Iowa Department of Public Health
Protecting and Improving the Health of Iowans

Gerd W. Clabaugh, MPA
Director

Kim Reynolds
Governor

Adam Gregg
Lt. Governor

Substance Use Disorder Provider Reimbursement Workgroup

Overview
Senate File 2418, the 2018 Iowa General Assembly directed the Iowa Department of Public Health (IDPH), in collaboration with the Department of Human Services (DHS), to engage a stakeholder workgroup to review Substance Use Disorder (SUD) provider reimbursement as follows:

SF2418. Page 5. Division III, Section 6
d. The department of public health, in collaboration with
13 the department of human services, shall engage a stakeholder
14 workgroup to review reimbursement provisions applicable
15 to substance use disorder services providers. The issues
16 considered by the workgroup shall include but are not limited
17 to the adequacy of reimbursement provisions including for
18 both outpatient and residential treatment, whether it is
19 appropriate to rebase reimbursement, whether there is equity in
20 reimbursement compared to the reimbursement methodologies used
21 for providers of similar behavioral health services, and access
22 to substance use disorder services providers including whether
23 the designated number of community mental health centers in the
24 state is sufficient. The workgroup shall review the reports
25 of previous workgroups including those authorized in 2014 Iowa
26 Acts, chapter 1140, section 3, subsection 1, and shall report
27 the workgroup's findings and recommendations to the general
28 assembly on or before December 15, 2018.

Goals:

- Review reimbursement provisions applicable to substance use disorder services providers.
    - Adequacy or reimbursement provisions; outpatient, residential
    - Appropriate to rebase reimbursement?
    - Equity in reimbursement compared to reimbursement methodologies used for providers of similar behavioral health services?
    - Access to substance use disorder services; designated number of community mental health centers sufficient?
- Review reports from previous workgroups
    - 2014 House File 2463
    - 2017 Complex Service Needs Workgroup Report
    - Other Resources?
- Report findings and recommendations to General Assembly by December 15.

Workgroup Members:

- Kermit Dahlen, President & CEO, Jackson Recovery Centers, Sioux City
- Neil Fagan, Project Manager Behavioral Health Services, Unity Point Health, Des Moines
- Jay Hansen, State Board of Health, Executive Director, Prairie Ridge, Mason City
- Chris Hoffman, Executive Director, Pathways Behavioral Services Inc., Waterloo
- LeAnn Moskowitz, IME/DHS Policy Unit
- Marcia Oltrogge, Executive Director, NE IA Behavioral Health, Decorah
- Kathy Stone, IDPH
- Deanna Triplett, IDPH
- D. Lowell Yoder, Assistant Director of Social Services, UIHC

Meeting Dates and Iowa Laboratories Facility at 2240 DMACC Blvd, Ankeny, IA on the DMACC Campus:

- August 23, Room 209
- September 20, Room 208
- October 4, Room 208

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MEETING AGENDA
August 23, 2018
10am - 3pm

Iowa Laboratories Facility at 2240 DMACC Blvd, Ankeny, IA

10:00 am Welcome and Introductions

10:15 am Review Directive

10:30 am Review Reports and Discuss

11:00 am Additional Issues

11:30 am Public Comment

12:00 am Lunch on your own

1:00 pm Reach Consensus on Directives

- Adequacy or reimbursement provisions; outpatient, residential
- Appropriate to rebase reimbursement?
- Equity in reimbursement compared to reimbursement methodologies used for providers of similar behavioral health services?
- Access to substance use disorder services; designated number of community mental health centers sufficient?

2:00 pm Reach Consensus on Next Steps

2:30 pm Public Comment

3:00 pm Adjourn

Iowa Department of Human Services

Complex Service Needs Workgroup Report

December 15, 2017

Executive Summary

The 2017 Iowa Acts, Chapter 109, Section 17 directed the Department of Human Services (Department) to convene a stakeholder workgroup to: *"…make recommendations relating to the delivery of, access to, and coordination and continuity of mental health, disability, and substance use disorder services and supports for individuals with mental health, disability, and substance use disorder needs, particularly for individuals with complex mental health, disability, and substance use disorder needs."*

The Complex Service Needs Workgroup recommends expanding and improving Iowa's mental health and substance use disorder services array to fill gaps for individuals with the most complex service needs by developing and implementing in strategic locations throughout Iowa:

- Six (6) access centers
- Twenty-two (22) Assertive Community Treatment teams
- A full array of mental health crisis response and sub-acute residential services
- Intensive residential service homes to serve a minimum of 120 individuals
- Tertiary care psychiatric hospitals including the mental health institutes and other hospitals

The Workgroup also recommends the following legislative action:

- Require mental health and disability services (MHDS) regions to establish, implement, and maintain the following services as required core services[1] in partnership with managed care organizations (MCOs) in strategic locations throughout Iowa:
    - Access centers
    - Assertive Community Treatment
    - Comprehensive crisis and sub-acute services
    - Intensive residential service homes
- Direct the Department to establish a single set of provider qualifications and access standards that are used for Chapter 24 accreditation, Iowa Medicaid Enterprise for Medicaid enrollment, MHDS Region standards, and MCO utilization review standards
- Direct the Department to establish access standards that allow and encourage multiple MHDS Regions to strategically locate and share intensive, specialized services among and between MHDS Regions to best serve Iowans in the most efficient manner possible
- Eliminate the Iowa code that limits the number of sub-acute care facility beds
- The 2018 Legislative Interim Committee on MHDS funding fiscal viability should consider this report in its deliberations.

The Workgroup recommends the Department of Human Services and Public Health (Departments) review this report with the Courts and seek their support for the recommendations. The Departments will seek agreement with the Courts to discuss how Iowa Code 125 and 229 could be amended to make the best use of these changes and include pre-commitment screening.

[1] "Core Services" are those services MHDS Regions are required to develop, implement, and maintain.

FILLING GAPS IN IOWA'S MENTAL HEALTH SERVICE AND SUPPORT ARRAY [1]

All Mental Health Conditions | **Moderately Severe Conditions** | **Acute Conditions** | **Severe Conditions**

- Prevention and outreach
- Screening, assessment and evaluation
- Individual, group and family therapy
- Peer and caregiver education and supports
- Integrate mental health and physical health care
- Medication Management
- Integrated mental health and substance use disorder treatment
- Case Management and Care Coordination
- Housing, employment, education and support services
- Supports, skill building, wellness and recovery
- Jail diversion and re-entry services
- Crisis intervention and stabilization
- Assertive Community Treatment
- Residential support
- Inpatient hospital psychiatric

RECOMMENDATIONS TO FILL GAPS FOR SERIOUS COMPLEX SERVICE NEEDS

- Crisis Response and Sub-acute
- Access Centers
- Assertive Community Treatment
- Intensive Residential Service Homes
- Tertiary Care Hospitals

1. Service Array derived from NAMI "Adult Mental Health Service Array"

Introduction

The Department of Human Services (Department) convened the Complex Service Needs Workgroup (Workgroup) made up of -diverse members that included: Department of Public Health (IDPH), advocates, community providers, hospital providers, law enforcement, mental health and disability services (MHDS) regions, and Department of Corrections. (Appendix A) The Workgroup conducted its work during six open public meetings on August 22, October 10, November 2, November 21, November 28, and December 12, 2017 and several subcommittee meetings. Public comment was heard at each Workgroup meeting. In its deliberations, the Workgroup discussed previous similar efforts related to its task. (Appendix B)

Recommendations

Providing individuals with severe, complex mental health or substance use disorder needs the right services by the right provider at the right time.

The following recommendations are intentionally not listed in priority order. Instead they are listed in alphabetical order. No single recommendation provides the solution to fill the gaps in services for individuals with serious complex service needs. The Workgroup recommends they be considered as a package to be added to Iowa's existing array of mental health and substance use disorder services.

These recommendations are based on the expectation that:

- MHDS Regions fund required services not reimbursable by Medicaid or services required by and provided to eligible individuals that are not enrolled in Medicaid; and
- MCOs fund services covered by Medicaid provided by a Medicaid enrolled contracted provider to a member that has demonstrated the need for the service.
- MHDS Regions and MCOs work cooperatively and collaboratively to successfully implement these recommendations.

Designate and/or develop six (6) access centers in strategic geographic locations throughout Iowa by the end of 2019.

Access centers are specially organized and designated crisis residential/sub-acute services that provide immediate, short-term assessment and treatment services to individuals that do not require inpatient psychiatric hospital level of care, but need significant amounts of support and services not immediately available in the individual's home or other available community-based setting such as non-designated crisis residential or sub-acute services.

Access centers should:

- Serve individuals that have a serious mental health and/or substance use disorder need that:
    - Are medically stable;
    - Do not need inpatient psychiatric hospital level of care; and
    - Do not have alternative, safe, effective services immediately available to them;
- Serve individuals with serious mental illness or substance use disorder on a no eject, no reject basis;
- Accept and serve individuals court ordered for mental health or substance use disorder treatment;
- Be Chapter 24 accredited as a mental health crisis residential provider and licensed as a mental health sub-acute provider;
- Be Chapter 155 licensed as a substance use disorder treatment program or have a cooperative agreement with and immediate access to licensed substance use disorder treatment services or medical care that incorporates withdrawal management;
- Provide person-centered mental health and substance use disorder assessments by appropriately licensed/credentialed professionals and peer support services based on a comprehensive assessment;
- Provide or arrange to provide necessary physical health services; and
- Ensure short stays by providing individuals care coordination that provides successful navigation and warm handoffs to the next service provider, and linkages to needed services such as housing, employment, shelters, etc.

MHDS Regions should be required to develop, implement, and maintain Access Center services as a core service in strategic areas throughout Iowa.

The Department should be required to establish Access Center designation criteria and access standards that allow and encourage multiple MHDS Regions to strategically locate and share this intensive level service. The Department should also clarify whether or not crisis residential service settings can accept court commitments.

MCOs and the MHDS Regions, in consultation with local law enforcement, should jointly select, develop, and implement six (6) access centers strategically located throughout Iowa by December 2019.

MHDS Regions should provide start-up funds for the establishment of the jointly selected access centers.

MCOs should offer contracts to the jointly selected access centers to provide Medicaid reimbursable services. MCOs should reimburse the access centers at the floor rate for covered Medicaid services the centers are enrolled to provide to Medicaid members that have a demonstrated need for the service.

MHDS Regions should be required to provide additional funding for non-Medicaid services (e.g., room, board, transportation, and reasonable operational vacancies).

Story – How Access Centers Can Work

Naomi, a woman in her late 20s, told her boyfriend she was tired of living and was going to overdose. Her boyfriend hid her medications and called for help. Police with specialized mental health training responded to the call. They found the boyfriend and head for the bedroom where Naomi was sitting on her bed.

Naomi tells police that she is OK and that she overreacted to a Halloween joke. The police don't believe her story and after asking more questions learn that she struggles with alcohol, had attempted suicide before, and takes psychiatric medication. The police tell Naomi that they don't think she is feeling well and they want to help.

Naomi tells them that she's tired of living, is estranged from her family, and is drinking again after several years of sobriety. The police build rapport and she agrees to pursue treatment, even as she's saying, "I don't want to go." As police watch carefully, she packs a small bag and walks to a patrol car waiting outside.

Once she is medically cleared at the emergency room, a decision is made that she doesn't have an acute psychiatric crisis and she is stating she does not want to hurt herself anymore so the physician determines inpatient hospital treatment is not needed. However, she cannot safely go home, so the physician obtains a court commitment to the Access Center. There she is watched closely, kept safe, provided preliminary treatment, and connected with treatment and support services as soon as possible. In two days she is heading home with follow up appointments and someone monitoring to make sure she stays engaged in treatment.

The number of Assertive Community Treatment (ACT) teams should be expanded so that a total of twenty-two (22) ACT teams are available in strategic locations throughout Iowa by the end of SFY19.

ACT provides interdisciplinary team-based individualized, flexible treatment and supports to individuals with mental illness in their home and community, 24 hours a day, seven days a week, 365 days a year. ACT team members are trained in the areas of psychiatry, social work, nursing, substance use disorder treatment, and vocational rehabilitation. Individuals served usually have schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), or bipolar disorder (manic-depressive illness); or are experiencing significant disability from other mental illnesses and are not helped by outpatient treatment models.

Currently, Iowa has ten (10) ACT programs currently operating and one (1) under development.

Program	**Counties Served**
Operating	
• Abbe Center ACT	Linn
• Berryhill	Webster, Hamilton
• Eyerly Ball – 2 (incl. FACT[2])	Polk
• Heartland Family Services	Pottawatomie
• University of Iowa IMPACT	Johnson, Cedar
• RHD	Blackhawk
• RHD	Marion, Monroe, Lucas, Wayne, Clarke, Decatur, Ringgold
• Seasons Center	Lyon, Osceola, Dickinson, O'Brien, Clay, Palo Alto, Buena Vista
• Vera French	Scott
Under Development	
• Eyerly Ball	Boone, Story

Literature on ACT estimates that .06% of the adult population or 51% of adults with a Serious Mental Illness could benefit from ACT services.[3] Following these estimates, eleven (11) more ACT programs should be developed in strategically located areas throughout Iowa. Based on population, consideration should be given to the following areas:

- Dubuque
- Sioux City – 2 Teams
- Mason City
- Waterloo – 2nd Team
- Davenport/Bettendorf – 2nd Team
- Des Moines – 3rd Team
- Ottumwa - Southeast Iowa
- Rural West Central Iowa
- Rural Northeast Iowa, e.g. Manchester/Independence (Already initially in development)
- Southeast Iowa, e.g., Burlington/Ft. Madison/Keokuk

The Department should be required to establish uniform, statewide accreditation standards for ACT based on national accreditation standards by July 1, 2018. The statewide standards should require that ACT teams meet fidelity to nationally recognized standards as determined by an independent review of each team that includes peer review. The Department should make allowance for nationally recognized small team standards. MCOs' utilization management requirements should not exceed the Department's established standards.

[2] FACT is an adaptation of assertive community treatment (ACT) for persons involved with the criminal justice system. All ACT should be capable of addressing issues related to criminal justice.
[3] Cuddeback G, Morrissey J, Meyer P. Psychiatric Services 57:1803-1806, 2006

MHDS Regions should be required to develop, implement, and maintain ACT as a core service in strategic areas throughout Iowa.

