorder (OUD)**

<table>
<thead>
<tr>
<th></th>
<th>Before ARTS (Apr-Dec 2016)</th>
<th>After ARTS (Apr-Dec 2017)</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Visits related to OUD</td>
<td>4,484</td>
<td>3,101</td>
<td>↓31%</td>
</tr>
<tr>
<td>Total Spending on ED Visits</td>
<td>$7,950,019</td>
<td>5,776,221</td>
<td>↓27%</td>
</tr>
</tbody>
</table>
Highlights From the First Nine Months of ARTS

Effect of ARTS on the Number of ED Visits for Medicaid Members with an Opioid Use Disorder

- **OUD**
- **Non-SUD**
- **OUD without ARTS**
## Highlights From the First Nine Months of ARTS

Decrease in total number of prescriptions and members with prescriptions for Opioid pain medications

<table>
<thead>
<tr>
<th></th>
<th>Before ARTS (Apr-Dec 2016)</th>
<th>After ARTS (Apr-Dec 2017)</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of prescriptions for opioid pain medication</td>
<td>420,883</td>
<td>299,598</td>
<td>↓ 29%</td>
</tr>
<tr>
<td>Number of members with prescriptions for Opioid pain medications</td>
<td>116,286</td>
<td>97,529</td>
<td>↓ 16%</td>
</tr>
</tbody>
</table>
Why ARTS is Achieving These Outcomes

Critical Elements for Successful ARTS Implementation

• Intensive stakeholder engagement – collaborated with MCOs, agencies, and providers to design and implement ARTS
• System transformation using national ASAM criteria
  ▪ Increased provider qualifications
  ▪ Payment for evidence-based treatment
• Innovative delivery models for Medication Assisted Treatment – Office-Based Opioid Treatment providers
• Implementation of CDC Opioid Prescribing Guidelines – collaborated with MCO pharmacy directors, MSV, DHP, VDH
• Extensive provider training by DBHDS and VDH
• Education and recruitment of providers by DMAS
• Enhanced reimbursement
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 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.

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

**More Medicaid members are receiving pharmacotherapy for treatment of opioid use disorders**

- The number of Medicaid members receiving pharmacotherapy for opioid use disorders increased by 28 percent during the first nine months of ARTS.

<table>
<thead>
<tr>
<th></th>
<th>Before ARTS April-December 2016</th>
<th>After ARTS April-December 2017</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members who received any pharmacotherapy for opioid use disorder</td>
<td>5,516</td>
<td>7,057</td>
<td>28%</td>
</tr>
<tr>
<td>Members who received buprenorphine</td>
<td>4,560</td>
<td>5,534</td>
<td>21%</td>
</tr>
<tr>
<td>Members who received methadone</td>
<td>394</td>
<td>781</td>
<td>98%</td>
</tr>
<tr>
<td>treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Members who received naltrexone or</td>
<td>595</td>
<td>826</td>
<td>39%</td>
</tr>
<tr>
<td>other medication treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**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.

<table>
<thead>
<tr>
<th></th>
<th>Before ARTS</th>
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<td>ED visits related to opioid use disorders</td>
<td>4,484</td>
<td>3,101</td>
<td>-31%</td>
</tr>
<tr>
<td>Total ED visits for all Medicaid members</td>
<td>706,325</td>
<td>601,586</td>
<td>-15%</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
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<th>Before ARTS</th>
<th>After ARTS</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of prescriptions for opioid pain medications</td>
<td>420,883</td>
<td>299,598</td>
<td>-29%</td>
</tr>
<tr>
<td>Number of prescriptions for opioid pain medications per 10,000 members</td>
<td>3,045</td>
<td>2,152</td>
<td>-29%</td>
</tr>
</tbody>
</table>

- The number of prescriptions for opioid pain medications per 10,000 Medicaid members varies widely across Virginia regions.
Addiction and Recovery Treatment Services
Access, Utilization, and Spending for the Period of April 1 – August 31, 2017

December, 2017
VCU Evaluation staff

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Acknowledgments

We would like to thank the Virginia Department of Medical Assistance Services for providing their technical expertise on the Medicaid claims data and the ARTS program.

The conclusions in this report are those of the authors, and no official endorsement by the Virginia Commonwealth University School of Medicine or Virginia Department of Medical Assistance Services is intended or should be inferred.
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Executive Summary

Virginia implemented the Addiction and Recovery Treatment Services (ARTS) program in April, 2017 to increase access to treatment for Medicaid members with opioid or other substance use disorders. The Department of Medical Assistance Services contracted with Virginia Commonwealth University School of Medicine to conduct an independent evaluation of the ARTS program.

The objective of this report is to describe changes in substance use disorder treatment utilization, expenditures, and access during the first 5 months of ARTS. The major findings from this report are as follows:

Supply of treatment providers

- There have been substantial increases in the number of practitioners and facilities providing addiction treatment services to Medicaid members, including residential treatment facilities, opioid treatment programs, and providers authorized to prescribe buprenorphine. The number of outpatient practitioners billing for ARTS services more than doubled.

- Gaps in access to some service providers – especially residential facilities and Office-Based Opioid Treatment clinics – remain in some areas of the state, including the Far Southwest and other rural areas.

Increased spending and utilization on addiction treatment services

- During the first 5 months of the ARTS program, almost 14,000 Medicaid members used addiction-related services, a 40 percent increase from the year before.

- Spending on paid claims for addiction-related services amounted to almost $10 million during the first 5 months of ARTS, a 32 percent increase from the prior year.

- Treatment rates for members with substance use or opioid use disorders increased by more than 50 percent. Treatment rates are higher for those with an opioid use disorder diagnosis (51 percent) than for those with alcohol use disorders (28 percent).

- ARTS added coverage for residential treatment and medically managed intensive inpatient services for substance use disorders, although outpatient treatment is by far the most frequently used service.

- The use of buprenorphine to treat opioid use disorders increased substantially during the first 5 months of ARTS, although many members using buprenorphine do not have any opioid use disorder diagnosis and are not getting other services consistent with professional guidelines.
**Decreased hospital emergency department use related to substance use disorders**

- The number of emergency department visits related to substance use disorders decreased by 31 percent during the first 5 months of ARTS while the number of members with a visit decreased by 14 percent.

- Total spending on emergency department visits related to substance use declined by 14 percent to about $16 million during the first 5 months of ARTS.

**Decreased prescribing for opioid pain medications**

- The number of prescriptions for opioid pain medications among Medicaid members decreased by 28 percent during the first 5 months of ARTS, while the number of prescriptions for non-opioid pain relievers increased by 2 percent.

**Regional variation**

- Spending on services related to substance use disorder treatment increased the most in the Southside region (77 percent), and increased the least in the Northern region (6 percent).

- The Far Southwest includes 52 percent of all buprenorphine prescriptions in the state despite having only 8 percent of Medicaid members. Yet, buprenorphine users in the Far Southwest are much less likely to be receiving other treatment services compared to buprenorphine users in other parts of the state.

- Emergency department visits and opioid prescribing rates are highest in the Far Southwest region, and lowest in the Northern region.

- Despite much lower increases in spending on substance use disorder treatment, Northern Virginia had the largest decrease in emergency department visits compared to other Virginia regions.

**Workforce development and new models of care delivery**

- Addiction disease management training sessions sponsored by the Virginia Department of Health led to increases in the provision of addiction treatment services after six months among those who attended the training, as well as improved prescribing patterns for controlled substances.

- New care delivery models through ARTS, especially the Office-Based Opioid Treatment program, seek to improve the quality and effectiveness of addiction treatment services, although utilization of such clinics has been low compared to other outpatient providers.
Introduction

This report shows changes in substance use disorder treatment services for Medicaid members during the first 5 months of the Addiction and Recovery Treatment Services (ARTS) program. ARTS is a major initiative by the Commonwealth of Virginia to expand access to treatment for substance use disorders among Medicaid members.

Addiction and Recovery Treatment Services (ARTS)

Over 1,100 Virginians died from opioid overdoses in 2016, nearly doubling since 2011.¹ Nationally, Medicaid members are four times more likely than people with private insurance to have ever used heroin or been dependent on pain relievers.²

Virginia implemented the Addiction and Recovery Treatment Services program in April, 2017 to increase access to treatment for Medicaid members with substance use disorders. ARTS benefits are based on American Society of Addiction Medicine’s criteria and cover a wide range of addiction treatment services.³ ARTS services include the following: inpatient withdrawal management, residential treatment, partial hospitalization, intensive outpatient programs, opioid treatment, peer recovery, and case management. ARTS services are carved into existing Medicaid managed care plans to support full integration of behavioral and physical health.

ARTS evaluation

The Department of Medical Assistance Services contracted with Virginia Commonwealth University School of Medicine to conduct an independent evaluation of the ARTS program. The evaluation is conducted by faculty and staff from the Department of Health Behavior and Policy and the Department of Family Medicine and Population Health.

How the analysis was conducted

The findings in this report are based on analysis of Medicaid paid claims, surveys of physicians who attended addiction disease management trainings sponsored by the Virginia Department of Health, and a review of applications of health care providers aiming to become certified as Office-Based Opioid Treatment programs.

For estimates of utilization and expenditures related to the treatment of substance use disorders, we compare estimates of paid claims during the first 5 months of the ARTS program (April 1 through August 31, 2017) to the same 5 month period in 2016. These estimates exclude claims for services during the study period that had not yet been submitted or paid at the time of the analysis, unpaid claims, and services not covered by Medicaid.

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² MACPAC June 2017 Report to Congress on Medicaid and CHIP. Chapter 2: Medicaid and the opioid epidemic.
³ American Society of Addiction Medicine (ASAM). What is ASAM criteria? https://www.asam.org/resources/the-asam-criteria/about.2017
The Supply of Addiction Treatment Providers Increases After ARTS

- The number of residential treatment programs increased from 4 facilities before ARTS to 78 facilities after ARTS. Except in the Far Southwest and other rural areas in the West and Southside, most Medicaid members have access to residential treatment programs within 30 miles of urban areas or 60 miles for rural areas (see map below).

Network Adequacy of Residential Treatment Programs

Note: Map provided by the Department of Medical Assistance Services and reflect providers as of November 2017. The map is based on zip codes that have at least two providers within 30 miles driving of an urban area or 60 miles driving of a rural area.

- The number of opioid treatment programs (OTPs) increased from 6 programs before ARTS to 29 programs after ARTS. Nevertheless, there are still large areas of the Commonwealth where OTPs are not accessible (see map below).