By April 1, 2018, MCOs and MHDS Regions should jointly agree on:

- The strategically located geographic areas in which additional ACT teams should be developed considering at least the following criteria:
    - The recommended list of locations above,
    - A review of known individuals with diagnoses that benefit from ACT,
    - Hospital inpatient psychiatric readmission rates,
    - Interest and readiness of the provider and community partners to form ACT,
    - Availability of psychiatric providers (MD, ARNP, PA) interested in the model,
- How independent review of fidelity to established standards will be accomplished.

MHDS Regions should be required to provide start-up funding to the jointly selected ACT teams that are not yet developed including assistance in achieving fidelity to practice standards and technical assistance.

MCOs should offer contracts to the jointly selected ACT teams. MCOs should reimburse at the floor rate ACT teams enrolled in Medicaid that provide services to Medicaid covered members that have a demonstrated need for ACT.

MHDS Regions should be required to ensure efficiently and effectively operated ACT teams remain viable including providing funding for general operations following guidance provided by the Department. (Note: Balance billing will not be allowed)

The Department should review ACT Medicaid reimbursement rates and, if appropriate, a recommendation to adjust reimbursement rates should be presented to the Governor and Legislature prior to the 2019 session. The Governor and Legislature may consider the recommendation and, if appropriations are approved, MCO per member per month rates should be established based on the approved appropriation to allow for adjustments to ACT reimbursement.

The Department should work with the University of Iowa to provide specific data that demonstrates ACT's effectiveness.

Story – How ACT can work

Steve is a 52 year old gentleman with schizoaffective disorder and polysubstance abuse that does not take his prescribed medications regularly. During these times, he acts on his paranoia in sometimes dangerous ways. He has a legal history for trespass, disorderly conduct, and assault while psychotic. He has been homeless and has experienced frostbite at least once during these periods. He has been hospitalized three times in the last two years and has been in residential care twice, once for three months and once for six months. Upon discharge from residential care he typically decompensates and experiences paranoia. He accuses his

physicians and care providers of various things such as stealing his money and has burned bridges with many care providers.

Steve was referred to ACT. ACT arranged for a payee service to assure his bills were paid. The Team stopped by his apartment daily to provide medications and to monitor his symptoms. The Team spends a good deal of time with Steve hearing his grievances and helping him with immediate needs such as furnishing his apartment and getting access to food stamps and other benefits. The Team helped him avert evictions and helped him to communicate more effectively with his payee and his landlord. The Team attended appointments with him. Over a period of months his consistent use of his mental health medications helped him to become less paranoid. He was willing to see a primary care physician to treat his hypertension and high cholesterol. He began engaging in problem solving with the Team when his paranoia reappeared. They accompanied him to the grocery store, laundry, another public places to learn to use these new skills. Steve has had no hospitalizations or arrests since beginning ACT. He is considering a part time job. He is still smoking, but uses illegal drugs less frequently. The ACT team sees him five days a week in his home.

A full array of mental health crisis response and sub-acute residential services should be developed in strategic locations by the end of SFY19.

Mental health crisis and sub-acute services include:

- Crisis assessment - face-to-face clinical interview to determine an individual's current and previous level of functioning, potential for dangerousness, physical health, and psychiatric and medical condition. The crisis assessment becomes part of the individual's action plan.
- Crisis screening - process to determine what crisis response service is appropriate to effectively resolve the presenting crisis.
- Crisis stabilization community-based services (CSCBS) - short-term community-based services designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis
- Crisis stabilization residential services (CSRS) - short-term alternative living arrangement designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis
- Mobile response - a mental health service which provides on-site, face-to-face mental health crisis services for an individual experiencing a mental health crisis. (Note: The Department should adjust access standards to mobile response to address Iowa's rural communities.)
- Single statewide twenty-four-hour crisis line - a crisis line providing information and referral, counseling, crisis service coordination, and linkages to crisis screening and mental health services 24 hours a day. (Consider building on the IDPH YourLifeIowa platform)

- Twenty-three-hour observation and holding - a level of care provided for up to 23 hours in a secure and protected, medically staffed, psychiatrically supervised treatment environment.
- Warm line - a telephone line staffed by individuals with lived experience who provide nonjudgmental, nondirective support to an individual who is experiencing a personal crisis. (Consider building on the IDPH YourLifeIowa platform)
- Sub-acute services - a comprehensive set of wraparound services for individuals who have had or are at imminent risk of having acute or crisis mental health symptoms that threatens removal of the individual from their home and community, but do not need acute inpatient care.

MHDS Regions should be required to develop, implement, and maintain the full array of crisis services as core services in strategic areas throughout Iowa. MHDS Regions should be required to provide funding for their initial start-up.

MHDS Regions and MCOs should jointly agree on which sub-acute facilities are designated in strategic geographic locations throughout Iowa.

MCOs should offer contracts to all mental health crisis service providers and jointly designated sub-acute facilities. MCOs should reimburse at the floor rate Medicaid enrolled mental health crisis and sub-acute providers for services provided to Medicaid covered members that have a demonstrated need for the service.

MHDS Regions should be required to provide ongoing funding for services that are not reimbursed by Medicaid (e.g., services to individuals not enrolled in Medicaid, warm lines, etc.)

The statutory limit of 75 publicly funded sub-acute beds should be eliminated. Iowa Code Section 135G.6 (b) (2) states…

"…The department of human services shall not give approval to an application which would cause the number of publicly funded subacute care facility beds licensed under this chapter to exceed seventy-five beds."

The Department should review crisis and sub-acute services' Medicaid reimbursement rates and, if appropriate, a recommendation to adjust reimbursement rates should be presented to the Governor and Legislature prior to the 2019 session. The Governor and Legislature may consider the recommendation and, if appropriations are approved, MCO per member per month rates should be established based on the approved appropriation to allow for adjustments to crisis and subacute services' reimbursement.

Intensive residential service homes (IRSHs) capable of serving a statewide total of one hundred twenty (120) individuals should be designated and/or developed in strategic locations by the end of SFY19.

Individuals served in IRSHs are adults that have a diagnosis of mental illness and may also have an accompanying co-occurring diagnosis of developmental/intellectual disability and/or substance use disorder. The individuals' functional assessment – an analysis of daily living skills that takes into consideration the strengths, stated needs, and level and kind of disability of the individual using the service - reflect that the individuals have a serious and persistent mental illness including:

- Having a diagnosis of a serious mental illness (e.g., schizophrenia, schizoaffective disorder, major depression, bipolar disorder, or other serious psychiatric disorder);
- Having three or more areas of significant impairment in activities of daily living or instrumental activities of daily living;
- Needing 24-hour supervised, monitored and focused treatment to maintain or improve functioning and avoid relapse that would require a higher level of treatment;
- Not being responsive to an adequate trial of active treatment at a less intensive level of care;
- Being at risk of significant functional deterioration if intensive residential services are not received; and
- Having one or more of the following:
    - Three psychiatric hospitalizations in 6 months
    - Greater than 30 medically unnecessary psychiatric hospital days
    - Greater than 90 psychiatric hospital days per one stay
    - Three emergency room visits related to a serious psychiatric diagnosis in 6 months
    - Residing in State Resource Center with a serious psychiatric diagnosis
    - Being served out-of-state due to unavailability of mental health residential services in Iowa
    - In jail due to a serious psychiatric diagnosis or, being released from jail or prison with a serious psychiatric diagnosis
    - Being precariously housed or homeless

IRSH are specially developed and/or designated residential services that provide intensive, 24 hour, seven day a week, 365 day a year, coordinated supported community living services for individuals with the most intensive serious and persistent mental illness described above. Since the skills required to serve each sub-group of individuals dramatically differs, IRSH should serve a homogeneous group of individuals (e.g., individuals that have similar characteristics such as only an serious and persistent mental illness or a serious and persistent mental illness with intellectual disability, or serious and persistent mental illness with substance use disorder, etc.) IRSH services and supports should:

- Be enrolled with Iowa Medicaid Enterprise as a 1915i home and community based (HCBS) habilitation waiver and/or intellectual disability HCBS waiver supported community living provider
- Have adequate staffing that includes:
    - Appropriate specialty training including applied behavior analysis as appropriate;
    - Adequate direct care staffing ratios (e.g., no more than 2½ individuals served per staff on duty) with opportunities for lower staffing ratios based on demonstrated need; and
    - Swift access to additional staffing if serious incidents occur; and
    - Adequate pay and paid time off commensurate with the increased intensity of the services provided.
- Coordinate with the individuals' clinical mental health and physical health treatment including:
    - Ensuring treatment plans are developed by a comprehensive interdisciplinary team selected by the individual that develops and implements the individual's person-centered plan;
    - Ensuring access to active medication management and outpatient therapy, including evidence based therapy approaches;
    - Establishing a fully coordinated care plan that includes instructions on how to most effectively interact with the individuals served in home and in the community;
    - Accessing Assertive Community Treatment (ACT) services if there is a demonstrated need[4]; and
    - Developing a thorough Wellness Recovery Action Plan (WRAP) as appropriate.
- Be Chapter 155 licensed as a substance use disorder treatment program or have a cooperative agreement with and timely access to licensed substance use disorder treatment services for those it serves with a demonstrated need;
- Accept court ordered commitments;
- Have a high tolerance for serious behavioral issues; and
- Not eject or reject individuals referred to them based on the severity of the individuals' mental health and/or co-occurring needs.

IRSHs are the individuals' home. So, IRSHs should preferably be small (e.g., 4 individuals or less) and located in typical neighborhood settings to maximize community integration and natural supports[5]. Larger capacity IRSHs should be rare. In no case should an IRSH be larger than 16 beds.

[4] Recommend Iowa Administrative Code be revised to state that, when there is a demonstrated need, ACT can be provided simultaneously with 1915i Habilitation services.

[5] Housing options need to be compliant with Principles of the Olmstead Ruling, Centers for Medicare and Medicaid (CMS) Settings Rules, and the 16 bed limit related to the CMS institutions for mental disease rules.

The individual's length of stay in the program should be determined on an individual basis using person-centered planning and objective utilization review criteria with the goal to live in the most integrated setting practicable. The individual's status related to housing should be based on the individual's expected length of stay. Individuals expected to stay longer in the home should have the protections of a landlord tenant relationship. Individuals expected to stay shorter periods should not be hampered from moving by a long term lease.

In addition to IRSH, individuals should have opportunities for employment, vocational development, or other valued activities outside of the home such as day habilitation and vocational services.

MCOs and MHDS Regions should jointly select where IRSHs will be located by July 2018. Existing 1915i "habilitation homes" or Intellectual Disability HCBS Waiver supported community living providers that meet IRSH criteria should be considered for selection. MCOs and MHDS Regions should mutually agree on additional IRSH to be developed in strategic geographic locations. MCOs and MHDS Regions should work with the state mental health institutes, Broadlawns, and the University of Iowa Hospital and Clinics, or other interested hospitals with inpatient psychiatric programs to operate or affiliate with one IRSH each as an integral part of their mental health services.

MHDS Regions should be required to develop, implement, and maintain IRSHs as a core service in strategic areas throughout Iowa. MHDS Regions should be required to provide start-up funding for jointly selected IRSHs that are not yet operating.

MCOs should offer contracts to jointly selected IRSHs. MCOs should reimburse IRSHs for the covered Medicaid services the IRSH is enrolled with Medicaid to provide (e.g., home-based habilitation or supported community living) to Medicaid covered members that have a demonstrated need for the service. The mutually agreed upon contracts should include objective utilization review criteria. MCOs shall manage IRSHs to meeting individuals' needs consistent with the requirements of the Americans with Disabilities Act and the principles of the Supreme Court Olmstead decision.

MHDS Regions should be required to provide additional funding necessary for non-Medicaid funded services (e.g., room and board, reasonable vacancies, and transportation).

Story – How IRSH can work

John is 48 years old and has a serious and persistent mental illness and co-occurring intellectual disability and autism. He lives with 3 roommates and is on the Habilitation Waiver. He has been physically and verbally aggressive to staff and roommates resulting in his arrest. John has been admitted to the hospital for inpatient psychiatric services multiple times. When he was last admitted to the hospital his waiver provider discharged him from services. This is the third waiver provider who has discharged him due to his behaviors. John has been accepted by a service provider dedicated and specializing in serving individuals with serious

complex service needs. John is now succeeding because the home is specially designed to meet John's needs, the staff are specially trained, and there is access to intensive psychiatric services through ACT. His harmful behaviors are less frequent and he is positively engaged with staff and roommates. John has not had an inpatient hospital admission or run-ins with law enforcement for some time.

The role and responsibility of tertiary care[6] psychiatric hospitals within the array of intensive mental health services should be explicitly described and facilities designated in strategic locations by the end of SFY19.

Tertiary care psychiatric hospitals admit, care for, and treat individuals that other mental health care providers find too difficult to treat or too dangerous.[7] Tertiary care psychiatric hospitals should admit individuals on a no eject/no reject basis. Tertiary care psychiatric hospitals should be constantly seeking, developing, and implementing evidence-based, state-of- the-art practice and promising practice treatment approaches. Tertiary care psychiatric hospitals should be part of an array of well-defined routine and intensive mental health services. Tertiary care psychiatric hospitals should have strong linkages with the rest of the array of mental health services to ensure seamless and successful integration of individuals back into community settings including linkages to Access Centers.

Tertiary care psychiatric hospital roles and responsibilities should be clearly defined and should be complimentary to the roles and responsibilities of the full array of other mental health services, especially more intensive mental health services. Methods for referring and admitting individuals to tertiary care psychiatric hospitals should also be established including, but not limited to:

- Establishing admission criteria
- Describing the method for physician to physician consultation
- Describing how the tertiary care psychiatric hospital will decide whether or not to admit a patient
- Establishing a method for reconsidering admission decisions

Cherokee mental health institute and Independence mental health institute should be two of the designated tertiary hospitals. In addition, the Department and hospitals with inpatient psychiatric programs should agree upon and identify additional tertiary care psychiatric hospitals by July 2018.

[6] Tertiary Care is highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities. Marriam-Webster.com

[7] Substance of the description is from "The Vital Role of State Psychiatric Hospitals"; Joe Parks, M.D. Alan Q. Radke, M.D., M.P.H.; National Association of State Mental Health Program Directors; July 2014

A variety of funding options should be considered for state mental health institutes. Consideration should be given to the Department's cost containment proposal to allow state mental health institutes to retain 3rd party revenue to off-set the additional requirement for general funds. In addition, in the 2018 interim when the Legislature discusses sustainable funding for MHDS Regions, the amount MHDS Regions pay for mental health institute treatment for individuals that are their responsibility should be reviewed.