Network Adequacy of Opioid treatment Programs

Note: Map provided by the Department of Medical Assistance Services and reflect providers as of November 2017. The map is based on zip codes that have at least two providers within 30 miles driving of an urban area or 60 miles driving of a rural area.
• Overall, 526 providers prescribed buprenorphine to Medicaid members during the first 5 months of the ARTS program, a 7 percent increase from the previous year. The vast majority of Medicaid members now have access to buprenorphine prescribers that are part of a Medicaid health plan network (see map below).

**Network Adequacy of Buprenorphine Waivered Practitioners**

![Map of Virginia showing network adequacy of buprenorphine waivered practitioners.]

Note: Map provided by the Department of Medical Assistance Services and reflect providers as of November 2017. The map is based on zip codes that have at least two providers within 30 miles driving of an urban area or 60 miles driving of a rural area.

• The number of outpatient practitioners billing for addiction treatment services increased by 139% during the first 5 months of ARTS, compared to a similar time period in 2016. The increases were especially large for physicians and nurse practitioners (see table below).

**Number and type of outpatient practitioners providing SUD and OUD treatment before and after ARTS implementation**

<table>
<thead>
<tr>
<th></th>
<th>Before ARTS April-August 2016</th>
<th>After ARTS April-August 2017</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Substance use disorder (SUD) outpatient practitioners</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>758</td>
<td>1,815</td>
<td>139%</td>
</tr>
<tr>
<td>Physicians</td>
<td>162</td>
<td>934</td>
<td>477%</td>
</tr>
<tr>
<td>Nurse practitioners</td>
<td>9</td>
<td>106</td>
<td>1078%</td>
</tr>
<tr>
<td>Counselors and social workers</td>
<td>215</td>
<td>274</td>
<td>27%</td>
</tr>
<tr>
<td>Other</td>
<td>372</td>
<td>501</td>
<td>35%</td>
</tr>
<tr>
<td><strong>Opioid use disorder (OUD) outpatient practitioners</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>389</td>
<td>819</td>
<td>111%</td>
</tr>
<tr>
<td>Physicians</td>
<td>81</td>
<td>339</td>
<td>319%</td>
</tr>
<tr>
<td>Nurse practitioners</td>
<td>4</td>
<td>31</td>
<td>675%</td>
</tr>
<tr>
<td>Counselors and social workers</td>
<td>99</td>
<td>154</td>
<td>56%</td>
</tr>
<tr>
<td>Other</td>
<td>205</td>
<td>295</td>
<td>44%</td>
</tr>
</tbody>
</table>

Note: Outpatient practitioners refer to ASAM Level 1 practices, which are defined as outpatient services that consist of less than 9 hours of treatment per week.
Large Increases in Service Utilization and Spending Related to Substance Use Disorders after ARTS Implementation

- During the first 5 months of the ARTS program, 13,903 Medicaid members used a substance use disorder-related service – a 40 percent increase from the year before.

- The number of Medicaid members with opioid use disorders using services increased by 39 percent during the first 5 months of the ARTS program.

- Total spending on service utilization for any substance use or opioid use disorder increased by about one-third during the first 5 months of the ARTS program.

### Spending and utilization of services related to substance use disorders

<table>
<thead>
<tr>
<th></th>
<th>Before ARTS April-August 2016</th>
<th>After ARTS April-August 2017</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All substance use disorders (SUDs)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of members using SUD-related services</td>
<td>9,898</td>
<td>13,903</td>
<td>40%</td>
</tr>
<tr>
<td>Total spending on SUD-related services</td>
<td>$7,354,254</td>
<td>$9,743,899</td>
<td>32%</td>
</tr>
<tr>
<td><strong>Opioid use disorders (OUD)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of members using OUD-related services</td>
<td>6,268</td>
<td>8,697</td>
<td>39%</td>
</tr>
<tr>
<td>Total spending on OUD-related services</td>
<td>$5,932,824</td>
<td>$7,797,881</td>
<td>31%</td>
</tr>
<tr>
<td><strong>Alcohol use disorders (AUD)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of members using AUD-related services</td>
<td>2,080</td>
<td>3,194</td>
<td>54%</td>
</tr>
<tr>
<td>Total spending on AUD-related services</td>
<td>$952,679</td>
<td>$1,529,412</td>
<td>61%</td>
</tr>
</tbody>
</table>

Note: Services include those performed in an OBOT or Opioid Treatment Program setting, psychotherapy or counseling, physician evaluation or management, intensive outpatient, partial hospitalization, residential treatment, medically managed intensive inpatient services, pharmacotherapy, peer support, lab tests, and case management. Substance use disorder services and spending are counted using claims paid by plans to providers, (rather than the capitated rates that DMAS paid to health plans). Results are based on claims submitted between April and November, 2017 for services occurring between April 1 and August 31, 2017. As some claims may not have been submitted or paid at the time of analysis, actual utilization and spending may be higher than the estimates shown.
• Total spending on opioid use disorder services increased the most in the Southside region (77 percent) during the first 5 months of ARTS compared to a year earlier, while spending increased the least in the Northern region (6 percent) (see map below).

Percent change in total spending for OUD services between April-August, 2016 and April-August, 2017

Over one-third (34 percent) of all spending on services related to the treatment of opioid use disorders occurred in the Far Southwest region, although this region includes only 8 percent of all Medicaid members and 20 percent of members with an opioid use disorder.

By contrast, only 7 percent of all spending on services related to the treatment of opioid use disorders occurred in the Hampton Roads region, although this region includes 22 percent of all Medicaid members in the state and 16 percent of members with an opioid use disorder.

Spending on opioid-related services by region, April-August, 2017

<table>
<thead>
<tr>
<th>Region</th>
<th>Total spending on OUD services</th>
<th>Share of spending on OUD services by region</th>
<th>Share of members with OUD by region</th>
<th>Share of all members by region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virginia total</td>
<td>$7,797,881</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Central</td>
<td>$1,209,130</td>
<td>16%</td>
<td>22%</td>
<td>21%</td>
</tr>
<tr>
<td>Eastern</td>
<td>$119,997</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Hampton Roads</td>
<td>$577,337</td>
<td>7%</td>
<td>16%</td>
<td>22%</td>
</tr>
<tr>
<td>Northern</td>
<td>$601,484</td>
<td>8%</td>
<td>9%</td>
<td>22%</td>
</tr>
<tr>
<td>Southside</td>
<td>$359,319</td>
<td>5%</td>
<td>7%</td>
<td>8%</td>
</tr>
<tr>
<td>Far Southwest</td>
<td>$2,665,793</td>
<td>34%</td>
<td>20%</td>
<td>8%</td>
</tr>
<tr>
<td>Valley</td>
<td>$430,097</td>
<td>6%</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>West Central</td>
<td>$1,834,724</td>
<td>24%</td>
<td>18%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Note: Results are based on claims submitted between April and November, 2017 for services occurring between April 1 and August 31, 2017. As some claims may not have been submitted or paid at the time of analysis, actual spending may be higher than the estimates shown.
**ARTS Narrows the Treatment Gap for Members With Substance Use Disorders**

- About one-third of members with a diagnosis for substance use disorders received treatment during the first 5 months of ARTS, up from 22 percent in the prior year.

- More than half (52 percent) of members with a diagnosis of opioid use disorder received treatment during the first 5 months of ARTS, up from 40 percent the year before.

- Fewer people with an alcohol use disorder received treatment compared to those with an opioid use disorder, although treatment for alcohol use disorders increased substantially after ARTS implementation.

<table>
<thead>
<tr>
<th></th>
<th>Before ARTS April-August 2016</th>
<th>After ARTS April-August 2017</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total number of members with a substance use disorder (SUD)</strong></td>
<td>26,785</td>
<td>27,595</td>
<td>3%</td>
</tr>
<tr>
<td>Member with SUD receiving any SUD treatment</td>
<td>5,815</td>
<td>9,460</td>
<td>63%</td>
</tr>
<tr>
<td>Percent receiving treatment</td>
<td>22%</td>
<td>34%</td>
<td>58%</td>
</tr>
<tr>
<td><strong>Total number of members with an opioid use disorder (OUD)</strong></td>
<td>8,632</td>
<td>10,107</td>
<td>17%</td>
</tr>
<tr>
<td>Members with OUD receiving any OUD treatment</td>
<td>3,439</td>
<td>5,207</td>
<td>51%</td>
</tr>
<tr>
<td>Percent receiving OUD treatment</td>
<td>40%</td>
<td>52%</td>
<td>29%</td>
</tr>
<tr>
<td><strong>Total number of members with an alcohol use disorder (AUD)</strong></td>
<td>10,996</td>
<td>10,054</td>
<td>-9%</td>
</tr>
<tr>
<td>Members with AUD receiving any AUD treatment</td>
<td>1,391</td>
<td>2,770</td>
<td>99%</td>
</tr>
<tr>
<td>Percent receiving AUD treatment</td>
<td>13%</td>
<td>28%</td>
<td>118%</td>
</tr>
</tbody>
</table>

Note: Services include those performed in an OBOT or Opioid Treatment Program setting, psychotherapy or counseling, physician evaluation or management, intensive outpatient, partial hospitalization, residential treatment, medically managed intensive inpatient services, and pharmacotherapy. Substance use disorder services and spending are counted using claims paid by plans to providers, (rather than the capitated rates that DMAS paid to health plans). Results are based on claims submitted between April and November, 2017 for services occurring between April 1 and August 31, 2017. As some claims may not have been submitted or paid at the time of analysis, actual utilization and spending may be higher than the estimates shown.
• Before implementation of ARTS, treatment rates for opioid use disorders tended to be higher in the Far Southwest and West Central regions, and lowest in the Southside and Hampton Roads region.

Percent of members with an OUD diagnosis who received any OUD treatment services, Apr-Aug 2016

• With the exception of the Far Southwest region, treatment rates increased across all regions during the first 5 months of ARTS. Increases in treatment rates were especially large in the Northern, Valley, and Eastern regions.

• Regional differences in treatment rates continued during the first 5 months of ARTS.

Percent of members with an OUD diagnosis who received any OUD treatment services, Apr-Aug 2017
Decreases in Emergency Department Use Related to Substance Use Disorders

It is expected that improved access to addiction treatment services will decrease emergency department (ED) utilization and spending related to substance use disorders. Although our analysis did not directly examine the causal impact of increased treatment on emergency department utilization, the trends are suggestive of such a pattern.

- During the first 5 months of the ARTS program, the number of ED visits that had any diagnosis for substance use disorders decreased by 31 percent, while the number of ED visits that had a diagnosis for opioid use disorders decreased by 39 percent. These decreases were larger than for all emergency department visits for Medicaid members, which decreased by 24 percent.

- The number of members with an ED visit related to substance use disorders decreased by 14 percent during the first 5 months of ARTS.

- Total spending on ED visits related to substance use disorders decreased by 14 percent, from about $19 million before ARTS to $16 million during the first 5 months of the ARTS program.

<table>
<thead>
<tr>
<th></th>
<th>Before ARTS April-August 2016</th>
<th>After ARTS April-August 2017</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total ED visits for all Medicaid members</strong></td>
<td>409,507</td>
<td>310,122</td>
<td>-24%</td>
</tr>
<tr>
<td><strong>ED visits related to substance use disorders (SUD)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of visits</td>
<td>13,592</td>
<td>9,374</td>
<td>-31%</td>
</tr>
<tr>
<td>Number of members with a visit</td>
<td>6,824</td>
<td>5,862</td>
<td>-14%</td>
</tr>
<tr>
<td>Total spending on visits</td>
<td>$18,857,124</td>
<td>$16,260,829</td>
<td>-14%</td>
</tr>
<tr>
<td><strong>ED visits related to opioid use disorders (OUD)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of visits</td>
<td>2,714</td>
<td>1,669</td>
<td>-39%</td>
</tr>
<tr>
<td>Number of members with a visit</td>
<td>1,527</td>
<td>1,206</td>
<td>-21%</td>
</tr>
<tr>
<td>Total spending on visits</td>
<td>$4,667,770</td>
<td>$3,555,774</td>
<td>-24%</td>
</tr>
<tr>
<td><strong>ED visits related to alcohol use disorders (AUD)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of visits</td>
<td>6,654</td>
<td>4,288</td>
<td>-36%</td>
</tr>
<tr>
<td>Number of members with a visit</td>
<td>3,073</td>
<td>2,451</td>
<td>-20%</td>
</tr>
<tr>
<td>Total spending on visits</td>
<td>$9,884,337</td>
<td>$7,850,417</td>
<td>-21%</td>
</tr>
</tbody>
</table>

Note: ED visits with any primary or secondary diagnosis of a substance use disorder are considered to be visits related to substance use disorders. Results are based on claims submitted between April and November, 2017 for services occurring between April 1 and August 31, 2017. As some claims may not have been submitted or paid at the time of analysis, actual utilization and spending may be higher than the estimates shown.
- Emergency department visits related to opioid use disorders were highest in the West Central region (19 visits per 10,000 Medicaid members) and lowest in the Northern region (6 visits per 10,000 members) (see map below).

Number of OUD-related emergency department visits per 10,000 Medicaid members, April-August, 2017

- The percent decrease in emergency department visits related to opioid use disorders during the first 5 months of ARTS was greatest in the Northern region (61 percent decrease) and lowest in the West Central region (6 percent decrease) (see map below).

Percent change in OUD-related emergency department visits between April-August, 2016 and April-August, 2017
Service Utilization by ASAM Levels of Care for Substance Use and Opioid Use Disorders

Coverage of substance use disorder services provided by ARTS are based on the American Society of Addiction Medicine (ASAM) National Practice Guidelines, which comprise a continuum of care from screening, brief intervention, and referral to treatment (Level 0.5) to medically managed intensive inpatient services (Level 4).

- Screening, Brief Intervention, and Referral to Treatment (ASAM Level 0.5) is used to screen for substance use disorders in any healthcare setting, including primary care settings. During the first 5 months of ARTS, 221 members had screenings for substance use disorders.

- Outpatient services (ASAM Level 1), such as psychotherapy and counseling or physician evaluation, are by far the most frequently used services. During the first 5 months of ARTS, 6,861 members with a primary diagnosis of a substance use disorder had psychotherapy, counseling or a physician evaluation, including 3,492 members with an opioid use disorder.

- ARTS established a new integrated care delivery model – Office-Based Opioid Treatment. During the first 5 months of ARTS, 369 members obtained care through either this new model or an Opioid Treatment Program.

- ASAM Level 2 includes partial hospitalization and intensive outpatient services. During the first 5 months of ARTS, 386 members used these services, including 150 members with an opioid use disorder.

- ARTS added coverage of short-term residential treatment services (ASAM Level 3) and medically managed inpatient services (ASAM Level 4). During the first 5 months of ARTS, more than 1,200 members used medically managed inpatient services for substance use disorders, while 83 members used short-term residential treatment services.

Members who used treatment services for substance use disorders, April – August, 2017

<table>
<thead>
<tr>
<th>Members who had any ASAM level of service</th>
<th>All substance use disorders</th>
<th>Opioid use disorders</th>
<th>Alcohol use disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members who had any ASAM level of service</td>
<td>9,683</td>
<td>4,981</td>
<td>2,511</td>
</tr>
<tr>
<td>ASAM Level 0.5, Early Intervention</td>
<td>221</td>
<td>99</td>
<td>38</td>
</tr>
<tr>
<td>Office-Based Opioid Treatment/Outpatient Treatment Providers</td>
<td>369</td>
<td>183</td>
<td>107</td>
</tr>
<tr>
<td>ASAM Level 1, Outpatient Services</td>
<td>6,861</td>
<td>3,492</td>
<td>1,805</td>
</tr>
<tr>
<td>ASAM Level 2, Intensive Outpatient/Partial Hospitalization</td>
<td>386</td>
<td>150</td>
<td>123</td>
</tr>
<tr>
<td>ASAM Level 3, Residential/Inpatient Services</td>
<td>83</td>
<td>41</td>
<td>26</td>
</tr>
<tr>
<td>ASAM Level 4, Medically Managed Intensive Inpatient Services</td>
<td>1,228</td>
<td>257</td>
<td>679</td>
</tr>
</tbody>
</table>

Note: Results are based on claims submitted between April and November, 2017 for services occurring between April 1 and August 31, 2017. As some claims may not have been submitted or paid at the time of analysis, actual utilization and spending may be higher than the estimates shown.
Pharmacotherapy for Treatment of Opioid Use Disorders

Treatment of opioid use disorders often involves pharmacotherapy, including buprenorphine, methadone, and naltrexone as part of evidence-based care.

- During the first 5 months of ARTS, the number of members receiving pharmacotherapy for an opioid use disorder increased by 26 percent.
- Members receiving buprenorphine pharmacotherapy – the most widely prescribed medication for opioid use disorders – increased by 25 percent.
- Methadone treatment increased by 19 percent, while naltrexone and other medications treatment increased by 45 percent, although remaining a small portion of overall pharmacotherapy.

<table>
<thead>
<tr>
<th>Members who received pharmacotherapy for opioid use disorders</th>
<th>Before ARTS April-August 2016</th>
<th>After ARTS April-August 2017</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members who received any pharmacotherapy for opioid use disorder</td>
<td>4,259</td>
<td>5,380</td>
<td>26%</td>
</tr>
<tr>
<td>Members who received buprenorphine*</td>
<td>3,540</td>
<td>4,432</td>
<td>25%</td>
</tr>
<tr>
<td>Members who received methadone treatment*</td>
<td>347</td>
<td>413</td>
<td>19%</td>
</tr>
<tr>
<td>Members who received naltrexone or other medication treatment</td>
<td>385</td>
<td>558</td>
<td>45%</td>
</tr>
</tbody>
</table>

Note: Results are based on claims submitted between April and November, 2017 for services occurring between April 1 and August 31, 2017. As some claims may not have been submitted or paid at the time of analysis, actual utilization and spending may be higher than the estimates shown. *Excludes buprenorphine and methadone prescriptions used primarily to treat chronic pain.
Many Receiving Buprenorphine Pharmacotherapy Not Receiving Other Recommended Opioid Use Disorder Treatment Services

Per the American Society of Addiction Medicine’s National Practice Guidelines, treatment of opioid use disorders is most effective when medication is combined with other treatment services, such as psychotherapy and counseling. The ARTS program was developed on these best practice principles.

- Less than half (48 percent) of Medicaid members who received buprenorphine pharmacotherapy during the first 5 months of ARTS received other treatment services, such as outpatient counseling or psychotherapy, physician evaluation and management, intensive outpatient, partial hospitalization, residential treatment, or medically managed intensive inpatient services.

- However, this is still a substantial increase compared to the year before, when only 30 percent of buprenorphine users received other services.

### Members who received buprenorphine and other services for opioid use disorders

<table>
<thead>
<tr>
<th>Service</th>
<th>Before ARTS April-August, 2016</th>
<th>After ARTS April-August, 2017</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of members who received buprenorphine pharmacotherapy</td>
<td>3,540</td>
<td>4,432</td>
<td>25%</td>
</tr>
<tr>
<td>Percent of members who also received other treatment*</td>
<td>30%</td>
<td>48%</td>
<td>58%</td>
</tr>
<tr>
<td>Percent of members who received counseling or psychotherapy</td>
<td>29%</td>
<td>45%</td>
<td>57%</td>
</tr>
<tr>
<td>Percent of members who received a urine drug screen</td>
<td>32%</td>
<td>37%</td>
<td>14%</td>
</tr>
<tr>
<td>Percent of members who received case management services</td>
<td>3%</td>
<td>6%</td>
<td>124%</td>
</tr>
</tbody>
</table>

Note: Substance use disorder services and spending are counted using claims paid by plans to providers, (rather than the capitated rates that DMAS paid to health plans). Results are based on claims submitted between April and November, 2017 for services occurring between April 1 and August 31, 2017. As some claims may not have been submitted or paid at the time of analysis, actual utilization and spending may be higher than the estimates shown. *Treatment services include those performed in an OBOT or Opioid Treatment Program setting, psychotherapy or counseling, physician evaluation or management, intensive outpatient, partial hospitalization, residential treatment, and medically managed intensive inpatient services.
While the Far Southwest region includes 8 percent of all Medicaid members, 45 percent of members receiving buprenorphine and over half of all buprenorphine prescriptions filled were in the Far Southwest (findings not shown).

Buprenorphine users in the Far Southwest are only about half as likely (32 percent) to be receiving other opioid-related treatment services compared to other regions (60 percent). They are also much less likely to be receiving urine drug screens.