Impediments to fulfilling the tertiary care psychiatric hospital roles and responsibilities should be addressed including the Emergency Medical Treatment and Active Labor Act (EMTALA) requirements. EMTALA requires that a Medicare-participating hospital that has specialized capabilities, like a psychiatric hospital, must accept an appropriate transfer from another hospital of an individual with an unstabilized emergency medical condition who requires such specialized services. If an individual is found to have an emergency medical condition that requires specialized psychiatric capabilities and the psychiatric hospital has capacity, it is obligated to accept an appropriate transfer of that individual. This transfer must occur regardless of whether the individual meets tertiary care psychiatric hospital admission criteria.

The extent to which tertiary care psychiatric hospitals provide forensic services is another challenge. Forensic services include competency evaluations to stand trial, competency restoration treatment, and treatment for individuals found not guilty due to mental illness[8]. Individuals in these categories tend to have very long lengths of stay and often may not meet tertiary care psychiatric hospital admission criteria. This essentially reduces the number of available beds at these facilities. The Workgroup recommends a thorough review regarding how forensic mental health services are currently provided and funded with the goal of recommending improved methods of serving these individuals.

Additional Recommendations and Observations

In addition to the above recommendations, the Workgroup also recommends and takes note of the following:

- The Workgroup notes that, as these recommendations are implemented, there will be an opportunity to change and improve existing practices. Such changes will require education and effort for everyone supporting the mental health and SUD treatment system, including the courts. The Workgroup recommends that:
    - The Department of Human Services and the Department of Public Health arrange to educate judges regarding what changes can and should be made by the courts in the commitment process as these recommendations are implemented, and

[8] Iowa Code §812 and Iowa Ct. R. 2.22(8)

    - The Departments, representatives of the courts, and members of the Workgroup should develop recommendations for Iowa Code 125 and 229 including pre-commitment screening.
- The Department should convene a Task Force by July 2018 to develop and implement ACT teams and Systematic, Therapeutic, Assessment, Resources, and Treatment (START) Teams for individuals with co-occurring mental illness and intellectual/developmental disabilities.
- The Governor and Legislature should seek guidance from the Children's Mental Health and Well-being Advisory Committee for further development of a children's mental health and well-being system.
- The Workgroup takes notice that low reimbursement rates for substance use disorder residential treatment make it difficult to maintain capacity and workforce to serve patients with complex needs. (See December 2014 House File 2463 Report on adequacy and equity of reimbursement for substance use disorder treatment providers, submitted by IDPH.) The Department should review Medicaid substance use disorder residential treatment rates and, if appropriate, a recommendation to adjust reimbursement rates should be presented to the Governor and Legislature prior to the 2019 session. The Governor and Legislature may consider the recommendation and, if appropriations are approved, MCO reimbursement rates should be increased.
- The Workgroup takes notice of the challenges presented by the provision of forensic mental health evaluation and treatment. The Workgroup recommends that the Legislature direct the Department of Corrections in cooperation with the Department of Human Services to convene a Workgroup in the 2018 legislative interim to develop recommendations regarding how to more effectively and efficiently provide forensic mental health services.
- The Workgroup takes notice that individuals living with dementia represent another group of individuals with complex, difficult needs that are not being adequately met. The workgroup recommends that the Legislature consider recommendations from the December 15, 2017 joint report on dementia and work being undertaken by the Iowa Healthcare Association.
- The Workgroup takes notice that appropriately serving individuals with a history of sex offending adds a great deal of complexity, such as services are scarce, and the recommendations of the workgroup are unlikely to significantly resolve this issue and additional work is needed to address this issue.

Appendix A: Complex Service Needs Workgroup

Name	Agency
Rick Shults	Department of Human Services
Kathy Stone	Iowa Department of Public Health
Mary Ellen Barber	Family member of adult with SMI
Jerry Bartruff	Iowa Department of Corrections
Kevin Carroll	UnityPoint Behavioral Health
Jody Eaton	Central Iowa Community Services
Dr. Jerome Greenfield	Iowa Department of Corrections
Marc Hines	University of Iowa Hospital and Clinics
Chris Hoffman	Pathways Community Mental Health Center
Peggy Huppert	National Alliance on Mental Illness
Kathy Johnson	Abbe Center
Steve Johnson	Broadlawns Medical Center
David Lange	National Alliance on Mental Illness
Jeffrey Lipman	Polk County Magistrate
Bob Lincoln	County Social Services
Kim Murphy	Iowa Hospital Association
Marilyn Rhoten	CHI Health Behavioral Health
Jason Sandholt	Marion County Sheriff
Christina Schark	Southern Iowa Mental Health Center
Susan Seehase	Exceptional Persons, Inc
Dr. Jodi Tate	University of Iowa Hospital and Clinics
Tony Thompson	Black Hawk County Sheriff

Appendix B: Previous Work

Community Integration Workgroup for Adults with Serious Mental Illness Final Report
http://dhs.iowa.gov/sites/default/files/Community_Integration_Workgroup_for_Adults_with_SMI_Final_Report_12.15.2014.pdf

Getting Our ACT Together
https://dhs.iowa.gov/sites/default/files/ACTforIowaSept2011_09-15-2011.pdf

Mental Health and Disability Services Redesign Progress Report
http://dhs.iowa.gov/sites/default/files/MHDS_Redesign_Update_Report_Final_SFY17.pdf

IDPH House File 2463 Report – December 2014
https://www.legis.iowa.gov/docs/publications/DF/661296.pdf

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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August 5, 2016

Mr. Felix Milburn
Project Officer
Division of State Demonstrations and Waivers (DSDW)
Centers for Medicare and Medicaid Services (CMS)
7500 Security Boulevard
Mail Stop: S2-01-16
Baltimore, Maryland 21244

Dear Mr. Milburn:

The purpose of this letter is to request an amendment to Virginia's Section 1115 Medicaid Demonstration "The Virginia Governor's Access Plan (GAP)" (Project Number 11-W-00297/3). We propose to develop a comprehensive Medicaid Addiction and Recovery Treatment Services (ARTS) Benefit beginning on April 1, 2017. This letter serves as the Commonwealth's official notification to the Centers for Medicare and Medicaid Services (CMS) as outlined in the Special Terms and Conditions.

In response to the substance use epidemic, Governor Terry McAuliffe created a bipartisan Task Force on Prescription Drug and Heroin Addiction. This Task Force issued dozens of recommendations to address prescription drug abuse and opioid use disorder. A major recommendation was to increase access to treatment for opioid addiction for Virginia's Medicaid members by increasing Medicaid reimbursement rates. To implement this recommendation, the Department of Medical Assistance Services (DMAS) worked with the Virginia Department of Behavioral Health and Developmental Services (DBHDS) to develop a comprehensive Medicaid ARTS Benefit. This benefit expands short-term inpatient detox and residential treatment to all Medicaid members, significantly increases rates for the full continuum of community-based addiction and recovery services, and adds a new peer support service to support long-term recovery. Furthermore, this benefit promotes a comprehensive transformation of Virginia's ARTS delivery system by "carving in" the community-based addiction treatment services into Managed Care Organizations (MCOs) to promote full integration of physical health, traditional

mental health, and addiction treatment services. This benefit was included in the Governor's budget and passed the General Assembly with strong bipartisan support. This waiver is the critical next step needed to ensure the success of Virginia's addiction treatment delivery system transformation in expanding access to the treatment services that will save lives, improve patient outcomes, and decrease costs.

If you have any questions regarding this amendment, please contact Ashley Harrell, Policy and Planning Specialist at 804-593-2468 or Ashley.Harrell@dmas.virginia.gov. DMAS looks forward to working with you for approval of this amendment.

Sincerely,

Cynthia B. Jones
Director
Virginia Department of Medical Assistance Services

Enclosure

cc: Karen Kimsey, Deputy Director, DMAS
Dr. Kate Neuhausen, Chief Medical Officer
Tammy Whitlock, Director, Integrated Care and Behavioral Services Division, DMAS
Ashley Harrell, Policy and Planning Specialist, Integrated Care and Behavioral Services Division, DMAS

Virginia's Addiction and Recovery Treatment Services Delivery System Transformation

Virginia GAP Program for the Seriously Mentally Ill 1115 Demonstration

Application for Amendment

August 2016

Department of Medical Assistance Services

Application for Amendment to the Virginia GAP Program for the Seriously Mentally Ill 1115 Demonstration: Virginia's Addiction and Recovery Treatment Services Delivery System Transformation

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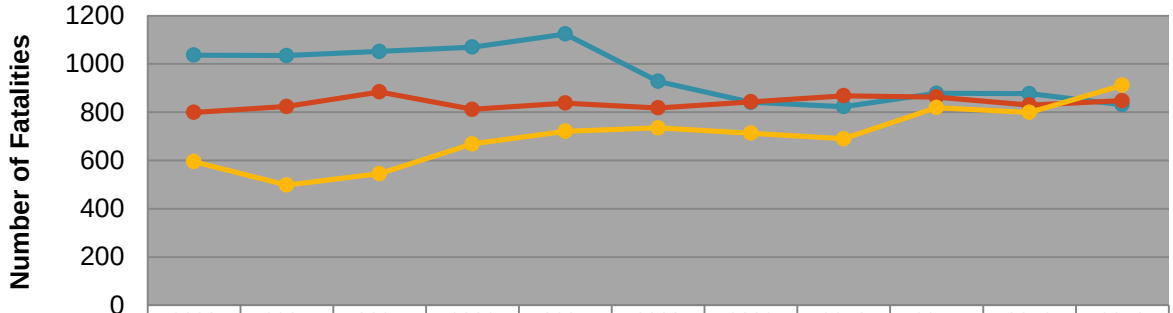
Executive Summary

Virginia is experiencing a substance use crisis of overwhelming proportions. In 2014, 986 people died due to fatal drug overdoses. More Virginians died from drug overdose than car accidents or homicides in 2013 (see Table 1 below). Nearly 80% of these deaths involved prescription opioids or heroin.



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Motor Vehicles	1037	1035	1052	1070	1124	928	841	823	878	877	831
Guns	799	824	884	812	838	818	843	868	863	830	848
Drug/Poisons	595	498	545	669	721	735	713	690	819	799	912

Table 1: Drug Fatalities in Virginia

Virginia's 1.1 million Medicaid members are disproportionately impacted by the substance use epidemic. The Virginia Department of Medical Assistance Services (DMAS) identified 216,555 members with a claim that included a substance use disorder (SUD) diagnosis in state fiscal year 2015 (see Figure 1). The financial impact is nearly as great as the human cost. Virginia spent $44 million on Medicaid members with a primary or secondary diagnosis of SUD who were admitted to hospitals or Emergency Departments in 2014.

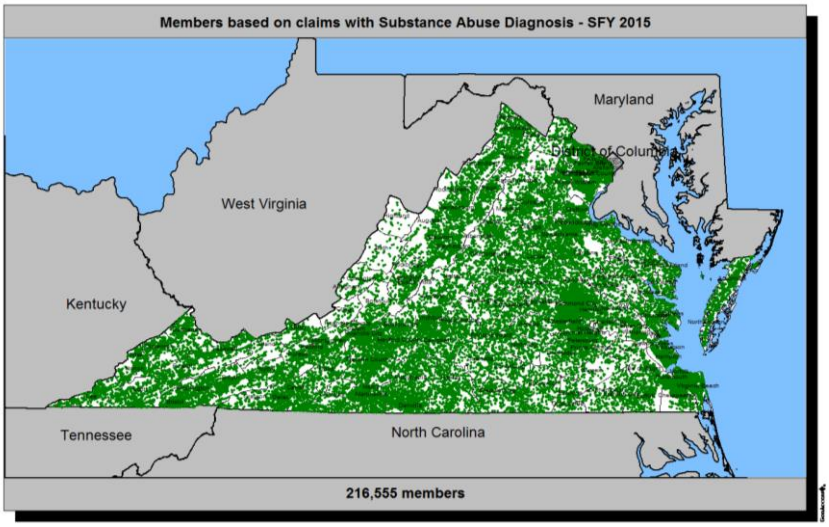


Figure 1: Virginia Medicaid Members with Claims with a SUD Diagnosis, SFY2015

In response to the epidemic, Governor Terry McAuliffe created a bipartisan Task Force on Prescription Drug and Heroin Addiction. This Task Force issued dozens of recommendations to address prescription drug abuse and opioid use disorder. A major recommendation was to increase access to treatment for opioid addiction for Virginia's Medicaid members by increasing Medicaid reimbursement rates.

To implement this recommendation, DMAS worked with the Virginia Department of Behavioral Health and Developmental Services (DBHDS) to develop a comprehensive Medicaid Addiction and Recovery Treatment Services (ARTS) Benefit. This benefit expands short-term inpatient detox and residential treatment to all Medicaid members, significantly increases rates for the full continuum of community-based Addiction and Recovery Treatment Services, and adds a new peer support service to support long-term recovery (see Figure 2). Furthermore, this benefit promotes a comprehensive transformation of Virginia's ARTS delivery system by "carving in" the community-based Addiction and Recovery Treatment Services into Managed Care Organizations (MCOs) to promote full integration of physical health, traditional mental health, and addiction and recovery treatment services. This benefit was included in the Governor's budget and passed the General Assembly with strong bipartisan support.

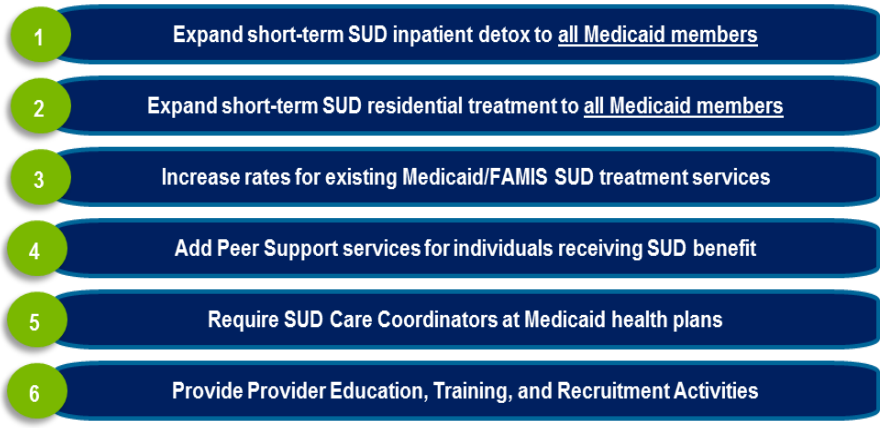


Figure 2: Medicaid ARTS Benefit Passed by Governor & General Assembly, March 2016

To ensure the successful implementation of the Medicaid ARTS Benefit on April 1, 2017, DMAS seeks amendment to its GAP 1115 Demonstration Waiver for its ARTS Delivery System Transformation. Virginia seeks to maintain its current waiver and expenditure authorities and obtain any waiver and expenditure authorities necessary to implement the Medicaid ARTS Delivery System Transformation as outlined in Figure 2. The waiver amendment is essential to achieving the expansion of residential treatment capacity required to meet the needs of Virginia's Medicaid population.