Members who received buprenorphine and other services for opioid use disorders

<table>
<thead>
<tr>
<th>Service</th>
<th>Far Southwest</th>
<th>All Other Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of members who received buprenorphine</td>
<td>1,978</td>
<td>2,454</td>
</tr>
<tr>
<td>pharmacotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of members who also received other treatment*</td>
<td>32%</td>
<td>60%</td>
</tr>
<tr>
<td>Percent of members who received counseling or psychotherapy</td>
<td>31%</td>
<td>57%</td>
</tr>
<tr>
<td>Percent of members who received a urine drug screen</td>
<td>27%</td>
<td>45%</td>
</tr>
<tr>
<td>Percent of members who received case management services</td>
<td>4%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Note: Substance use disorder services and spending are counted using claims paid by plans to providers, (rather than the capitated rates that DMAS paid to health plans). Results are based on claims submitted between April and November, 2017 for services occurring between April 1 and August 31, 2017. As some claims may not have been submitted or paid at the time of analysis, actual utilization and spending may be higher than the estimates shown. *Treatment services include those performed in an OBOT or Opioid Treatment Program setting, psychotherapy or counseling, physician evaluation or management, intensive outpatient, partial hospitalization, residential treatment, and medically managed intensive inpatient services.
Co-prescribing with Buprenorphine

Several medications that are often co-prescribed with buprenorphine are known to have the potential for abuse among persons with opioid use disorders, including benzodiazepines (anti-anxiety medications), gabapentin (used to treat nerve pain and withdrawal symptoms), and some stimulants.

- Co-prescribing of benzodiazepines among buprenorphine users decreased by 27 percent during the first 5 months of ARTS, while co-prescribing of gabapentin increased by 22 percent.

### Co-prescriptions with buprenorphine

<table>
<thead>
<tr>
<th></th>
<th>Before ARTS April-August, 2016</th>
<th>After ARTS April-August, 2017</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent also prescribed benzodiazepines</td>
<td>32%</td>
<td>23%</td>
<td>-27%</td>
</tr>
<tr>
<td>Percent also prescribed gabapentin</td>
<td>28%</td>
<td>34%</td>
<td>22%</td>
</tr>
<tr>
<td>Percent also prescribed other stimulants</td>
<td>6%</td>
<td>5%</td>
<td>-17%</td>
</tr>
<tr>
<td>Percent also prescribed opioid analgesics</td>
<td>6%</td>
<td>4%</td>
<td>-32%</td>
</tr>
</tbody>
</table>

Note: Results are based on claims submitted between April and November, 2017 for services occurring between April 1 and August 31, 2017. As some claims may not have been submitted or paid at the time of analysis, actual utilization may be higher than the estimates shown.

- Co-prescribing of benzodiazepines and gabapentin is much higher in the Far Southwest region compared to other regions in Virginia. Co-prescribing of other stimulants and opioid pain medications is relatively rare across all regions, but lower in the Far Southwest.

### Regional variation in co-prescribing with buprenorphine

<table>
<thead>
<tr>
<th></th>
<th>Far Southwest</th>
<th>All Other Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent also prescribed benzodiazepines</td>
<td>33%</td>
<td>15%</td>
</tr>
<tr>
<td>Percent also prescribed gabapentin</td>
<td>47%</td>
<td>25%</td>
</tr>
<tr>
<td>Percent also prescribed other stimulants</td>
<td>1%</td>
<td>9%</td>
</tr>
<tr>
<td>Percent also prescribed opioid pain medications</td>
<td>2%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Note: Results are based on claims submitted between April and November, 2017 for services occurring between April 1 and August 31, 2017. As some claims may not have been submitted or paid at the time of analysis, actual utilization may be higher than the estimates shown.
Decrease in Prescriptions for Opioid Pain Medications

The Department of Medical Assistance Services has taken a number of actions to limit opioid prescribing for pain management consistent with guidelines issued by the U.S. Centers for Disease Control and Prevention and the Virginia Board of Medicine.\(^4\)\(^5\) These include prior authorization requirements and quantity limits for new opioid prescriptions beginning in December, 2016, which was expanded to all members in health plans beginning in July 1, 2017. To encourage more substitution of non-opioid pain medications for opioids, non-opioid pain medications that do not require prior authorization have been added to Medicaid formularies.

- During the first 5 months of ARTS, the total number of prescriptions for opioid pain medications decreased by 28 percent compared to a similar time period in 2016.

- Total spending on opioid prescriptions and days supplied decreased by 34 percent during the first 5 months of ARTS.

- The number of non-opioid pain medications increased slightly (2 percent).

Prescriptions for opioid and non-opioid pain medications

<table>
<thead>
<tr>
<th></th>
<th>Before ARTS April-August 2016</th>
<th>After ARTS April-August 2017</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opioid pain medications</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of prescriptions</td>
<td>231,449</td>
<td>166,471</td>
<td>-28%</td>
</tr>
<tr>
<td>Total days supplied</td>
<td>3,533,147</td>
<td>2,348,834</td>
<td>-34%</td>
</tr>
<tr>
<td>Total spending on paid claims for prescriptions</td>
<td>$7,564,271</td>
<td>$4,957,460</td>
<td>-34%</td>
</tr>
<tr>
<td>Number of prescriptions per 10,000 members</td>
<td>1,786</td>
<td>1,273</td>
<td>-29%</td>
</tr>
<tr>
<td><strong>Non-opioid pain medications</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of prescriptions</td>
<td>950,034</td>
<td>972,623</td>
<td>2%</td>
</tr>
<tr>
<td>Total days supplied</td>
<td>23,190,737</td>
<td>23,851,310</td>
<td>3%</td>
</tr>
<tr>
<td>Total spending on paid claims for prescriptions</td>
<td>$25,846,113</td>
<td>$27,285,973</td>
<td>6%</td>
</tr>
<tr>
<td>Number of prescriptions per 10,000 members</td>
<td>7,333</td>
<td>7,436</td>
<td>1%</td>
</tr>
</tbody>
</table>

Note: These results are based on claims submitted between April and November, 2017 for services occurring between April and August, 2017. As some claims may not have been submitted or paid for at the time of analysis, actual utilization and spending may be higher than the estimates shown.


\(^5\) Medical Society of Virginia. Opioid and Buprenorphine Prescriber Regulations Guide.
• The rate of opioid prescribing is highest in the Far Southwest region (2,311 prescriptions per 10,000 Medicaid members) and lowest in the Northern region (668 prescriptions per 10,000 Medicaid members).

Number of prescriptions for opioid pain medications per 10,000 Medicaid members, April-August 2017

• Opioid prescribing decreased the most in the Eastern region (35 percent) and decreased the least in the Valley region (25 percent).

Percent change in the number of prescriptions for opioid pain medications between April-August, 2016 and April-August, 2017
Workforce Development for Treatment of Addiction Disorders

Multiple efforts have been undertaken to increase the addiction disease management workforce in the Commonwealth of Virginia. Between January and March, 2017, the Virginia Department of Health (VDH) sponsored 27 day-long training sessions on addiction disease management (ADM) that were attended by 264 prescribers (physicians, nurse practitioners and physician assistants) and 544 behavioral health professionals.

To understand the impact of these training sessions on the provision of addiction treatment services, surveys were administered to attendees both at the time of the training and 6 months after the training. At the time of the training, 419 attendees completed surveys on current and intended addiction management practices. Among those who completed the initial survey, 126 (30 percent) completed follow-up surveys. The results of the survey are summarized below:

**Drug Enforcement Agency (DEA) waiver to prescribe buprenorphine**

- Prior to attending the VDH ADM training, 10 percent of potential prescribers had a waiver to prescribe buprenorphine from the DEA.
- Six months after attending the training, 41 percent of those who did not have a waiver had obtained a buprenorphine prescribing waiver
- Among those who had obtained a waiver since attending the training, 77 are currently prescribing buprenorphine to patients.

**Changes in treatment practices**

- The percent of attendees who provided buprenorphine treatment increased from 31 percent before attending the training to 39 percent after attending the training.
- The percent of attendees billing Medicaid for services increased from 30 percent to 40 percent after attending the training.

![Addiction disease management practices before and after attending VDH ADM training](image-url)
Other practice changes following the training

- Practitioners reported improved awareness of substance use disorders.
- Practitioners reported improved controlled substance prescribing patterns including co-prescription of naloxone (a rescue medication) when prescribing buprenorphine or other opioid use disorder medications.
- After attending trainings, practitioners were more likely to use motivational interviewing skills and other counseling skills taught during the addiction disease management training.
- More clinic staff were trained on addiction disease management.

Barriers identified to starting or increasing buprenorphine treatment

- Although the number of waivered practitioners increased, practitioners reported reluctance to initiate buprenorphine treatment due to insufficient numbers of licensed providers at their clinic.
- The cost to the practice of providing addiction treatment services remains a barrier to providing care.
- Practitioners need further educational activities and/or support in naloxone training, Medicaid billing details, ongoing mentoring support, and development of regional networks of established practitioners who provide Medication-Assisted Treatment.

Increase in number of buprenorphine waivered providers

- From 2016 to 2017, there was a 29% increase (507 providers in 2016 to 653 providers in 2017) in the total number of buprenorphine waivered providers in Virginia.

Number of buprenorphine waivered providers in Virginia by waivered patient limits, 2016 to 2017

![Graph showing the number of buprenorphine waivered providers in Virginia by waivered patient limits from 2016 to 2017. The graph displays a significant increase from 2016 to 2017, with a notable jump in the total number of providers from 507 to 653.]
Office-Based Opioid Treatment Models

Effectively combating the opioid addiction epidemic requires expanding access to medication-assisted treatment (MAT) in community settings and coordinating with other medical and behavioral health providers. To incentivize this expansion of services and treatment capacity, ARTS provides higher reimbursement rates and a $243 per-member per-month payment to “gold card” Office-Based Opioid Treatment (OBOT) clinics that combine MAT, behavioral health therapy, and coordination with other medical and social needs. Based on an analysis of 43 applications representing 70 new OBOTs as of October, 2017, we examined the growth and geographic distribution of clinic sites, clinic settings and care models, roles and responsibilities of clinical team members, and care coordination activities.

Growth and geographic distribution of OBOTs

- Statewide access to integrated MAT treatment at OBOTs has greatly expanded, from 38 treatment locations on April 1, to 76 treatment locations nine months later.

![Growth in OBOTs by Month, 2017](image)

- However, most OBOTs are clustered around urban centers, leaving many rural areas without access to integrated MAT options.

Network adequacy of OBOT providers

Note: Map provided by the Department of Medical Assistance Services and reflect providers as of November 2017. The map is based on zip codes that have at least two providers within 30 miles driving of an urban area or 60 miles driving of a rural area.
Characteristics of OBOT settings and clinic care models

- OBOT settings vary, with Community Service Boards comprising almost half of all applications. OBOTs also include addiction treatment centers, health system outpatient clinics, primary care clinics, and psychiatric clinics.

**Type of OBOT setting**

<table>
<thead>
<tr>
<th>Type of OBOT setting</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community service board</td>
<td>19</td>
</tr>
<tr>
<td>Addiction treatment center</td>
<td>7</td>
</tr>
<tr>
<td>Outpatient health system clinic</td>
<td>6</td>
</tr>
<tr>
<td>Primary care clinic</td>
<td>2</td>
</tr>
<tr>
<td>Psychiatry clinic</td>
<td>2</td>
</tr>
<tr>
<td>Federally qualified Health Clinic</td>
<td>1</td>
</tr>
<tr>
<td>Other (unspecified)</td>
<td>6</td>
</tr>
</tbody>
</table>

Note: Based on 43 applications submitted to DMAS as of October 2017 representing more than 70 locations.