Under this demonstration, Virginia will pursue a broad and deep transformation of the Commonwealth's delivery system to ensure a comprehensive continuum of addiction and recovery treatment based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria including withdrawal management, short-term inpatient and residential treatment, partial hospitalization, intensive outpatient treatment, outpatient treatment including Medication Assisted Treatment (MAT), and long-term recovery supports. DMAS is partnering with DBHDS and MCOs to ensure that licensing aligns with ASAM, ARTS providers are credentialed using ASAM criteria, and providers are trained to deliver ARTS services with fidelity to ASAM criteria.

Virginia will also use the demonstration to support reforms and practice changes including:

- promoting strategies to identify individuals with SUD;
- disseminating evidence-based best practices including Screening, Brief Intervention and Referral to Treatment (SBIRT) and MAT;
- increasing use of quality and outcome measures and developing value-based payment models with the MCOs;

- developing innovative care coordination models to link individuals to ARTS providers, primary care, community resources, and long-term recovery support services and ensure seamless care transitions between different levels of ARTS care and primary care;
- implementing strategies to address prescription drug abuse and opioid use disorders including promoting the CDC Opioid Prescribing Guidelines;
- increasing the MAT provider workforce through intensive education and training statewide; and
- conducting a robust evaluation with outside academic experts to assess the impact of the demonstration.

By funding the Medicaid ARTS services benefit, Virginia's Governor and General Assembly have demonstrated the bipartisan commitment to creating one of the most comprehensive Medicaid addiction and recovery treatment benefits in the country. The benefit will provide the full continuum of treatment needed to address the substance use crisis and reverse the opioid epidemic. This waiver is the critical next step needed to ensure the success of Virginia's ARTS delivery system transformation in expanding access to the treatment services that will save lives, improve patient outcomes, and decrease costs.

Transforming the Delivery System of Addiction and Recovery Treatment Services

Current Delivery System

The Virginia Medicaid program covers approximately 1.1 million individuals: 80% of members receive care through contracted Managed Care Organizations (MCOs) and 20% of members receive care through Fee-for-Service (FFS). The majority of members enrolled in Virginia's Medicaid program includes children, pregnant women, parents, and the Aged, Blind, and Disabled. Within the current system, non-traditional community-based addiction and recovery treatment services are "carved out" of the MCOs and managed by Magellan, a Behavioral Health Service Administrator (BHSA). For members enrolled in FFS, Magellan covers all traditional and non-traditional addiction and recovery treatment services. The non-traditional services include:

- Residential Treatment,
- Opioid Treatment,
- Substance Abuse Day Treatment,
- Crisis Intervention,
- Intensive Outpatient Treatment,
- Substance Abuse Case Management, and
- Peer Supports.

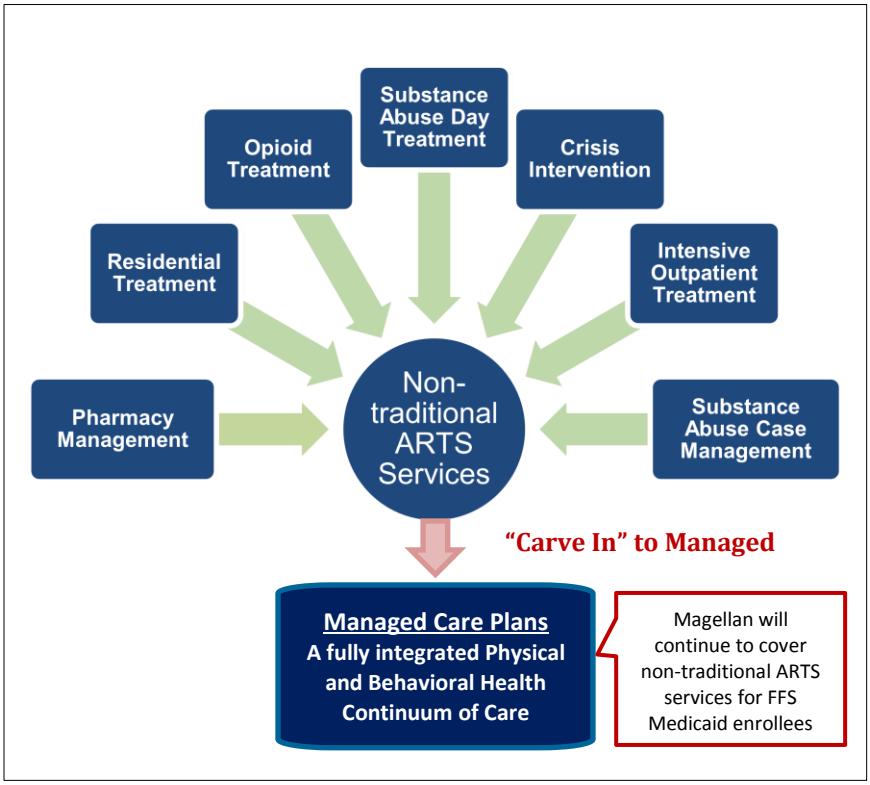


Figure 3: Transformed ARTS Services System

The "carve out" of the community-based ARTS services from MCOs contributes to Virginia's historically fragmented system in which community-based ARTS services are delivered in separate siloes from mental health and physical health services. Providers who deliver these services have complained that the rates are lower than the cost of providing care and have struggled to understand who to bill for services. Patients have struggles to understand where to seek services. Furthermore, the rate structure for ARTS services has not been adjusted since 2007 when Virginia Medicaid first started reimbursing for ARTS services. Low Medicaid reimbursement rates have severely limited the number of providers willing to provide these services to Medicaid members and resulted in inadequate access to treatment. Virginia Medicaid only spent approximately $2 million on community-based ARTS services in State Fiscal Year 2015 and served an average of 734 people per month, demonstrating the underutilization of these services.

Transformed Addiction and Recovery Treatment Service System under the Waiver

To address the fragmentation and siloes, Virginia sought the authority to fully integrate physical and behavioral health services for individuals with SUD and expand access to the full continuum of services. DMAS obtained approval from the Governor and General Assembly to "carve in" community-based ARTS services into Managed Care for members who are already enrolled in MCOs as illustrated in Figure 3.

Since the MCOs already manage all the physical health services as well as the inpatient services, outpatient services, and medications for mental health and substance abuse, "carving in" the community-based ARTS services will allow them to provide members with the full continuum of ARTS services based on their level of need and to integrate the ARTS services with physical health and traditional mental health treatment services. Magellan will continue to cover these services for those Medicaid members who are enrolled in FFS.

The ARTS waiver is necessary to provide Virginia the authority to provide short-term inpatient detox and residential substance abuse treatment in facilities with greater than sixteen beds. The waiver will allow Virginia providers to expand their residential treatment capacity to meet the needs of Virginia's Medicaid population. Residential treatment services will be integrated and coordinated with the full continuum of ARTS services. Seamless care transitions will occur from residential treatment to lower levels of care such as intensive outpatient and outpatient treatment with Medication Assisted Treatment and long-term recovery supports available to all Medicaid members.

Addiction and Recovery Treatment Service	Current	SFY 17	SFY 18
Inpatient Detox – All Adults	0	24	47
Residential Treatment – Non-Pregnant Adults	0	122	534
Residential Treatment – Pregnant Women	84	157	269
Day Treatment/Partial Hospitalization – Pregnant & Non-Pregnant Adults	42	50	64
Intensive Outpatient – All Adults	690	818	1047
Opioid Treatment (Medication Assisted Treatment) – All Adults	552	654	837
Case Management – All Adults	1101	1250	1618
Peer Supports – All Adults	0	822	2839

Note: Numbers indicated are likely an under-representation of members who will require services in the first two years of the demonstration. Significant increases in provider capacity will be required over several years, especially in residential treatment, Medication Assisted Treatment, and peer recovery supports.

Table 2: Estimated Addiction and Recovery Treatment Services Enrollment

The estimated number of Medicaid members who will receive services under the new ARTS services benefit in State Fiscal Years 2017 and 2018 is illustrated in Table 2. While a far greater number of Medicaid members have a substance use disorder than the numbers in this table, these estimates account for the current limited treatment capacity and the time that providers will require to expand new ARTS services.

Goals and Objectives of the Addiction and Recovery Treatment Service Benefit

Virginia's overall goal for the ARTS services benefit is to achieve the Triple Aim of improved quality of care, improved population health, and decreased costs for the Medicaid population with SUD. DMAS' specific objectives for this benefit are outlined below in Figure 4.

Improve quality of care and population health outcomes for the Medicaid population.	• Improve quality of ARTS services (as measured by performance on identified quality measures). • Reduce prescription opioid drug abuse (measured by Pharmacy Quality Assurance opioid performance measures). • Decrease fatal and non-fatal drug overdoses among Medicaid members.
Increase Medicaid members' access to and utilization of community-based and outpatient ARTS services.	• Increase the percentage of Medicaid members living in communities with an adequate supply of clinicians offering ARTS services to Medicaid members. • Increase the quantity of community-based and outpatient ARTS services used by Medicaid members with SUD.
Decrease utilization of high-cost Emergency Department and hospital services by Medicaid members with SUD.	• Decrease ED visits, inpatient admissions, and readmissions to the same level of care or higher for a primary diagnosis of SUD. • Decrease inappropriate utilization for other physical and behavioral health care services for other conditions such as chronic diseases and serious mental illness.
Improve care coordination and care transitions for Medicaid members with SUD.	• Improve the coordination of ARTS services with other behavioral and physical health services. • Improve care transitions to outpatient care, including hand-offs between levels of care within the ARTS care continuum and linkages with primary care upon discharge.
Increase the number and type of health care clinicians providing ARTS services to Medicaid members with SUD.	• Increase number of ARTS service providers providing all ASAM Levels of Care in each region of the Commonwealth. • Increase the number of buprenorphine-waivered physicians and the number of physicians providing Medication Assisted Treatment. • Increase the number of clinicians with substance abuse training and the number of behavioral health clinicians providing ARTS services.

Figure 4: Addiction and Recovery Treatment Service Waiver Objectives

Comprehensive Evidence-Based Benefit Design

Overview of Benefit

DMAS and DBHDS designed a comprehensive ARTS benefit that guarantees access to a full continuum of evidence-based best practices designed to address the immediate and long-term physical, mental and ARTS care needs of all Medicaid members. This benefit was approved by the Governor and General Assembly in the 2016 legislative session. It includes the full spectrum of ARTS services, including short-term inpatient and short-term residential ARTS services for individuals in IMDs of unlimited bed size, which will supplement and coordinate with community-based services and supports including partial hospitalization, intensive outpatient programs, outpatient services including Medication Assisted Treatment (MAT), crisis intervention, case management, and peer recovery supports.

To increase access to community-based services and supports, the benefit includes significant reimbursement rate increases ranging from 50% to 400% to align Medicaid rates with, or even exceed, commercial reimbursement rates. The benefit will improve use of evidence-based practices, including SBIRT, withdrawal management, MAT, care coordination, and peer recovery supports and services.

The comprehensive ARTS benefit approved by the Governor and General Assembly includes the following core components:

- **Expanded coverage of inpatient detox and inpatient substance abuse treatment** (ASAM Level 4.0) for up to 15 days for all Medicaid members (previously only available to children).

- **Expanded coverage of residential detox and residential substance abuse treatment** (ASAM levels 3.1, 3.3, 3.5, and 3.7) for all Medicaid members (previously delivered using outdated, state-defined program rules).

- **Increased rates for existing substance abuse treatment services** currently covered by Medicaid by 50% for Substance Abuse Case Management and by 400% for Substance Abuse Partial Hospitalization (ASAM Level 2.5), Substance Abuse Intensive Outpatient (ASAM Level 2.1), and Opioid Treatment – counseling component of MAT to align with current industry standards.

- **Added coverage of Peer Supports for individuals with SUD and/or mental health conditions.** Reimbursement will be provided for peers certified by DBHDS who will provide intensive recovery coaching to individuals with SUD at all ASAM Levels of Care and to those who need long-term recovery supports.

The comprehensive Medicaid ARTS benefit is a transformative redesign of the Virginia Medicaid benefit for individuals with SUD that fully aligns with CMS expectations for comprehensive, evidence-based benefit design. The major changes under the benefit are illustrated below in Table 3.

Addiction and Recovery Treatment Service	Children < 21	Adults*	Pregnant Women
Traditional Services			
Inpatient (ASAM Level 4.0)	X	Added	Added
Outpatient (ASAM Level 1.0)	X	X	X
Medication Assisted Treatment – medication component	X	X	X
Non-Traditional Services			
Residential (ASAM Levels 3.1, 3.3, 3.5, and 3.7)	X	Added	50% rate increase
Partial Hospitalization (ASAM Level 2.5)	400% rate increase	400% rate increase	400% rate increase
Intensive Outpatient (ASAM Level 2.1)	400% rate increase	400% rate increase	400% rate increase

Addiction and Recovery Treatment Service	Children < 21	Adults*	Pregnant Women
Opioid Treatment – counseling component of MAT (ASAM Level 1.0)	400% rate increase	400% rate increase	400% rate increase
Crisis Intervention	X	X	X
Case Management	50% rate increase	50% rate increase	50% rate increase
Peer Recovery Coaching (DBHDS certified peers)	Added**	Added**	Added

X = service was previously covered.
Added = service will be covered under the comprehensive ARTS benefit passed by the General Assembly starting on April 1, 2017. Rate increases were also included in ARTS benefit and will take effect on April 1, 2017.
* Dual eligible individuals have coverage for inpatient and residential treatment services through Medicare.
** Peer support services for adults and family support partners for children and families will be added when the Virginia Department of Behavioral Health and Developmental Services finalizes the peer certification standard and DMAS is able to ensure that CMS requirements are met for Peer Support Services.

Table 3: Changes under Comprehensive Medicaid ARTS Benefit Passed by Governor & General Assembly in March 2016

Medical Criteria for Addiction and Recovery Treatment Services Benefit

In order to receive services, the member must be enrolled in Virginia Medicaid and must meet the following medical necessity criteria:

- Must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; or be assessed to be at risk for developing substance use disorder (for youth under 21).

- Must meet the American Society of Addiction Medicine (ASAM) Criteria definition of medical necessity for services based on the ASAM Criteria.

- If applicable, must meet the ASAM adolescent treatment criteria. *NOTE: Beneficiaries under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Nothing in this ARTS services demonstration will override any EPSDT requirements.*

Determination of Medical Need based on ASAM Criteria for ARTS Benefit

The MCOs and Magellan will hire ARTS Care Coordinators who are Licensed Practitioners of the Healing Arts including Licensed Clinical Psychologists, Licensed Clinical Social Workers, Licensed Professional Counselors, Nurse Practitioners, or Registered Nurses with substance abuse experience and the necessary competencies

to use the ASAM Patient Placement Criteria. The ARTS Care Coordinator or a licensed physician or Medical Director employed by the MCO or BHSA will perform an independent assessment of requests for all ARTS residential treatment services (ASAM Levels 3.1, 3.3, 3.5, 3.7) using member information transmitted by providers via a uniform service review request form with attached clinical documentation (see *Appendix A).* The MCOs and Magellan will use the ASAM Criteria to perform a multidimensional assessment of members, place members at appropriate levels of care, and make recommendations for length of stay in the residential treatment setting.

Reimbursement Structure

A detailed description of the ARTS services reimbursement structure in included as *Appendix B.*

Standards of Care

The Virginia General Assembly in the 2016 Session directed DMAS to amend the state plan and/or seek federal authority to provide coverage for specific ARTS services and provided DMAS the authority to implement this change prior to the completion of any regulatory process undertaken in order to effect such change. Application for this 1115 waiver amendment provides Virginia an effective vehicle for comprehensive revisions to its Addiction and Recovery Treatment Services Benefit. Through revision of its Contract Requirements for MCOs and Magellan, State Plan, state regulations, and provider manuals, DMAS will establish standards of care for addiction and recovery treatment services that incorporate industry standard benchmarks from ASAM for defining medical necessity criteria, covered services, and provider qualifications. A timeline for completion of draft and final revisions to the State Plan, regulations, and provider manuals is included as *Appendix C.*

ARTS Service Continuum and ASAM Criteria

DMAS is aligning definitions of all community-based ARTS services with ASAM criteria, including the new inpatient detox and residential ARTS services as well as all other existing ARTS modalities and levels of care. DMAS convened a ARTS Core Workgroup comprised of representatives from all key state health agencies including DBHDS, the Virginia Department of Health, and Virginia Department of Health Professions; Chief Medical Officers (CMOs) from all the MCOs and Magellan; addiction medicine experts; and representatives from public and private behavioral health providers, FQHCs, hospitals, peer organizations, and consumers to provide recommendations on the design and implementation of the Medicaid ARTS services benefit and ensure alignment with ASAM criteria (see Table 4).

ASAM Level of Care	Service Title	Brief Description	Is this an existing Medicaid Service?	Is this a new Medicaid service?
N/A	SUD Case Management	Assists children, adults, and their families with accessing needed medical, psychiatric, SUD, social, educational, vocational services and other supports essential to meeting basic needs.	Yes	No

ASAM Level of Care	Service Title	Brief Description	Is this an existing Medicaid Service?	Is this a new Medicaid service?
N/A	Crisis Intervention	Immediate care due to acute dysfunction requiring immediate clinical attention to prevent exacerbation of condition, prevent injury to member or other and provide treatment in least restrictive setting.	Yes	No
.5	Screening, Brief Intervention and Referral to Treatment (SBIRT)	A comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. The purpose of SBIRT is to identify individuals who may have alcohol and/or other substance use problems. Following a screening, a brief intervention is provided to educate individuals about their use, alert them to possible consequences and, if needed, begin to motivate them to take steps to change their behavior.	Yes	No
1	Outpatient Services	Organized outpatient treatment services of fewer than 9 hours per week delivered in a variety of settings. Services include professionally directed screening, evaluation, treatment, and ongoing recovery and disease management services.	Yes	No
1	Peer Recovery Supports	Peer provided support services for adults, adolescents and family support partner services to impacted family members to initiate clinical service utilization and self-determination strategies. Peer Providers have supervisory arrangement with licensed clinicians and certification by DBHDS. Peers may work under supervision, in a variety of service settings.	No	Yes
2.1	SUD Intensive Outpatient	Structured program delivering 9-19 hours per week, before/after work/school, in evening and/or weekends to meet complex needs of people with addition and co-occurring conditions. Arranges medical and psychiatric consultation, psycho-pharmacological consultation, addiction medication management and 24-hour crisis services.	Yes	No
2.5	SUD Partial Hospitalization	20 or more hours of clinically intensive programming per week with a planned format of individualized and family therapies. Service includes: direct access to psychiatric, medical, laboratory and toxicology services, MD consult within 8 hours by phone and 48 hours in person, Emergency Services available 24/7, and coordination with more and less intensive levels of care and supportive housing.	Yes	No
3.1	Clinically Managed Low Intensity Residential Services	Supportive living environment with 24-hour staff and integration with clinical services; at least 5 hours of low-intensity treatment per week.	No	Yes
3.3	Clinically Managed Population-Specific High Intensity Residential Services	Clinically managed therapeutic rehabilitative facility for adults with cognitive impairment including developmental delay. Staffed by credentialed addiction professionals, physicians/physician extenders, and credentialed MH professionals.	No	Yes

ASAM Level of Care	Service Title	Brief Description	Is this an existing Medicaid Service?	Is this a new Medicaid service?
3.5	Clinically Managed High Intensity Residential Services	Clinically managed therapeutic community or residential treatment facility providing high intensity services for adults or medium intensity services for adolescents. Staffed by licensed/credentialed clinical staff including addiction counselors, LCSWs, LPCs, physicians/physician extenders, and credentialed MH professionals.	No	New model; Services expanded to all Medicaid adults
3.7	Medically Monitored Intensive Inpatient Services	Medically monitored inpatient services in a freestanding residential facility or inpatient unit of an acute care hospital or psychiatric unit. 24 hour clinical supervision including physicians, nurses, addiction counselors and behavioral health specialists.	Yes, for pregnant women and available under EPSDT for adolescents	Yes
4	Medically Managed Intensive Inpatient	Acute care general or psychiatric hospital with 24/7 medical management and nursing supervision and counseling services 16 hours/day. Managed by addiction specialist physician with interdisciplinary team of credentialed clinical staff knowledgeable of biopsychosocial dimensions of additions.	No	Yes
1 WM	Ambulatory Withdrawal Management Without Extended On- Site Monitoring	Ambulatory withdrawal management without extended on-site monitoring with specialized psychological and psychiatric consultation and supervision.	No	Yes
2 WM	Ambulatory Withdrawal Management With Extended On- Site Monitoring	Ambulatory withdrawal management with extended on-site monitoring with clinical (medical) consultation and supervision.	No	Yes
3.2 WM	Clinically Managed Residential Withdrawal Management	Moderate withdrawal, but needs 24 hour support to complete withdrawal management and increase likelihood of continuing recovery.	No	Yes
3.7 WM	Medically Monitored Inpatient Withdrawal Management	Severe withdrawal and needs 24 hour nursing care and physician visits as necessary, unlikely to complete withdrawal management without medical, nursing monitoring.	No	Yes
4 WM	Medically Managed Intensive Inpatient Withdrawal Management	Severe, unstable withdrawal and needs 24 hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	No	Yes
OTP	Opioid Treatment Program	Physician supervised daily or several times weekly opioid agonist medication and counseling to maintain multidimensional stability for those with severe opiate use disorder provided by DBHDS-Licensed CSBs and Private Methadone Clinics.	Yes	No
OBOT	Office Based Opioid Treatment	Physician supervised daily or several times weekly opioid agonist medication and counseling to maintain multidimensional stability for those with severe opiate use disorder provided by Primary Care and other Physician Offices, FQHCs, etc.	Yes	No

Table 4: Redesigned, Evidence-Based Virginia Medicaid Benefit for Individuals with SUD and Alignment with ASAM Criteria

Addiction and Recovery Treatment Services Providers and ASAM Criteria

DMAS will require that providers of ARTS services meet ASAM Criteria prior to participating in the Medicaid program. DMAS contracts with the MCOs and Magellan will stipulate that they must maintain provider credentialing requirements compliant with ASAM criteria. Virginia has ensured that its provider licensing requirements are consistent with ASAM criteria and, through future provider manual revisions (see *Appendix C*), will ensure all provider requirements are compliant with ASAM criteria. See *Appendix D* for a detailed comparison of ASAM key elements by level of care and DBHDS licensing requirements. Table 5 illustrates the crosswalk between ASAM LOC and Virginia's licensing standards:

ASAM LOC	ASAM Description	Licensing Standard
OTP	Opioid Treatment Program	• Opioid Treatment Services
1	Outpatient Services	• Outpatient Services
2.1	Intensive Outpatient Treatment	• Substance Abuse Intensive Outpatient Service For Adults, Children, and Adolescents
2.5	Partial Hospitalization Treatment	• Substance Abuse Partial Hospitalization or Substance Abuse/Mental Health Partial Hospitalization
3.1	Clinically Managed Low Intensity Residential Services	• Mental Health & Substance Abuse Group Home Service for Adults or Children • Substance Abuse Halfway House for Adults
3.3	Clinically-Managed, Population-Specific High Intensity Residential Services for Special Populations with Cognitive Disabilities	• Supervised Residential Treatment Services for Adults • Substance Abuse Residential Treatment for Adults
3.5	Clinically-Managed, Medium/High Intensity Residential Treatment	• Substance Abuse Residential Treatment Services for Adults or Children • Psychiatric Unit
3.7	Medically-Monitored Intensive Inpatient Treatment	• Psychiatric Unit within an acute care general hospital • Acute/Freestanding psychiatric hospital –with a Medical Detox license; • Substance Abuse Residential Treatment Services for Adults or Children with a Medical Detox license; • Residential Crisis Stabilization Units with a detox license
4.0	Medically-Managed Intensive Inpatient Treatment	• Acute care general hospital - 12-VAC5-410

Table 5: Licensing Standards by ASAM Level of Care

Through collaboration with DBHDS, MCOs, and Magellan, DMAS will ensure implementation of a comprehensive plan of workforce development to ensure providers are knowledgeable and capable to deliver effective, evidenced based ARTS practices across all ASAM levels of care. Partnering with DBHDS, DMAS will implement a robust statewide training program to ensure that ARTS service workforce members obtain an in-depth understanding of ASAM criteria through live training with Dr. David Mee-Lee, Chief Editor of *The ASAM Criteria*. DBHDS will organize a series of two day ASAM trainings across the state led by Dr. Mee-Lee that will be widely promoted by DMAS and DBHDS to all public and private behavioral health providers. These trainings will provide participants with opportunities for practice applying ASAM criteria at every stage of the treatment process: assessment, engagement, treatment planning, continuing care, and discharge or transfer. Providers will also have access to the ASAM e-Training series and a variety of webinars that educate clinicians, counselors and other professionals involved in standardizing assessment, treatment and continued care. These trainings will help ensure that providers fully understand the ASAM criteria and support them in aligning their existing and new treatment services with ASAM requirements for all Levels of Care.

Following the principles of The ASAM Criteria will change the way you engage people in recovery, assess their needs and strengths, design, deliver and track their progress and outcomes. Embrace the spirit and content of these criteria and together we can serve more people, stretch resources, and provide all the services needed for a long-term and healthy recovery.

– David Mee-Lee, M.D.

Assessment and ASAM Patient Placement Criteria

Through MCO and Magellan contract requirements, regulations, and provider manuals, DMAS will require that assessment for all ARTS services, level of care and length of stay recommendations will be based upon ASAM Patient Placement Criteria ensuring a multidimensional assessment of beneficiaries and placement of beneficiaries at appropriate levels of care. For residential treatment services, MCO and Magellan Care Coordinators will use ASAM to perform independent assessments to determine level of care and length of stay recommendations. The Virginia Association of Health Plans will offer training with Dr. Mee-Lee to all the MCO care coordinators, physicians, and CMOs to ensure they gain competency in use of the ASAM patient placement criteria.

MCOs and Magellan Care Coordinators will conduct service authorizations and will proactively monitor utilization by members to identify complex needs, gaps in services, and overlapping services that may reflect duplication of interventions. The use of ASAM Patient Placement Criteria will be documented by all MCOs, Magellan, and providers by using a uniform service review request form (see *Appendix A).*

Network Development Plan

DBHDS will license providers and MCOs and Magellan will credential providers based on their ability to deliver services consistent with ASAM criteria and provide evidence-based ARTS practices. DBHDS will also certify the

individuals providing peer support services. MCOs and Magellan will build networks of health systems, community service boards (public behavioral health providers), FQHCs, and providers in each region who will be licensed by DBHDS and credentialed by MCOs and Magellan. MAT providers will be developed and will receive coordinated training and education to enhance the delivery of evidence-based MAT services based on ASAM criteria. MCOS and Magellan will build networks with certified peer recovery coaches to provide long-term recovery services and supports after acute treatment.

DMAS analyzed the existing number of service providers by region and ASAM level of care as well as the number of Medicaid members with identified SUD (see table below). DMAS recognizes the need to increase network adequacy by increasing the number of its ARTS service providers, especially residential treatment providers.

ASAM Level of Care:	2.1	2.5	3.1	3.3 & 3.5	3.7	4	Total Providers	Total Members
Region:								
Central Region	25	24	0	4	10	27	90	5958
Charlottesville Region	6	5	2	2	4	7	26	1801
Far Southwest Region	13	14	1	6	6	36	76	4765
Halifax/Lynchburg Region	8	8	1	6	4	6	33	1865
Northern/Winchester Region	32	25	7	10	13	19	106	2674
Roanoke/Alleghany	21	20	3	5	10	16	75	3566
Tidewater Region	23	22	4	11	15	24	99	4497
	128	**118**	**18**	**44**	**62**	**135**	**505**	**25,126**

Table 6: Existing Providers and Members with Primary SUD Diagnosis by Region

DMAS seeks CMS approval of the 1115 waiver for ARTS services six to eight months prior to its proposed April 1, 2017 implementation date to enable providers sufficient opportunity to increase bed capacity to deliver ASAM compliant residential programs. Following approval of the 1115 waiver, each MCO and Magellan will submit a comprehensive network development plan to DMAS. DMAS recognizes that there may still be challenges with achieving network adequacy in certain regions in the first year of implementation due to the lack of providers. DMAS will not consider plans to be in violation of their contract if they do not have a specific provider type in a region because those providers do not exist and if they have exhausted all providers in the State, both in and out of their networks.