- Most OBOTs (85%) appear to have been providing behavioral health and substance use disorder treatment services prior to ARTS.

- OBOT clinical team members include a total of 117 buprenorphine prescribers, 123 licensed behavioral health treatment providers, and 40 specialized substance abuse counselors.

- Waivered buprenorphine prescribers are primarily physicians, with significantly fewer nurse practitioners and physician assistants.

- The majority of OBOTs plan to use waivered buprenorphine prescribers to manage patients’ pharmacotherapy (90%) and conduct medical intake assessments (73%).

- The majority of OBOTs directly employ prescribers, with fewer using negotiated service contracts and space rental agreements.

- Behavioral health providers include a wide array of clinical psychologists, licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, certified substance abuse counselors, and residents in counseling.

- Behavioral health providers are primarily tasked with providing individual (76%) and group counseling (78%) services.
• Less than half of OBOTs plan to use certified substance abuse counselors (CSAC) or other substance abuse counselors in their clinical teams.

• Only 3 OBOTs plan to use peer recovery specialists.

**Care coordination roles and responsibilities**

• Care coordination plans were underdeveloped in the majority of OBOT applications. Most did not designate a specific care coordinator or define care coordination activities.⁶

• Over half of OBOTs (56%) plan to use team meetings to coordinate patient care. About half of those using team meetings plan to meet weekly.

• Most OBOTs did not plan to use prescribers in care coordination activities.

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⁶ DMAS provided additional guidance on care coordination responsibilities and requirements in an update to the ARTS manual on Oct 31, 2017. In the updated manual care coordination is defined as “connecting members with community resources to facilitate referrals and respond to social service needs, as well as linking members with peer supports and tracking and supporting members when they obtain medical, behavioral health, or social services outside the practice.”
Conclusion

The first 5 months of ARTS have seen substantial gains in access to and use of substance disorder services among Medicaid members. While the impact of new programs is often not observed until months or even years after they are implemented, the substantial increase in access and utilization during the first 5 months of ARTS is likely due in part to extensive preparations and outreach by the Department of Medical Assistance Services (DMAS) and the Virginia Department of Health (VDH) prior to the April 1, 2017 implementation. These include provider trainings, presentations and briefings to stakeholders by DMAS and VDH staff across the state, and efforts by health plans to recruit providers of substance use disorder services into their networks. High “pent-up demand” for services due to low access prior to ARTS may have also contributed to the surge in service utilization for substance use disorders during the first 5 months of the program.

Most notably, the supply of providers for addiction-related services increased significantly. This increase is especially apparent for residential treatment centers, which increased from 4 to 78 programs state-wide. While nearly all members now have geographic access to a buprenorphine-waivered practitioner for medication treatment of opioid use disorder, many areas of the state still lack full opioid treatment programs.

Indeed, the use of pharmacotherapy to treat opioid use disorders has dramatically increased, however, only about half of all members receiving pharmacotherapy also receive other services. Furthermore, members in some regions of the state – especially the Far Southwest – have very high rates of prescribing for buprenorphine, but much less use of other treatment services. Since outcomes tend to be better when pharmacotherapy is combined with psychotherapy and counseling, this raises concerns about the quality and effectiveness of care being received in these regions.

Higher rates of treatment for substance use disorders combined with less opioid prescribing may be related to fewer emergency department visits for substance use disorders during the first 5 months of ARTS. This decrease was larger than the decrease observed for all emergency department visits, although the report did not specifically test the impact of ARTS or other policy actions on emergency department utilization. Nevertheless, the trends are consistent with the expectation that increased access to treatment should result in fewer overdoses and other addiction-related health emergencies.

Despite gains in overall access to treatment services during the first 5 months of ARTS, some important challenges remain. Most notably, two-thirds of members with substance use disorders – and about half of members with opioid use disorders – did not receive any treatment services paid for by Medicaid. Treatment rates are considerably lower in the Southside and Hampton Roads regions compared to other areas of the state. While it is possible that some members are receiving services not paid for by Medicaid (for example, as uncompensated care or paid out-of-pocket), such care is likely to be more fragmented and ad-hoc than when received through a more organized system of treatment paid for by Medicaid.

Also, utilization of some services is still quite low, such as SBIRT (Screening, Brief Intervention, and Referral to Treatment), care coordination, intensive outpatient, partial hospitalization, and residential services. Finally, some areas of the state still lack access to some services, such as residential treatment, opioid treatment, and OBOT programs.

The ARTS evaluation team will continue to monitor trends in access, service utilization, and outcomes related to substance use disorders among Medicaid members. Future reports will examine whether the gains in access to treatment continue, and will identify new or ongoing challenges in member access and treatment.
2018 General Assembly

*(01) **Dental Fee Schedule Update — March, 2018:** DMAS is adding text to the state plan regarding the reimbursement of dental services, to reflect the inclusion of updated dental procedure codes in the agency fee schedule. Following internal DMAS coordination and review, this state plan amendment was submitted to HHR on 3/20/18. The SPA was forwarded to CMS on 3/23, and approved on 4/2/18.

*(02) **EVMS & VA Tech Carilion Supplemental Payments:** This fast-track regulatory action serves to add new regulation regarding supplemental payments for certain teaching hospitals. A LCME affiliated teaching hospital, known as Sentara Norfolk General, and a LCME affiliated teaching hospital, known as Carilion Medical Center, began receiving quarterly supplemental payments effective July 1, 2017 for inpatient services. This regulation is essential to protect the health, safety, and welfare of citizens in that implementation of these supplemental payments will assist in increasing access to care for the citizens of the Commonwealth. These two primary teaching hospitals are affiliated with public medical schools that will transfer the funds to DMAS for the state share for these payments. Following internal DMAS coordination and review, the regs were submitted to the OAG on 2/13/18 for review, and to DBP on 3/26/18.

*(03) **CHKD Hospital Inflation, FFS Providers, & Reimbursement Services on a Cost Basis:** The methodology for hospital reimbursement includes an annual inflation adjustment. In state fiscal year 2017, the inflation adjustment was 50% of inflation and in state fiscal year 2018, the inflation adjustment was eliminated. This regulatory action aims to create an update which will allow an exception of 100% inflation for the Children’s Hospital of the King’s Daughters (CHKD) in both FY2017 and FY2018. These technical changes incorporate language into the regulations that CMS has approved in State Plan amendments in order to provide more clarity. Internal DMAS coordination and review was conducted, and the regs were submitted to the OAG on 2/21/18 for review.

*(04) **Utilization Control: Nursing Facilities – Contract Termination (Fast Track):** DMAS terminates specialized care provider contracts when one or more of three conditions have been met. Currently, the State Plan includes a section on contract termination however, this language does not exist within the VAC. This regulatory action seeks to bring the VAC in-line with the State Plan and to include this long-standing DMAS policy in regulatory language. Following internal DMAS coordination and review, the regs were submitted to the OAG on 2/6/18 for review.

*(05) **DSH Payments for Inpatient Psychiatric Hospitals:** This fast-track action is an amendment to existing regulations to update the procedure for the Disproportionate Share Hospital (DSH) payment calculations for inpatient psychiatric hospitals. Beginning July 1, 2017, the annual DSH payment was calculated for each eligible hospital by dividing the total inpatient psychiatric hospital allocation by each hospital’s percentage of the total
uncompensated care costs for the most recent DSH audit year. Prior to July 1, 2017, the DSH per diem for state inpatient psychiatric hospitals was calculated by dividing the total state inpatient psychiatric hospital allocation by the number of DSH days and multiplying each hospital’s DSH days by the DSH per diem. Following internal DMAS coordination and review, the regs were submitted to the OAG and forwarded to DPB on 4/4/2018.

*(06) Peers Amendments: This fast-track regulatory action corrects citations and removes an annual caseload limit that was found to be a barrier to receiving peer support services. (A limit of 12 to 15 individuals in a peer support specialist’s care at any one time remains in place). This action serves to replace incorrect citations with either correct citations or text, and an annual caseload limit has been removed. Following internal DMAS review, the regs were submitted to the OAG on 3/30/18 for review.

*(07) Community Mental Health Services Documentation of Qualifications: This emergency regulatory action will require providers to maintain documentation to establish that Community Mental Health Services (CMHS) are rendered by individuals with appropriate qualifications and credentials, including proof of licensure or registration when applicable. The Department of Health Professions has begun to register Qualified Mental Health Professionals, and those working toward registration as Qualified Mental Health Professionals, and this regulation specifically includes documentation requirements for those individuals. The regs have been reviewed internally, and approved by the Agency Director. Awaiting 2018 budget specifications prior to submitting the reg package to the OAG.

*(08) Electronic Visit Verification (EVV): This NOIRA action intends to amend regulations in order to include provisions related to Electronic Visit Verification (EVV) as required by the 21st Century CURES Act, 114 U.S.C. 255, enacted December 13, 2016 (the CURES Act) and the 2017 Appropriations Act Chapter 836, Item 306. YYYY. The CURES Act requires states to implement an EVV system for personal care services by January 1, 2019 and home health care services by January 1, 2023. The 2017 Appropriations Act authorizes DMAS to require EVV for personal care, respite care and companion services. The CURES Act requires that the EVV system must verify: 1) The type of service(s) performed; 2) The individual receiving the service(s); 3) The date of the service; 4) The location of service delivery; 5) The individual providing the service, and 6) The time the service begins and ends. DMAS intends to seek input regarding the EVV system from individuals receiving services, family caregivers, providers of personal, respite and companion care services, home health care services, provider associations, managed care organizations, health plans and other stakeholders. DMAS shall seek input on the current use of EVV in the Commonwealth and the impact of EVV implementation. The NOIRA is currently circulating for internal DMAS review.

2017 General Assembly

*(01) Reimbursement of PDN, AT, and PAS in EPSDT: This state plan amendment serves to add text to the state plan regarding reimbursement practices that currently are in place relating to reimbursement of private duty nursing, assistive technology, and personal assistance services under EPSDT. The SPA was submitted to CMS on 9/22/2017. Per request, revisions were sent to CMS on 11/7/17. Additional questions were received from CMS on
11/21; and DMAS forwarded the responses on 12/1/17. The SPA was approved on 12/7/17. The corresponding fast-track regulatory changes are currently being drafted.