To address the Commonwealth's current lack of provider infrastructure for ARTS services, DMAS will implement the following plan:

- ⇒ Each MCO and Magellan will submit an Addiction and Recovery Treatment Services Network Development Plan to DMAS in Fall 2016 describing its current ARTS services network and plan to develop a more comprehensive network by ASAM level of care in each region.
- ⇒ Each MCO and Magellan will submit an Addiction and Recovery Treatment Services Network Readiness Plan to DMAS in early 2017 describing its ARTS services network by region and specifying which ASAM levels of care will have adequate numbers of providers and which lack specific provider types.

- ⇒ DMAS will compare addiction and recovery treatment services networks with the list of all addiction and recovery treatment service providers who meet each ASAM level of care in each region and are licensed by DBHDS to verify that each MCO and Magellan have developed the most comprehensive networks possible given the shortages of specific provider types in specific regions.
- ⇒ To the greatest extent possible, the MCOs and Magellan will aim to maintain compliance with length of stay limits, e.g., 30 day average length of stay for residential services. Should length of stay limits be exceeded, the MCO or Magellan will provide evidence to DMAS that such limits were exceeded due to the lack of availability of a level of care as identified in their ARTS Network Readiness Plan.

Care Coordination

DMAS, the MCOs and Magellan will continue to work with community-based coalitions of key stakeholders in each region to enhance coordination between addiction and recovery treatment service providers, primary care, FQHCs, corrections systems, medical schools, pharmacy schools, and long-term services and supports to ensure the coordination of care for all members. Substance abuse case managers and certified recovery coaches at the provider level will provide case management and peer navigation for members receiving ARTS services.

The MCOs and Magellan will implement structured care coordination plans for achieving seamless transitions of care. These plans will address overall care coordination for the new ARTS benefit, transitions between all ARTS levels of care, transitions between ARTS service providers, transitions between delivery systems (i.e., moving from FFS to MCO), collaboration between behavioral health and physical health systems, and collaboration between the MCOs and Magellan.

Plans for Overall Care Coordination for the Addiction and Recovery Treatment Services Benefit

DMAS, in collaboration with the MCOs and Magellan, will ensure that care coordination practices will focus on each individual's unique needs in order to provide targeted, high quality care that will improve patient engagement and support long term recovery. Practices will be built on person-centered planning, principles of recovery and resiliency, and fidelity to wrap-around principles. Goals for care coordination will include improving the health and wellness of individuals with complex and special needs and integrating services around the care needs and life circumstances of individuals. Care managers will perform the full range of service coordination beginning with pre-service and concurrent authorization review through intensive case management, when required.

The model for SUD Care Coordination will involve assessing the whole person including physical health, mental health and substance use. Once an assessment is completed and the member's needs have been identified, appropriate referrals will be made to ensure that the member's needs are met in support of their holistic and whole-person health.

The MCOs and Magellan will utilize data from multiple sources, including utilization data, health risk assessments, state agency aid categories, demographic information, Health Department epidemiology reports, and various other sources to ensure identification of members with complex health needs, i.e., members who

require the extensive use of resources and who need help in navigating the system to facilitate appropriate delivery of care and services. The MCOs and Magellan will ensure that SUD Care Coordination for members with complex needs helps them regain optimum health and/or improved functional capability, in the right setting and in a cost-effective manner. "High-touch" members will be assisted by connecting them with community based providers and coordinating with those providers and other entities to ensure each member's needs are met. The MCOs and Magellan will coordinate and engage in case conferences with providers to discuss each member's needs and to ensure that those needs are included in a comprehensive plan of care.

Research has shown that some women observe a decrease or cessation of their menstrual period, either directly from drugs or from lifestyle issues when using substances, and as a result erroneously believe they are infertile and that contraception is unnecessary. Further, research has shown that women, while under the influence of substances, often did not take into account the importance of contraceptive use during sexual activity. The MCOs and Magellan will be encouraged to develop special management care coordination structures to manage pregnant and post-partum populations with histories of or current use of substances. This care coordination will facilitate a healthier recovery environment with focus on family planning strategies to concurrently address improvements in maternal and child health and positive birth outcomes along with addiction and recovery treatment approaches.

In order to minimize barriers to care, the MCOs and Magellan will ensure that behavioral health professionals performing addiction and recovery treatment service assessments have telehealth capabilities. Care managers will be knowledgeable about the telehealth delivery system in Virginia and will refer members in rural and other hard to access areas to these systems in order to receive an assessment. It is expected that there will be some members who will not be able to access this evaluation through a telehealth solution or an office visit due to transportation, psychosocial, or health issues, thus the MCOs and Magellan will contract with a subset of evaluators to provide in home evaluations in order to accommodate the needs of these members.

The MCOs and Magellan will provide members access to clinical staff twenty-four hours a day, seven days a week through a toll-free number. Through such access, clinical staff will work with members to determine their needs, discuss behavioral health service options and assist them in identifying an appropriate provider. If at any time, a caller is in distress or appears to have complex needs or a complicating condition such as a physical disability, a clinical care manager will provide appropriate triage and referral.

The MCOs and Magellan will support proactive, collaborative multi-agency case planning processes for adults and youth with special needs to ensure access to appropriate community resources. Mechanisms for this collaboration may include letters of agreement and an array of actions such as the following:

- consistent communications,
- supportive written policies, procedures and processes,
- joint case reviews and treatment planning,
- regular meeting participation,
- data sharing and reporting,
- joint projects and initiatives,

- coordinating with early intervention services, and
- coordination with the adult criminal justice and juvenile justice systems.

Transitions between All ARTS Levels of Care

The MCOs and Magellan will ensure seamless transitions and information sharing between levels and settings of care. Whenever possible and clinically indicated, the MCOs and Magellan will assign each member to a specific care manager who will work with the member and providers throughout the course of treatment. This assignment practice will allow the case manager to become familiar with the unique needs of the member and ensure that all relevant information will be shared with the treating provider as the member transitions from one level of care to the next.

Additionally, all providers will be required to engage in appropriate discharge planning including coordination with the providers at the next level of care to ensure there are no gaps and that the new provider is aware of the progress and activities from the prior treatment level of care. The MCOs and Magellan will provide ongoing education to providers about these expectations and conduct chart reviews to ensure compliance and opportunities to improve quality of care.

Transitions between ARTS Providers

The MCOs and Magellan will build on their current care coordination models to further develop appropriate links for individuals receiving ARTS services to specific and qualified ARTS service providers. In addition to the care coordination practices described above, the MCOs and Magellan will work with members and providers to ensure smooth transitions between providers in order to avoid disruptions in care. The MCOs and Magellan will facilitate the transfer of necessary clinical information between treating practitioners to foster continuity of care and progress toward a member's recovery. Coordination of treatment approaches and integration of member and provider communication will help to keep members safe and informed of care planning options and choices.

Collaboration between Behavioral Health and Physical Health Systems

The MCOs and Magellan will inform entities including CSBs, private behavioral health providers, FQHCs, primary care physicians, emergency departments, and hospitals of the resources available to them when integrating services or developing comprehensive plans of care for members. The MCOs and Magellan will also work with these entities to develop workflows specific to operational interfaces and to streamline communication and efforts to maximize efficiencies when assisting with member access to necessary care. Virginia's electronic Health Information Exchange is piloting the sharing of PMP data with health systems and Emergency Department EHRs and will be leveraged as possible. Activities to support improved collaboration between systems will continue to be explored.

Collaboration between MCOs and Magellan for Mental Health Services

The MCOs will continue to refer and collaborate with Magellan for mental health services not specifically related to substance use disorders. Magellan case management staff will assess member needs for carved out psychiatric or psychosocial services and refer as necessary to providers. Magellan will ensure communication via medical records and other appropriate means to enable the MCOs to adequately track member progress.

Integration of Physical Health and Addiction and Recovery Treatment Services

DMAS is committed to integrating physical and behavioral health care services for members to improve health outcomes and reduce costs in addiction and recovery treatment services. To fully integrate physical and behavioral health services for individuals with SUD and expand access to the full continuum of services, DMAS obtained approval from the Governor and the General Assembly to "carve in" the community-based addiction and recovery treatment services into managed care for members who are already enrolled in MCOs. These services include the following:

- Residential Treatment,
- Opioid Treatment,
- Substance Abuse Day Treatment,
- Crisis Intervention,
- Intensive Outpatient Treatment,
- Substance Abuse Case Management, and
- Peer Supports.

Since the MCOs already manage all the physical health services as well as the inpatient services, outpatient services, and medications for mental health and substance abuse, "carving in" the community-based ARTS services will allow them to provide members with the full continuum of addiction and recovery treatment services based on their level of need and to integrate the ARTS services with physical health and traditional mental health treatment services. Magellan will continue to cover these services for those Medicaid members who are enrolled in Fee-for-Service.

All activities under this demonstration will maintain focus on the primary care physician (PCP) relationship as the member's provider "health home." This strategy will promote one provider having knowledge of the member's health care needs, whether disease specific or preventive care in nature. Through contractual language, training, and program components, the MCOs and Magellan will ensure that PCPs are educated regarding their responsibilities.

DMAS is in the process of amending the managed care contracts and Medallion 3 Waiver to facilitate an integrated care model to support the coordination of physical health and behavioral health services, e.g., through care coordination practices identified by the ARTS Core Workgroup with MCOs, providers, health systems, FQHC, and consumer representatives. This integrated model will begin with implementation of the ARTS demonstration effective on April 1, 2017.

Program Integrity

DMAS requires each MCO and Magellan to be NCQA accredited or to attain such accreditation within 36 months of the onset of delivering care to members. Plans that are not accredited at start-up will adhere to NCQA while they are working on accreditation. NCQA requires the plan to adhere to all requirements based

on the most current version of NCQA Standards and Guidelines for the Accreditation of MCOs. The standard categories include: Quality Management and Improvement, Standards of Utilization Management, Standards for Members' Rights and Responsibilities, Healthcare Effectiveness Data and Information Set (HEDIS) measures required for credentialing (Medicaid products), CAHPS survey, and Standards for Credentialing and Re-credentialing. *Appendix E* provides an illustration of the DMAS process for ensuring MCO and Magellan compliance with contractual requirements.

Risk-Based Screening and Credentialing of All Newly Enrolled Providers and Revalidating Existing Providers

In accordance with NCQA Credentialing and re-credentialing requirements, the MCOs and Magellan will have the proper provisions to determine whether physicians and other health care professionals who are licensed by the Commonwealth and who are under contract with the plan or its providers are qualified to perform addiction and recovery treatment services. The MCOs and Magellan will maintain written policies and procedures for the credentialing process that matches the credentialing and re-credentialing standards of the most recent guidelines from NCQA and in accordance with 12 VAC 5-408-170. The re-credentialing process must include the consideration of performance indicators obtained through the QIP, utilization management program, grievance and appeals system, and member satisfaction surveys.

Ensuring That ARTS Providers Have Entered Into Contracts

MCOs and Magellan are Medicaid payers of all ARTS Medicaid benefits and will ensure that all providers of addiction and recovery treatment services have entered into contracts or provider agreements.

Processes To Address Billing and Other Compliance Issues

The MCOs and Magellan will have rigorous program integrity protocols in place to safeguard against fraudulent billing. They will require their providers to fully comply with Federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against Federal related health care programs.

Quality Reviews of ARTS Providers

DMAS will require the MCOs and Magellan to perform an annual review on all providers to assure that the health care professionals under contract with the provider are qualified to perform addiction and recovery treatment services and that services are being provided in accordance with contract, ASAM and waiver requirements. The MCOs and Magellan will have in place a mechanism for reporting to the appropriate authorities any actions that seriously impact quality of care and which may result in suspension or termination of a practitioner's license. They will be required to report quarterly all providers who have failed to meet accreditation/credentialing standards or been denied application (including MCO-terminated providers) including program integrity-related and adverse actions.

Benefit Management

The MCOs and Magellan will delineate utilization management and quality review processes in their provider contracts. Minimum requirements are outlined in Table 7 below:

Process	Description
Standardized Benefit Structure	Use of standardized benefit structure that defines service levels and supports placement using American Society of Addictions Medicine levels of care.
Unified Model of Care	ARTS services benefits will be administered by all MCOs and Magellan using a unified model of care that is defined by the use of standardized unit values, reimbursement codes and a minimum reimbursement value for each service level.
Uniform Clinical Operations	Standardized service review formats will be used by the MCOs and Magellan to ensure that clinical operation processes are uniform and designed to collect information in line with MHPAEA requirements to ensure appropriate placement, allow for quality management and facilitate opportunities for integrated care and coordination of service delivery options for individuals.
Service Review Requirements	ASAM Levels 2.1-4.0 will be subject to utilization management requirements including service review requirements to facilitate initiation of services with quality oversight structures in place as specified in the CMS SMD # 15-003. ❖ Upon admission to Intensive Outpatient or Partial Hospitalization services a service provider will be required to conduct an assessment of need and submit clinical information to either an MCO or Magellan for their review. ❖ Prior to admission to Residential Treatment and Inpatient, service providers will be required to complete a preadmission assessment of the individuals clinical needs and submit the clinical information to either an MCO or Magellan for their review. ❖ All residential levels of care will require an ASAM multidimensional assessment to be reviewed by the MCO or Magellan as part of the utilization management structure for accessing residential services in both IMD and non-IMD residential service settings. ❖ Each service review will be provided to assess service needs, coordination needs and to ensure appropriate placement into an effective level of care based on the individual's needs as demonstrated in the ASAM multi-dimensional assessment tool.
Quality Reviews	Targeted post-payment quality reviews to ensure fidelity with ASAM service models and assess for the use of evidence based delivery services.
MAT Management	Medication Assisted Treatment services will be managed using a multifaceted approach that includes pharmacy and laboratory management and data mining to provide surveillance of service delivery. This approach will ensure counseling, physician services, pharmacy and labs are administered in accordance with ASAM guidelines for MAT while allowing immediate access to withdrawal management and treatment. MAT will also be managed using standardized approaches to provider credentialing requirements that enforce evidence-based service delivery and enable more effective management of the Office Based Opioid treatment program. This will ensure pharmacy management and integrated services are delivered and quality assurances are met in accordance with newly defined credentialing standards for buprenorphine-waivered physicians and other providers who administer MAT services in office settings.
Prescription Monitoring	Billing and pharmacy system edits will be implemented to ensure appropriate access to methadone, buprenorphine, extended-release injectable naltrexone, and other evidence-based medications for MAT while increasing surveillance of other pharmacy prescribing behaviors to ensure alignment with the CDC Opioid Prescribing Guidelines. As part of the Medication Assisted Treatment administration multiple drug classes will receive additional utilization management controls to ensure effective treatment and a safe recovery environment is maintained for the individuals in recovery. Current efforts are focused on pharmacy management and edits to the DMAS preferred drug list to limit opiate and benzodiazepine utilization by individuals engaged in Medication Assisted Treatment. Additional utilization management controls are being discussed to ensure tighter network controls are in place to manage physician prescribing activity on targeted drug classes and to enforce network alignment for selected pharmacy benefit management. In addition, the MCOs are implementing a Lock-in program that allows them to monitor members who are prescribed buprenorphine by only allowing them to obtain controlled substances from one pharmacy and one physician.

Table 7: Components of ARTS Benefit Management

The MCOs and Magellan will implement a standardized benefit management and reimbursement structure to enhance aggressive network recruitment efforts. The MCOs and Magellan will conduct initial and concurrent authorizations using the criteria and benefit limits delineated in the addiction and recovery treatment services reimbursement structure (see *Appendix B).*

Compliance with Mental Health Parity and Addiction Equity Act

The MCOs and Magellan will ensure compliance with the Mental Health Parity and Addiction Equity Act. Criteria for requiring prior authorization will be applied consistently across ARTS services, behavioral health services, and physical health services.

The ARTS utilization and quality management structures will be required to ensure that individualized recovery and resiliency-oriented services are delivered according to the ASAM care model. Both the MCOs and Magellan will be encouraged to develop a quality management program that focuses on driving and rewarding service delivery using ASAM standards; measuring, assessing, and continually improving member outcomes; and ensuring the use of evidence-based practices, especially those for community-based services.

Community Integration

Under this demonstration, MCOs and Magellan will require providers to ensure, to the greatest extent possible, that ARTS services are based upon identified specific member needs and documented and justified in a person-centered service plan.

Person-Centered Planning

The MCOs and Magellan will ensure that requirements for person-centered planning are incorporated into all ARTS service planning and service delivery efforts. ARTS service planning and delivery will be based upon a person-centered assessment designed to help determine and respond to what works in the person's life and thus needs to be maintained or improved and what does not work and thus needs to be stopped or changed. Service planning will address each individual's vision of a good life, individual talents and contributions and "what's working/what's not working" in the following life areas:

- Home,
- Community and interests,
- Relationships,
- Work and alternates to work,
- Learning and other pursuits,
- Money,
- Transportation and travel, and
- Health and safety.

The MCOs and Magellan will implement strategies to collect member experiences, e.g., surveys and complaint/grievance processes. Results will be reviewed and analyzed on a continuous basis as a measure of

member satisfaction. Low or inadequate scores will be analyzed, opportunities for improvement identified and interventions such as changes in workflows and/or processes implemented to improve member satisfaction.

Cultural and Linguistic Competency

The MCOs and Magellan will ensure that providers deliver services in a manner that demonstrates cultural and linguistic competency. Members will be able to select programs and providers within those programs that meet their needs for self-determination, recovery, community integration, and cultural competency.

To ensure that programs and services meet the cultural and linguistic needs of members, the MCOs and Magellan will utilize sources such as census data and enrollment files to identify member language, race and ethnicity when possible to determine additional languages for written materials, compatibility with practitioner networks, cultural and linguistic needs of members and other potential healthcare needs that might be associated with cultural beliefs and healthcare behaviors.

Peer Supports

In the 2016 session of the General Assembly DBHDS proposed a bill to create a state certification for substance abuse peer providers. This bill will become law on July 1, 2016. Under this demonstration, peer support services will be made available to Medicaid members receiving ARTS services at all levels of care effective on July 1, 2017.

Peer support resources will be an integral component of community integration. DBHDS will establish a certification and define the scope of practice for "Certified Peer Recovery Specialists." The ARTS Core Workgroup reviewed the proposed scope of practice which is included as *Appendix F.*

Strategies to Address Prescription Drug Abuse

Across the Commonwealth, 986 people died due to fatal drug overdoses in 2014. Nearly 80% of these deaths involved prescription opioids or heroin. The Virginia Department of Health reported a 38% increase in deaths from prescription opioid and heroin overdoses between 2012 and 2014 with fatal drug overdoses occurring in counties and cities across Virginia (see Figure 5). According to a recent study of the Centers for Disease Control and Prevention (CDC), "Payments for Opioids Shifted Substantially to Public and Private Insurers While Consumer Spending Declined, 1999-2012," released in *Health Affairs*, changes in financing and cost of opioid pain relievers coincide with the large increase in overdose deaths associated with these drugs. The study documents declining opioid drug unit costs, and the shifting of those costs from the consumer to insurers during these years. The study highlights the need to scale up effective programs which include opioid prescribing guidelines and strategies to equip health care providers with data, tools, and guidance so they can make informed treatment decisions.

The Governor's Task Force on Prescription Drug and Heroin Abuse in Virginia proposed numerous recommendations to the Administration that were designed to strengthen the Prescription Monitoring Program (PMP) and to support providers in proper prescribing and dispensing practices. In both the 2015 and 2016 General Assembly sessions, bipartisan legislation was introduced to align to these and other recommendations of the Task Force.

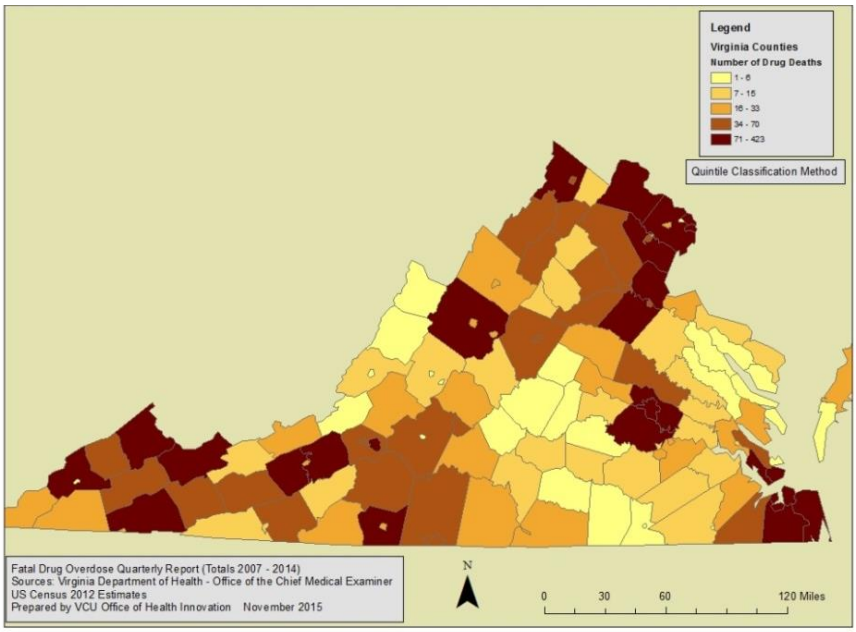


Figure 5: Number of Fatal Drug Overdoses in VA Counties and Cities, 2007-2014

In the 2015 session, legislation was passed to include pharmacists in Virginia's mandatory PMP registration and removed the administrative requirement that PMP registration be done upon licensure renewal. Recognizing that diversion of prescribed opiates is a major contributor to the overdose epidemic, legislation to require hospice settings to notify pharmacies of a patient's death was also passed. Additionally, an existing regional pilot that made naloxone available to friends and family members, i.e., "lay rescuers," was expanded statewide by the General Assembly; the same piece of legislation created an avenue to allow pharmacists to dispense naloxone under proper protocol.

In the 2016 General Assembly session, several bills were passed that focused specifically on the utilization of the PMP for both prescribers and dispensers. Virginia will now require that providers check the PMP for every opioid prescription written for more than 14 days. Furthermore, the PMP Director can now send unsolicited reports on egregious provider behavior for internal review, a practice that is already codified for suspected doctor-shopping behavior by patients. Another piece of legislation reduced reporting time for dispensers from 7 days to 24 hours to help flag and curb doctor-shopping behavior, allowed for clinical consultation with pharmacists regarding patient history, and clarified that a copy of a PMP patient report could be included in a patient's medical history. Finally, the General Assembly passed a bill that mandates completion of 2 hours of Continuing Medical Education (CME) for identified prescribers (based on prescribing history data) on topics related to pain management, responsible prescribing, and the diagnosis and management of addiction. Another bill grants access to the PMP to Medicaid MCOs to identify members with behaviors suggesting opioid abuse or misuse. These bills will become law on July 1, 2016.

The ARTS Core Workgroup convened by DMAS developed comprehensive strategies to address prescription drug abuse at the state, MCO, patient, pharmacy and provider level that will be implemented across Medicaid the MCOs and Magellan and will complement this robust PMP legislation. These strategies include integrating *CDC Guidelines for Prescribing Opioids for Chronic Pain* into the DMAS FFS Preferred Drug List (PDL) and into

the MCO formularies, implementing an innovative Lock-In program to identify members with or at risk of prescription drug abuse and opioid use disorder and refer them to addiction and recovery treatment services, and introducing claims edits for concurrent opioid and benzodiazepine prescriptions.

Integrating CDC Opioid Prescribing Guidelines into DMAS FFS PDL and MCO Formularies

In accordance with changes approved by the DMAS Pharmaceuticals and Therapeutics Committee in April 2016, the MCOs and Magellan will implement requirements for prescribing short and long-acting narcotics to align Medicaid prescription drug coverage with the *CDC Guidelines for Prescribing Opioids for Chronic Pain*. These requirements are described below.

Short and Long Acting Narcotics

- Prescriber must calculate the morphine milligram equivalents (MME) for prescribed drug
  - If MME is 51-90 per day – prescriber must offer naloxone and overdose prevention education.
  - If MME is > 90 per day – prescriber must give member a prescription for naloxone, provider overdose prevention education and consider a consultation with a pain specialist.
  - A link to a MME calculator and to Virginia's PMP will be included.
- Prescriber must document what other non-pharmacological alternatives the patient has tried including physical therapy, weight loss, aerobic exercises, aquatic exercises, resistance exercises, arthrocentesis, intraarticular glucocorticoid injection, subacromial corticosteroid injection, and psychological therapies such as cognitive behavioral therapy.
- Prescriber must document what other non-opioid pharmacological therapies have been tried including NSAIDs, muscle relaxants, anti-convulsants, Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs).
- Prescriber must attest that the PMP has been checked for all new prescriptions and they have discussed with the patient any findings and the risks of using other central nervous depressants such as benzodiazepines, alcohol, other sedatives, illicit drugs such as heroin, or other opioids.
- The service authorization form asks "Does this patient exhibit signs of opioid use disorder?" and requires the prescriber to indicate if the patient has a history of addiction to the requested drug, frequent request for odd quantities, requests for short-term or PRN use of long-acting narcotics, frequent requests for early refills, and frequent reports of lost or stolen tablets.
- The service authorization form requires the physician to attest that a realistic treatment plan with goals to address the benefits and harm of opioid therapy has been established with the patient. The prescriber must address all five CDC recommendations for this treatment plan:
  - Established expected outcome and improvement in both pain relief and function or just pain relief as well as limitations (i.e., function may improve yet pain persist OR pain may never be totally eliminated).
  - Established goals for monitoring progress toward patient-centered functional goals e.g., walking the dog or walking around the block, returning to part-time work, attending family sports or recreational activities, etc.
  - Goals for pain and function, how opioid therapy will be evaluated for effectiveness & the potential need to discontinue if not effective.
  - Emphasize Serious Adverse Effects of Opioids (including fatal respiratory depression & opioid use disorder, OR alter the ability to safely operate a vehicle).
  - Emphasize Serious Common Side Effects of Opioids (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, withdrawal)
- Prescriber agrees to evaluate and reassess the benefits and harm of continued opioid therapy with the patient every 3 months or more frequently if dose changes.

- A link to a prescriber/patient opioid use contract in the event the prescriber does not have a standardized form which he/she currently uses is included on the service authorization form.
- A link to the CDC Guidelines for Prescribing Opioids is included on the service authorization form.

Short Acting Narcotics

- Quantity limits will be placed on all short acting narcotics based on 120 MME/day x 10 day supply. Anything above these quantity limits will trigger a service authorization.
- The exception to 120 MME/day will be any combination narcotic that contains acetaminophen. The quantity limit will be based on the maximum 4 grams/day of acetaminophen.

Long Acting Narcotics

- Requirement of a urine drug test at least annually
- Trial and failure of a short-acting opioid for at least one week

Implementation of an Innovative Lock-In Program by MCOs

Under this demonstration the MCOs will continue implementation of the existing innovative Patient Utilization Management and Safety (PUMS) Program to identify members with or at risk of prescription drug abuse or opioid use disorder and connect them with treatment. The program will ensure that members are accessing and utilizing prescription drugs appropriately and are provided care coordination and referrals to ARTS services when they exhibit behaviors consistent with prescription drug abuse and/or an opioid use disorder.

Members will be placed in the PUMS program for 12 months when either:

1) the MCO's utilization review of the member's past 12 months of medical and/or billing histories indicates the member may be accessing or utilizing health care services inappropriately, or

2) medical providers or social service agencies provide direct referrals to DMAS or the MCO.