*(02) LMHP-R, RP, and S May Provide Outpatient Psychiatric Services: This fast-track regulatory action updates the Virginia regulations related to physicians, other licensed practitioners, and clinics to incorporate Licensed Mental Health Professional Residents and Supervisees into the regulatory text and to reflect text changes required by CMS. Residents in professional counseling, residents in psychology, and supervisees in social work have completed the education requirements for licensure, but have not yet completed the experience requirements for licensure, and the resident/supervisee status allows them to gain that experience while practicing under licensed clinical supervision. The Department of Health Professions permits these individuals to practice under licensed clinical supervision, and DMAS permits these individuals to provide billable outpatient behavioral health services to Medicaid members, provided that they practice in accordance with the DHP supervision requirements. This regulatory action includes this long-standing DMAS policy in regulatory language. The regs were sent to the OAG on 12/1/17 for review, and forwarded to DPB on 1/3/2018. Following a conf. call with DPB on 1/25/18, DPB posted the EIA on 2/12, and DMAS posted the corresponding response on 2/13 and received approval. The regs were sent to HHR on 2/13/18.

*(03) Supplemental Payments to State Owned or Operated Clinics: This fast-track regulatory action serves to add a new section and revised provider reimbursement language (required by the 2015 Acts of Assembly, Chapter 665, Item 301, the 2016 Acts of Assembly, Chapter 780, Item 306 and the 2017 Acts of Assembly, Chapter 836, Item 306) to the regs, to implement supplemental payments to state-owned or operated clinics. This action also brings state regulations into line with federal rules and current Virginia practice. The action is essential to protect the health, safety, and welfare of citizens of the Commonwealth in that these reimbursement rules help to ensure the continued financial viability of the Virginia Medicaid Program. Following internal DMAS coordination and review, the project was submitted to the OAG 9/20/17; forwarded to DPB on 10/10/17; and sent to the Sec. Office on 11/17/17. The action was sent to the Gov. Office for review on 12/8/17.

*(04) Former Foster Care Youth: This state plan amendment proposes to update current regs to add a new section entitled “Coverage of Former Foster Care Youth.” Currently, language exists, outlining Medicaid coverage for former foster care youth who aged out of care while receiving Medicaid in a state other than Virginia. Due to a recent review and decision made by the Centers for Medicare and Medicaid Services (CMS), this coverage is no longer available under the State Plan, but instead has been approved under an 1115 waiver. As a result, this language must be moved to the “state only” section of the VAC. Following internal review, the SPA was submitted to HHR on 9/12/17 and forwarded to CMS on 9/21. CMS issued informal questions on 11/3/17, which DMAS responded to on 11/9/17, 11/15, and 11/17. The SPA was approved on 12/12/17. The corresponding VAC regulatory package was drafted and circulated for internal review on 12/14/17. The regs for forwarded to the OAG for review on 2/8/2018.

*(05) Reduction of Inpatient Cost Sharing to Comply with Federal Regulation: This state plan amendment serves to bring DMAS into compliance with 42 CFR 447.52(b)(2).
Amendments to 42 CFR 447.52 require states to limit cost-sharing for inpatient hospitalization to $75 on or before July 1, 2017. As of July 1, 2017, DMAS has reduced its cost sharing for inpatient hospitalization from $100.00 to $75.00. In federal fiscal year 2017, the total cost is $45,250.00, half of which ($22,625.00) will be covered with federal funds. In federal fiscal year 2018, the total cost is $79,028.00, half of which ($39,514.00) will be covered with federal funds. The SPA was submitted to HHR for review on 9/15/17 and forwarded to CMS on 9/21. Following internal project coordination and conf. calls with CMS on 9/27 and 10/26, DMAS received a Request for Additional Information (RAI) on 12/15/17. This SPA was taken off the clock on 2/7/18, and DMAS is awaiting additional feedback from CMS.

*(06) CMHRS Changes Required by CMS: This NOIRA regulatory action serves to comply with CMS requirements related to service definitions, service components, and staffing requirements for community mental health rehabilitative services. CMS also required DMAS to provide detail on the unit of service and date that reimbursement rates were set; these are not changes in DMAS rates or units, but instead, include existing DMAS rates and units in the regulations. DMAS last updated these regulations on January 30, 2015. During the following two years, CMS reviewed those regulatory changes and required that DMAS clarify that community mental health rehabilitative services fit under the umbrella of “rehabilitative services” under 42 CFR 440.130(d): services that are recommended by a physician or licensed practitioner for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level. More specifically, CMS required DMAS to more clearly define each service, list and define the subcomponents of each service, specify what type of professional could provide each subcomponent, specify what a unit of service is for each service, and the date that existing reimbursement rates were set. The NOIRA regs began circulating for internal review on 9/28/17. The action was forwarded to DPB on 11/8/17 and to HHR on 11/21/17.

*(07) Reimbursement of Community Mental Health Services and Dental Interpretive Services: This state plan amendment serves to add text to the state plan regarding reimbursement practices that currently are in place relating to reimbursement of community mental health services, private duty nursing, assistive technology, and personal assistance services, and to reflect the inclusion of updated dental procedure codes in the agency fee schedule. The SPA was drafted internally; submitted to HHR on 7/17; and forwarded to CMS on 7/25/17. DMAS fielded questions from CMS and sent responses on 8/25 and 9/1. Following a conf. call with CMS on 9/21/17, the SPA was approved on 10/17/2017. *(As a result of the conf. call on 9/21, Dental and CMHRS remained in this SPA, while PDN, AT, and PAS were moved to a new SPA). This SPA was approved on 10/17/2017.
*(08) Supplemental Drug Rebates and Managed Care Organizations: This state plan amendment enables DMAS to collect supplemental rebates for Medicaid member utilization through MCOs. The Department has the authority to seek supplemental rebates from pharmaceutical manufacturers. Currently, DMAS only collects supplemental rebates for fee-for-service claims. This update to the State Plan will allow the Department the option to also collect supplemental payments for Medicaid member utilization through MCOs. The state supplemental rebates from managed care organizations for Medicaid member utilization will occur in the same manner in which fee-for-service supplemental rebates are collected. The contract will exist between the manufacturer and the State and will remain separate from federal rebates in compliance with federal law §§ 1927(a)(1) and 1927(a)(4) of the Social Security Act (Act). The SPA package was reviewed internally and submitted to HHR on 7/12/17, and after approval, forwarded to CMS on 7/20/17. The SPA was approved by CMS on 9/7/17. VAC changes are required following the SPA approval. DMAS circulated the Fast Track regulation revisions for internal review on 11/6. The regs were submitted to the OAG on 2/13/18 for review.

*(09) Reduction of Inpatient Cost Sharing to Comply with Federal Regulation: This final exempt regulatory action decreases the cost sharing amount charged per inpatient hospitalization from $100 to $75 in order to comply with federal rules at 42 CFR 447.52(b)(2). Under current DMAS regulations, DMAS requires members to share the cost of inpatient hospitalization by paying $100 toward the cost of their care. As of July 1, 2017, this cost must be changed to $75 for DMAS to remain in compliance with federal rules. The regs and state plan amendment were drafted internally. The SPA was submitted to HHR on 9/15 and forwarded to CMS on 9/21. Following conf. calls with CMS on 9/27 and 10/26, DMAS is currently drafting responses to CMS inquiries. This SPA is currently off the clock, as DMAS awaits responses from CMS regarding reimbursement information.

*(10) Reimbursement for Nursing Facility Evacuation Costs: In the event of a disaster resulting in an evacuation, nursing facilities seek to relocate individuals to nursing facilities in safer areas. DMAS is submitting this state plan amendment to clarify reimbursement provisions relating to reimbursement to the disaster-struck nursing facility. In November, 2016, CMS announced a final rule entitled "Emergency Preparedness" (42 CFR 483.73) which requires long term care facilities to establish and maintain an emergency preparedness program. The Virginia Department of Health, the Virginia Department of Emergency Management, the Virginia Hospital and Healthcare Association, and the long-term care provider community worked to establish a Long Term Care Mutual Aid Plan and a Memorandum of Understanding (MOU) for all facilities to sign. All nursing facilities in Virginia have signed this MOU, which details their responsibilities in the event of a disaster. Following a draft and internal review which began in March 2017, DMAS submitted the SPA to HHR on 5/30 for review. The action was then submitted to CMS for review on 6/6/17 and approved on 7/14/17. The corresponding regulatory changes were drafted on 7/20 and circulated for internal review and forwarded to the OAG on 9/22. DMAS received inquiries from the OAG on 9/28 and sent responses back on 10/3 and 10/5. Following a conf. call with the OAG on 11/6, the regs were submitted to DPB for review on 11/7. DMAS responded to DBP inquiries on 12/6 and 12/12. The Agency response to the Economic Impact Analysis (EIA) was posted on 12/15. DBP submitted the regs to HHR for review on 12/15/17.
*(11) Average Commercial Rate Calculation for Physicians Affiliated with Type One Hospitals: DMAS is issuing this state plan amendment to update the average commercial rate calculation of supplemental payments for physicians affiliated with Type One Hospitals in Virginia. The state plan includes physician supplemental payments for physician practice plans affiliated with Type One hospitals (state academic health systems). A Type One physician is a member of a practice group organized by or under the control of a state academic health system or an academic health system that operates under a state authority and includes a hospital, which has entered into contractual agreements for the assignment of payments in accordance with 42 CFR 447.10. This regulatory action will update the maximum rate to 256% of the Medicare rate effective April 1, 2017, and 258% effective May 1, 2017 based on the most recent information on the average commercial rate (ACR) furnished by the state academic health systems and consistent with appropriate prior public notices. Following a draft and internal review which began in May 2017, DMAS submitted the SPA to HHR on 6/8 for review. The SPA was then submitted to CMS on 6/22 for review. DMAS responded to CMS inquiries on 8/15/17 and split the SPA into two sections per CMS request. CMS approved the SPAs on 8/31. The corresponding VAC changes were drafted, reviewed internally, and submitted to the OAG on 11/2/17. DMAS responded to an OAG inquiry on 11/9. The regs were forwarded to DPB for review on 11/14. DMAS posted the EIA on 12/11. DBP submitted the regs to HHR for review on 12/15/17. The reg package was forwarded to the Gov. on 12/27/17.

*(12) VIDES Criteria for Care in ICFs/IID: This fast-track regulatory action implements the same assessment standard to be applied to individuals for admission to an Intermediate Care Facility for Individuals with Intellectual Disability as is being used for admitting such individuals to home and community based Developmental Disability waiver services. Using the same assessment standard for all individuals, regardless of whether they seek institutional care or community care, ensures the uniformity and consistency of evaluation and treatment to protect the health and welfare of these vulnerable citizens. These reg amendments propose to replace the current Level of Functioning survey standards with the new Virginia Individual Developmental Disabilities Eligibility Survey (VIDES) standards for individuals seeking care in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). The Commonwealth has recently adopted the VIDES standards for the comparable level of waiver services in communities. By using the VIDES standards for institutional care in this action, the Commonwealth is restoring the consistency of functional standards for individuals regardless of whether they obtain their care in their communities or in ICF/IID institutions. The reg package was drafted, circulated internally for review, and subsequently submitted to OAG on 2/2/18. Following a call, revisions were sent to the OAG on 2/22. The fast-track project was submitted to DPB on 3/14. The corresponding SPA was drafted and approved internally on 2/22; forwarded to HHR on 2/27; and submitted to CMS on 3/7/18.
*(13) **Requirements for LTC Facilities:** This final exempt regulatory action amends DMAS' nursing facility requirements for Medicaid participation so that they are in line with CMS requirements. A series of CMS revisions to CFR Part 483 (Requirements for States and Long Term Care Facilities) necessitates changes to what are now outdated CFR citations in DMAS regulations. Beginning April 2017, the reg package was drafted and circulated for internal review. The regs were submitted to the OAG on 6/22. DMAS responded to OAG inquiries on 6/28 and 8/9/17. The regs were OAG certified on 8/14, submitted to DPB on 8/15, and submitted to the Registrar on 8/16. The regs were published in the Register on 9/4, with an effective date of 10/19/17. A notification of 'final reg available for review' was sent to Town Hall users on 9/5. The corresponding SPA package was circulated for internal DMAS review as of 9/25; forwarded to HHR on 11/1; and submitted to CMS on 11/13. Following a conf. call on 12/4 with CMS, DMAS submitted revised state plan pages on 12/5. The SPA was approved by CMS on 1/11/18.

*(14) **Clarifications for Durable Medical Equipment and Supplies:** This NOIRA regulatory action will serve to update coverage and documentation requirements to better align them with best practices and Centers for Medicare and Medicaid (CMS) guidance, and to eliminate unnecessary elements that create confusion among DME providers. Specifically, these proposed changes include elements around: enteral nutrition, implantable pumps, delivery ticket components, and replacement DME after a natural disaster. It is expected that these changes will clarify coverage of DME and supplies for DME providers and Medicaid beneficiaries, and reduce unnecessary documentation elements for DME providers. Further, the changes will improve coverage by permitting newer and better forms of service delivery that have evolved in recent years and align Virginia’s coverage with recent guidance from CMS for enteral nutrition. Following an internal DMAS review, the package was submitted to DPB on 3/13/17. DPB moved the regs to the Governor's Office for review/approval on 3/27/17. The Governor signed the regulatory action on 4/14; and the regs were published on 5/15, with the comment period ending on 6/14/17. The proposed stage regs were drafted on 6/16 and submitted to the OAG on 10/25. The OAG submitted questions on 12/11 and DMAS coordinated and submitted responses on 1/3/18. Additional revisions were forwarded to the OAG on 2/13/18. The regs were certified by the OAG on 3/8 and submitted to DPB on 3/9/18.
**(15) CCC Plus WAIVER:** DMAS has requested federal approval to merge the current Elderly or Disabled with Consumer Direction waiver population with that of the Technology Assistance Waiver, under the Commonwealth Coordinated Care Plus (CCC+) program. This regulatory action seeks to streamline administration of multiple waiver authorities by merging the administrative authority of two §1915(c) HCBS waivers into one §1915(c) waiver to be known as the Commonwealth Coordinated Care Plus (CCC+) waiver. The proposed merger of the EDCD waiver and Tech waivers will not alter eligibility for the populations and will expand the availability of services to encompass those currently available in either waiver to both populations. These populations will be included in the overall CCC+ program. The CCC+ Program will operate under a fully integrated program model across the full continuum of care that includes physical health, behavioral health, community based, and institutional services. CCC+ will operate with very few carved out services. Further, through person-centered care planning, CCC+ health plans are expected to ensure that members are aware of and can access community based treatment options designed to serve members in the settings of their choice. This action is essential to protect the health, safety, and welfare of citizens in that it allows for care coordination for the high-risk dually eligible population and ensures access to high quality care. The program includes systems integration, contract and quality monitoring, outreach, and program evaluation. The reg project was processed and reviewed internally. The action was submitted to the OAG for review on 11/9/17. Responded to OAG inquiries on 12/7/17, and additional inquiries on 2/22/18 and 3/19/18. Awaiting further direction from the OAG.

**(16) New Qualifying Hospitals:** This state plan amendment will update the list of qualifying hospitals for supplemental payments for private hospital partners of Type One hospitals. Hospital inpatient and outpatient reimbursement is being amended to change supplemental payments for private hospital partners of Type One hospitals by adding new qualifying hospitals. The State Plan supplemental payment provisions currently only apply to Culpeper Hospital. The amendment will add Haymarket and Prince William hospitals, where the University of Virginia has a minority ownership. The package was prepared internally and submitted to HHR on 3/10/2017. The SPA was forwarded to CMS on 3/21/17, and following responses to inquiries, the SPA was approved on 6/15/17. The corresponding fast-track regs were drafted and reviewed internally, and submitted to the OAG on 9/14/17 for review. OAG certification was received; the reg projected was submitted to DPB; and the DPB economic statement was posted on 2/14/18. The regs were forwarded to the Secretary’s office for review on 3/16. The Agency response to EIA was posted 3/26/18.
*(17) **Home Health Accrediting Organizations:** This fast track regulatory action brings accreditation requirements in line with: 1) the state licensure requirements outlined in §32.1-162.8 of the Code of Virginia; and 2) the CMS list of approved accreditation organizations for Medicare HHAs. Consistency among approved accreditation organizations will clarify and streamline requirements for DMAS providers. This regulation is essential to protect the health, safety, or welfare of citizens in that it provides consistency between the regulations and the Code with regard to the licensure requirements for HHAs. This consistency will help ensure that HHAs are appropriately licensed to provide services to Medicaid members. The regs circulated for internal review and were forwarded to the OAG for review on 4/27/17. DMAS responded to an OAG inquiry on 5/12. The regs were OAG certified on 5/17 and were submitted to DPB on 5/17/17. Following a conf. call with DPB on 6/16, the regs were submitted to HHR on 6/23, and to Governor on 7/5/16. The Governor approved the action on 8/4, with an effective date of 10/19/2017. A notification of a 'final reg available for review' was sent to Town Hall users on 9/5. The corresponding SPA was drafted and reviewed internally and submitted to HHR on 12/6 for review. The SPA submission was forwarded to CMS on 12/13 and approved on 12/14/17.

**2016 General Assembly**

*(01) **FAMIS Eligibility Changes:** This NOIRA regulatory action was required by 2016 budget language. This regulation will serve to improve access to eligible individuals that may be served by the Family Access to Medical Insurance Security Plan (FAMIS) program. DMAS is currently circulating the corresponding regulations for internal review. This regulatory action was submitted to DPB on 10/27/2016 and forwarded to the Governor's Office on 11/10. The regulations were signed by the Governor on 12/16/16 and published on 1/9/2017, with a public comment period through 2/8/17. Two comments were submitted. DMAS coordinated the next regulatory phase, and forwarded the regs to the OAG on 7/19/17. DMAS responded to several rounds of OAG inquiries between Sept 2017 and Jan. 2018. The regs were forwarded to DPB on 1/11/18. Following a meeting with DPB on 1/30, the EIA was posted. A response to the EIA was posted on 2/16/18. The regs were submitted to HHR on 2/21/18.

*(02) **Applied Behavioral Analysis:** This action establishes Medicaid coverage for behavior therapy services for children under the authority of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, which is a mandatory Medicaid-covered service that offers preventive, diagnostic, and treatment health care services to young people from birth through the age of 21 years. The proposed regulations define the behavioral therapy service requirements, medical necessity criteria, provider clinical assessment and intake procedures, service planning and progress measurement requirements, care coordination, clinical supervision, and other standards to assure quality. These regulations have been drafted, subsequently circulated for internal review, and were submitted to the OAG on 8/4. Revised regulatory text was submitted to the OAG on 10/4 and 11/21. Additional revisions were made to the regulatory text and re-submitted to the OAG on 2/22/17. The action was certified and sent to DPB on 3/2/17. The project was submitted HHR and then to the Governor's office on 5/10/17. The regs were signed by the Governor on 6/30 and submitted to the Registrar. The regs were published on 7/24, with a 60-day comment period. A comment
summary was submitted to commenters on 10/13. The final stage reg package began circulating internally on 10/13. The regs were forwarded to the OAG on 12/1/17 for review. Following a call with the OAG on 2/21/18, DMAS made revisions to the regs. The final stage regulations were submitted to DPB on 3/14/18.

*(03) Three Waiver Redesign: This emergency regulatory action is required by 2016 budget language. The Individual and Family Developmental Disabilities Support Waiver is changing to the Family and Individual Supports Waiver (FIS); Intellectual Disability Waiver is changing to the Community Living Waiver (CL), and; the Day Support Waiver for Individuals with Mental Retardation is changing to the Building Independence Waiver (BI). This redesign effort, ongoing between DMAS, DBHDS, consultants, and stakeholders for the last two years, combines the target populations of individuals with both intellectual disabilities and other developmental disabilities and offers new services that are designed to promote improved community integration and engagement. The regulatory action was OAG-certified on 8/18/2016 and DPB and the Secretary's Office approved the regulations on 8/22/16. The action was approved by the Governor on 8/24 and published in the Register on 9/19/16, with a public comment period through 10/24 (1 comment submitted). The Proposed Stage regs were drafted on 12/2016 and following internal DMAS review, submitted to the OAG on 7/31/17, and re-submitted on 9/7/17. Following a conference call on 9/18, DMAS coordinated revisions and submitted changes on 11/1/17. DMAS submitted an ER extension request for this project on 12/8/17. The ER has been extended until 8/30/18.

*(04) CCC Plus (MCOs - B Waiver) – formerly known as 'Managed Long Term Care Services and Supports (MLTSS)’: This emergency regulatory action is required by 2016 budget language. The regulation changes will transition the majority of the remaining Medicaid fee-for-service populations into an integrated, managed long-term services and supports (MLTSS) program. DMAS intends to launch an MLTSS program that provides a coordinated system of care that focuses on improving quality, access, and efficiency. The regulations were drafted, reviewed internally, and submitted to the OAG for review on 3/9/2017. DMAS received requests for revisions from the OAG on 3/16, 3/20 and 3/21. Following conference calls on 4/7 and 4/11 and a meeting on 5/1, the action was certified on 5/12 and then submitted to the DPB. The regs were forwarded to HHR on 5/22/17 and on to the Governor on 5/29. The Gov. signed the action on 6/16/17, with an effective date between 6/16 and 12/15/2018. The regs were published in the Register on 7/10, with a comment period through 8/9 (three comments were submitted). DMAS drafted the next stage of the regulatory review. The regs were submitted to the OAG on 1/9/18. DMAS received inquiries from the OAG and responded on 2/26/18. Following internal edits, DMAS sent additional revisions to the OAG on 3/5/18. DMAS is currently coordinating responses to more inquiries that were received on 3/15.

(05) Barrier Crimes Not Permitted: This fast-track regulatory action is required by the 2016 budget language. This regulatory action will amend existing regulations relating to provider requirements. Current regulations do not specifically bar all providers who have been convicted of barrier crimes from participating as Medicaid or FAMIS providers. These regulatory changes bar enrollment to, or require termination of, any Medicaid or FAMIS provider employing an individual with at least 5 percent direct or indirect ownership who has been convicted of a barrier crime. The regulations were drafted, reviewed internally, and
submitted to the OAG for review on 2/17/2017. The OAG issued inquiries on 3/21 and a conference call occurred on 4/26 to discuss the regs. DMAS is currently coordinating the responses for the OAG.

*(06) No Coverage of Overtime Hours for CD Personal Assistance, Respite and Companion Services: This regulatory action is required by 2016 session of the Virginia General Assembly. This action establishes that DMAS will not reimburse for more than 40 hours per week for consumer-directed personal assistance, respite and companion services for any one provider or working for any one consumer. An attendant may exceed 40 hours of work in a week working for multiple consumers. This limit will not apply to live-in attendants consistent with the U.S. Department of Labor's requirements (Fact Sheet 79B). This change, which will eliminate inconsistencies regarding pay for services in excess of 40 hours, applies to EPSDT-covered attendant services as well as waiver-covered attendant services. The regulations were sent to the OAG on 9/26 and subsequently revised. A submission was sent to DPB on 10/18/16. DPB submitted the action to HHR for review on 11/1; the regs were forwarded to Governor on 11/3; and the Governor signed the regulatory action on 12/6. The item was published in the Register on 12/26, with a 30-day comment period to follow (one comment was generated). This regulatory action is currently in the proposed stage and the package was drafted internally on 5/16. The regs were submitted to the OAG on 8/16/17 for review. Following a conf. call with the OAG on 10/3, the action was submitted to DPB on 10/10/17. A call with DPB was held on 11/9. The regs were submitted to HHR for review on 11/28/17. The regs were forwarded to the Governor on 12/11/17.

2015 General Assembly

*(01) Pre-Admission Screening Changes: This regulatory action is required by 2015 budget language. The regulation will improve the preadmission screening process for individuals who will be eligible for long-term care services. These regulatory changes were drafted and reviewed internally, and submitted to the OAG. The OAG certified the regulations and they were sent to the DPB on 4/25/16. The regulatory action was submitted to HHR on 5/4 and to the Governor on 5/17. The regulations were published in the Register on 7/11 and became effective on 9/1/2016. The corresponding SPA was sent to HHR on 8/24, and then submitted to CMS on 9/15/2016. CMS approved the SPA on 11/21/2016. The regulatory action transitioned to the Proposed Stage and was submitted to the OAG on 11/4/2016. DMAS responded to OAG inquiries on 12/6 and 1/25/17 and participated in a conference call with the OAG on 2/16/17. DMAS submitted responses to additional OAG questions. The OAG approved the regs on 4/25, and the action was forwarded to DPB. The action was submitted to HHR on 6/14; to the Governor on 7/5; and the Gov. signed the action on 8/4. The regs were published in the Register on 9/4, which will open a 60-day comment period. Comments were received from DARS, VHHA, and VDH and were summarized. The agency summary of comments received was sent to commenters on 11/20/17. The final stage reg package was created and circulated for internal review on 11/30 and approved at the DMAS-level on 2/27. The regs were submitted to the OAG on 2/28/18. DMAS is awaiting feedback.
*(02) Utilization Review Changes: DMAS drafted a NOIRA to implement regulatory changes to more accurately reflect current industry standards and trends in the area of utilization review. The regulatory action was submitted to the OAG on 11/2/2015, and comments were received on 11/10. A revised agency background document was sent to the OAG on 11/18. A NOIRA was sent to DPB on 11/30, and the regulatory action was moved to HHR on 12/4. The Governor signed the action on 12/11. The NOIRA was published in the Town Hall Register on 1/11/2016, with the comment period in place through 2/10. Following internal DMAS review, the regulatory action was submitted to the OAG on 6/23/16. Per request, further edits were made and submitted to the OAG on 7/21, 8/4, 10/7, 10/28, and 11/15/16. DMAS made additional edits on 2/21/17. The regs were forwarded to DPB on 3/28 and DMAS responded to follow-up questions from DPB on 4/20. The action was submitted to HHR on 5/12 and sent to the Governor's Office for review on 5/16. The action was signed by the Governor on 6/30 and submitted to the Register. The regs were published on 7/24, with an open 60-day public comment period. The final stage reg processing began internally on 9/26/17. The regulatory project was forwarded to the OAG on 3/15/18.

2014 General Assembly

*(01) GAP SMI Demonstration Waiver Program: The agency began work designing this new non-Medicaid program in early September in response to the Governor's directive. It provides a package of limited benefits to individuals who are 21 to 64 years old, uninsured, and residents of the Commonwealth. Some of the benefits are: physician, clinic, diagnostic outpatient procedures for both medical health conditions and behavioral health conditions related to diagnoses of serious mental illness. CMS approved the program in December, 2014. The emergency regulation action became effective 1/1/2015. The General Assembly proposed changes to this program in the 2015 budget and DMAS drafted a revised emergency regulation to incorporate these changes, which became final on 6/24/15. The proposed stage regulation, which incorporated the changes from both emergency regulations, was submitted to the OAG for review on 11/16/2015. DMAS revised the regulations, updated the Town Hall accordingly, and re-submitted the action to the OAG on 11/20/15. DMAS responded to OAG requests for revisions on 3/8/16 and 4/26. This regulatory action was re-submitted to the OAG on 5/23/16. DMAS submitted further updated info on 7/22 and received OAG revisions on 8/1. DMAS resubmitted info to the OAG on 9/13. The action was subsequently certified and sent to DPB on 9/20/16. Following a meeting with DPB on 10/25, and the submission of follow-up responses, DPB approval was secured on 11/3. HHR approved the action on 11/3; the item was sent to the Governor on 11/3; and the Governor signed the regulatory action on 12/6. It was published on 12/26, with a comment period through 2/24/17. The regulatory project moved to the final stage and following internal DMAS review, it was submitted to the OAG on 5/5. The action was pulled back from OAG review to make amendments on 5/9/17 and was re-submitted to the OAG on 6/15, with a revision sent to the OAG on 6/27. Inquiries were received on 7/19/17 and 8/25, and DMAS forwarded responses on 7/21 and 9/26. The regs were certified by the OAG and sent to the DPB on 10/5/17 for review; to HHR on
10/18/17; and to the Governor on 11/1/17. The Gov. approved the final stage regs on 12/19/17; they were filed w/ the Registrar on 12/19/17; and became effective on 2/7/2018.

2013 General Assembly

*(01) Mental Health Services Program Changes to Ensure Appropriate Utilization and Provider Qualifications:

This Emergency/NOIRA complies with the 2010 Appropriations Act that required DMAS to make programmatic changes in the provision of Intensive In-Home services and Community Mental Health services in order to ensure appropriate utilization and cost efficiency. The final NOIRA regulations became effective on 1/30/2015. A SPA was submitted to CMS on 3/25/15 and was signed by the Governor on 11/30/2015. Emergency regulations were published in the Register on 1/11/16, with NOIRA comment period from 1/11thru 2/10. This regulatory action was circulated for internal DMAS review on 2/24/2016. Following internal DMAS revisions, the regulatory action was submitted to the OAG on 5/9/2016. No SPA action is required. DMAS revised the regulations and resubmitted them to the OAG on 9/6. Per request, DMAS made additional OAG edits on 10/25/16. The regulatory action was OAG-certified on 11/1 and submitted to DPB on 12/8. The EIA was posted on 1/29, and DMAS' response was posted 2/1. The regulations were sent to HHR on 1/29/2017 and forwarded to the Governor's Office on 2/12. The Gov. signed the action on 4/14 and it was published in the Register on 5/15, with comment period through 7/14. One comment was generated and a summary of the public comment was sent back to the commenter. Final stage reg coordination was initiated. The reg action was submitted to DBP for review on 12/5/17. Questions were received from DPB on 12/13, with responses provided. The regs were forwarded to HHR on 12/15/17.

2010 General Assembly

*(01) Consumer Directed Services Facilitators:

This Emergency/NOIRA complies with the 2012 Acts of the Assembly Item 307 XXX that directed the DMAS to strengthen the qualifications and responsibilities of the Consumer Directed Service Facilitator to ensure the health, safety and welfare of Medicaid home-and-community-based waiver enrollees. This regulatory package was certified by the OAG on 11/2/2015 and was signed by the Governor on 11/30/2015. Emergency regulations were published in the Register on 1/11/16, with NOIRA comment period from 1/11thru 2/10. This regulatory action was circulated for internal DMAS review on 2/24/2016. Following internal DMAS revisions, the regulatory action was submitted to the OAG on 5/9/2016. No SPA action is required. DMAS revised the regulations and resubmitted them to the OAG on 9/6. Per request, DMAS made additional OAG edits on 10/25/16. The regulatory action was OAG-certified on 11/1 and submitted to DPB on 12/8. The EIA was posted on 1/29, and DMAS' response was posted 2/1. The regulations were sent to HHR on 1/29/2017 and forwarded to the Governor's Office on 2/12. The Gov. signed the action on 4/14 and it was published in the Register on 5/15, with comment period through 7/14. One comment was generated and a summary of the public comment was sent back to the commenter. Final stage reg coordination was initiated. The reg action was submitted to DBP for review on 12/5/17. Questions were received from DPB on 12/13, with responses provided. The regs were forwarded to HHR on 12/15/17.
1/27, the SPA was approved on 2/12/18, with effective date of 7/1/17. The corresponding proposed reg text began circulating for internal review on 12/7. The regs were forwarded to the OAG on 1/11/2018. Revisions were sent to the OAG on 1/29, 2/12, and 2/20/18. DMAS is currently awaiting further direction.

*Items that have completed both their state regulatory process and their federal approval process, if a federal approval process was necessary, have been dropped off of this report.*