Criteria to evaluate a member for possible placement in the PUMS program are outlined below in the table below:

Descriptor	Criteria
Buprenorphine Containing Product	Therapy in the past 30 days (AUTOMATIC LOCK-IN)
High Average Daily Dose of Prescription Opioid	Greater than 120 morphine milligram equivalents per day over the past 90 days
Overutilization	Filling of greater than 7 claims for any controlled substance in past 60 days
Doctor or Pharmacy Shopping	Greater than 3 prescriptions OR greater than 3 pharmacies writing/filling claims for any controlled substance in the past 60 days
Use with a History of Dependence	Any use of a controlled substance in the past 60 days with at least 3 occurrences of a medical claim for controlled Substance Abuse or Dependence in the past 365 days

Use with a History of Poisoning/Overdose	Any use of a controlled substance in the past 60 days with at least 3 occurrences of a medical claim for controlled Substance Abuse or Dependence in the past 365 days
"Frequent Flyer"	Greater than 3 Emergency Department visits in the last 60 days
Poly-Pharmacy	Greater than 9 unique prescriptions in a 34 day period written by greater than 3 physicians OR filled by greater than 3 pharmacies

Table 8: Prescription Utilization Management Safety Program Evaluation Criteria

The MCOs will apply the lock-in by limiting a member to a single pharmacy, a single primary care provider (PCP), or a single controlled substances prescriber. At the end of the 12 month period, the member will be re-evaluated to determine if the member continues to display behavior or patterns that indicate the member should remain in the PUMS Program.

Strategies to ensure the same protections for members in Fee-for-Service will be identified prior to implementation of this demonstration, for example through Magellan's coordination with the Client Medical Management program.

Introducing Claims Edits for Concurrent Opioid and Benzodiazepine Prescriptions

DMAS and the MCOs are exploring implementation of point of service edits for managing opioid and benzodiazepine prescriptions and for which an override would require prescriber involvement. Identified edits will be implemented under the ARTS demonstration. Potential edits include:

1) initiation of concurrent opioid and benzodiazepine prescriptions; or
2) any additional oral benzodiazepine prescriptions for patients currently on benzodiazepines and opioids; or
3) any additional opioid prescriptions for patients currently on benzodiazepines and opioids; or
4) benzodiazepine prescription for patients currently being treated with an oral buprenorphine containing drug.

Strategies to Address Opioid Use Disorder

DMAS and DBHDS will leverage this demonstration to support the U.S. Department of Health and Human Services priority areas of promoting opioid prescribing practices, expanding use and distribution of naloxone, and expanding MAT to reduce opioid use disorders and overdose. This demonstration will implement the following specific strategies:

1) promoting the CDC Guidelines for Prescribing Opioids for Chronic Pain to providers across the Commonwealth;
2) encouraging providers to co-prescribe naloxone with opioids and widely disseminating naloxone through Project *REVIVE!*, the state's opioid overdose reversal program;
3) increasing MAT coverage and promoting evidence-based best practices through standardized service authorization forms;
4) implementing a robust benefit package to incentivize providers to offer MAT for opioid addiction;

5) delivering a Comprehensive MAT Provider Education and Training Campaign statewide; and
6) partnering with the Board of Medicine to develop guidelines for buprenorphine providers.

Promoting CDC Guidelines for Prescribing Opioids for Chronic Pain

Virginia is actively addressing the opioid overdose crisis. In May 2016, Virginia's Secretary for Health and Human Services sent a letter (see *Appendix G*) to all prescribers in the Commonwealth encouraging them to follow the recommendations in the *CDC Opioid Prescribing Guidelines* and announcing the requirement, effective July 1, 2016, that all prescribers must check the PMP for most prescriptions lasting more than fourteen days. In addition, DMAS and the MCOs are aligning Medicaid prescription drug coverage with the *CDC Opioid Prescribing Guidelines* as described above.

Expanding Access to Naloxone Statewide

DMAS and the MCOs all cover intranasal naloxone without a Prior Authorization and will encourage providers and pharmacies to carry naloxone. In addition, DMAS and the MCOs will require prescribers to offer naloxone to any patient taking greater than 50 morphine milligram equivalents of a prescription drug per day and require prescribers to give prescriptions for naloxone to any members taking greater than 90 morphine milligram equivalents per day.

Virginia's efforts to widely disseminate naloxone were bolstered by legislation passed by the Virginia General Assembly in 2015 that authorizes a pharmacist to dispense naloxone pursuant to an oral, written or standing order issued by a prescriber, and in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health. The law also allows a person to possess and administer naloxone to another person who is believed to be experiencing or about to experience a life-threatening opiate overdose. Additionally, law-enforcement officers and firefighters who have completed a training program may also possess and administer naloxone.

REVIVE! is the Opioid Overdose and naloxone Education (ONE) program for the Commonwealth of Virginia. *REVIVE!* is a statewide program that distributes naloxone kits and provides training across the Commonwealth to health care professionals, law enforcement officers, firefighters, advocates, and others on how to recognize and respond to an opioid overdose emergency with the administration of naloxone. *REVIVE!* is a collaborative effort led by DBHDS working collaboratively with the Virginia Department of Health, the Virginia Department of Health Professions, recovery community organizations, OneCare of Southwest Virginia, the Substance Abuse and Addiction Recovery Alliance of Virginia (SAARA), and other stakeholders.

Increasing MAT Coverage and Promoting Evidence-Based Best Practices

MCOs and DMAS currently cover an array of medications approved for MAT for opioid use disorder and alcohol use disorder. Under the ARTS waiver, access to these medications will be expanded by minimizing prior authorizations (see table below).

Medication	Service Authorization Required	Availability (Opioid Treatment Program (OTP), Pharmacy (Rx), Physician Administered Drug(PAD))
Buprenorphine Containing Drugs	Initiation (7 days) – no Maintenance - yes	OTP, Rx, PAD
Methadone	yes	OTP, Rx, PAD
Naloxone	Yes	OTP, Rx, PAD
Naltrexone Tablets	No	OTP, Rx, PAD
Naltrexone Long-Acting Injection (Vivitrol®)	No	OTP, PAD
Disulfiram	No	OTP, Rx, PAD
Acamprosate	No	OTP, Rx, PAD

Table 9: Availability of MAT in Virginia Medicaid's Program

Clinicians have expressed that they are more likely to prescribe buprenorphine containing drugs to Medicaid members if there are fewer administrative barriers and they can utilize standardized service authorization request forms for DMAS FFS members and all Medicaid health plan members regardless of the MCO. To promote evidence-based best practices, the MCOs and Magellan will all use uniform service authorization request forms for buprenorphine/naloxone or buprenorphine initiation and maintenance. Standardized forms were created by the ARTS Core Workgroup (see *Appendix H and Appendix I*). These forms are designed to increase access to a life-saving medication for opioid addiction, ensure that Virginia's Medicaid members receive evidence-based best practices for MAT such as counseling and urine drug screening, avoid non evidence-based restrictions such as daily or lifetime limits, and minimize the risk of diversion and abuse. Eliminating the service authorization requirement for Vivitrol® (Extended Release Naltrexone) removes another barrier to best practice (i.e., members are no longer required to fail oral naltrexone before Vivitrol® can be used).

MAT Benefit Package and Incentives for Clinicians to Provide MAT

Under the ARTS services demonstration, MCOs and Magellan will administer a robust MAT benefit package for opioid use disorder that supports comprehensive, evidence-based treatment at Opioid Treatment Programs and in Office-Based Opioid Treatment settings such as FQHCs, primary care clinics, and psychiatry practices. The MAT reimbursement structure is outlined in the table below (purple highlights indicate new services; blue highlights indicate new rates).

Medication Assisted Treatment (MAT/OTP) / Opioid Treatment Programs (OTP) / Office Based Opioid Treatment (OBOT) and Withdrawal Management							
Billing Code	Service Name	Service Description	ASAM Level	Unit Lengths Annual Limit (per fiscal year)	Rates per Unit	Auth Required	Notes
G9012 (HO)	(OBOT) Medication Assisted Treatment (MAT) care coordination (Bachelors level)	OBOT Care coordination to manage MAT treatment	OTP/OBOT	1 unit=15 minutes (208 units)	$16.00	No	Used in OBOT setting
G9012 (HD)	(OBOT) Medication Assisted Treatment (MAT) care coordination (Masters/Licensed level)	OBOT Care coordination to manage MAT treatment	OTP/OBOT	1 unit=15 minutes (208 units)	$24.00	No	Used in OBOT setting
H0006 (HO)	Alcohol and/or drug services - Substance abuse case management (Bachelors Level)	Targeted Case Management Services- provided by the CSB's but can be opened to other private providers	N/A	1 unit=15 minutes (208 units)	$16.00	No	Used in OTP Setting or by Virginia DBHDS licensed providers

Medication Assisted Treatment (MAT/OTP) / Opioid Treatment Programs (OTP) / Office Based Opioid Treatment (OBOT) and Withdrawal Management							
Billing Code	**Service Name**	**Service Description**	**ASAM Level**	**Unit Lengths Annual Limit (per fiscal year)**	**Rates per Unit**	**Auth Required**	**Notes**
		and used in clinic settings (MAT)					
H0006 (HD)	Alcohol and/or drug services - Substance abuse case management (Masters/Licensed level)	Targeted Case Management Services- provided by the CSB's but can be opened to other private providers and used in clinic settings (MAT)	N/A	1 unit=15 minutes (208 units)	$24.00	No	Used in OTP Setting or by Virginia DBHDS licensed providers
H0020	Opioid treatment services	Opioid Treatment - individual, group counseling and family therapy and medication administration	OTP/OBOT	1 unit=15 minutes (208 units)	$24.00	No	
H0014	Medication Assisted Treatment (MAT) induction	Alcohol and/or drug services; ambulatory detoxification; All non-facility withdrawal management inductions	OTP/OBOT	Per encounter	$140.06	No	
99201-99215	Evaluation and management visit	Physician Services	OTP/OBOT	CPT values		No	CPT rates as of July 1, 2016: Age <21 = $112.14 to 160.35 Age >20 = $97.95 to 140.06
G0477 - G0479	Urine drug screen	Toxicology/Lab	OTP/OBOT	CPT values	$14.96 to 79.25	No	G0477-$14.86, G0478-$19.81, G0479-$79.25
G0480 - G0483	Definitive drug testing	Toxicology/Lab	OTP/OBOT	CPT values	$79.74 to 215.23	No	*Proposed limit of 50/year* G0480-$79.74, G0481-$122.99, G0482-$166.03, G0483-$215.23
S0109 J0571 J0572 J0573 J0574 J0575 J2315	Medication administration in clinic	Medication administration by provider	1WM-2WM and other settings 2.1-3.1	Per Diem-Bundled Services	S0109 $0.26/5 mg *J codes (TBD)*	No*	MD visits, counseling, case management and medical services allowed concurrently. *S0109 Methadone oral 5 mg* *J0571 Buprenorphine, oral, 1 mg* *J0572 Buprenorphine/naloxone oral <=3 mg* *J0573 Buprenorphine/naloxone oral >=3 mg but <= 6 mg* *J0574 Buprenorphine/naloxone oral >=6 mg but <=10 mg* *J0575 Buprenorphine/naloxone oral >10 mg* **Initiation (7 days) – no SA* **Maintenance – SA required*
Q3014 – GT	Telehealth originating site facility fee		1WM-2WM	Per Visit	$20.00	No	
99211-99215	Evaluation and management services established patient	Evaluation and Management services established patient	1WM-2WM	N/A	$13.48 to 112.14	No	CPT rates as of July 1, 2016: Age <21 = $15.43 to 112.14 Age >20 = $13.48 to 97.95
99201-99205	Evaluation and management services new patient	Evaluation and Management services new patient	1WM-2WM	N/A	$29.84 to 160.35	No	CPT rates as of July 1, 2016: Age <21 = $34.16 to 160.35 Age >20 = $29.84 to 140.06
G0477-G0479	Urine drug screen	Toxicology/Lab	OTP/OBOT 1WM-2WM	CPT values	$14.96 to 79.25	No	G0477-$14.86, G0478-$19.81, G0479-$79.25

Medication Assisted Treatment (MAT/OTP) / Opioid Treatment Programs (OTP) / Office Based Opioid Treatment (OBOT) and Withdrawal Management							
Billing Code	**Service Name**	**Service Description**	**ASAM Level**	**Unit Lengths Annual Limit (per fiscal year)**	**Rates per Unit**	**Auth Required**	**Notes**
G0480-G0483	Definitive drug testing	Toxicology/Lab	OTP/OBOT 1WM-2WM	CPT values	$79.74 to 215.23	No	*Proposed limit of 50/year* G0480-$79.74, G0481-$122.99, G0482-$166.03, G0483-$215.23
90832 – alone or GT (w/o E&M)	Psychotherapy, 30 minutes with patient and/or family member	Outpatient service	1 and 1WM	Varies based on MD face time with patient	$54.67	No	
90833 – alone or GT (w/ E&M)	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service	Outpatient service	1 and 1WM	Varies based on MD face time with patient	$56.51	No	List separately in addition to the code for the primary procedure
90834 – alone or GT (w/o E&M)	Psychotherapy, 45 minutes with patient and/or family member	Outpatient service	1 and 1WM	N/A	$72.69	No	
90836 – alone or GT (w/ E&M)	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service	Outpatient service	1 and 1WM	N/A	$71.78	No	List separately in addition to the code for the primary procedure
90837 – alone or GT (w/o E&M)	Psychotherapy, 60 minutes with patient and/or family member	Outpatient service	1 and 1WM	N/A	$109.04	No	
90838 – alone or GT (w/ E&M)	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service	Outpatient service	1 and 1WM	N/A	$94.68	No	List separately in addition to the code for the primary procedure
90846 alone or GT	Family psychotherapy (without patient present)	Outpatient service	1 and 1WM	45 minutes to 1 hour	$88.27	No	
90847 – alone, GT or HF if SA	Family psychotherapy (with patient present)	Outpatient service	1 and 1WM	45 minutes to 1 hour	$91.32	No	
90853 – alone, GT or HF if SA	Group psychotherapy (other than multi-family)	Outpatient service	1 and 1WM	45 minutes to 1 hour	$21.99	No	Use 90853 in conjunction with 90785 for the specified patient when group psychotherapy includes interactive complexity.
90863 – alone, GT or HF if SA	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	Outpatient service	1 and 1WM	Use in conjunction with 90832, 90834, 90837	$21.99	No	List separately in addition to the code for the primary procedure

Table 10: MAT Reimbursement Structure

Recognizing that counseling and psychosocial supports, i.e., case management and care coordination must be provided alongside medication to ensure the best outcomes for patients, DMAS will implement financial incentives to provide sustainable Medicaid reimbursement for such supports. These services and fiscal incentives are described in the table below:

Medication Assisted Treatment Psychosocial Supports	
Opioid Treatment	
Description	Psychosocial Treatment for Opioid Use Disorder including at a minimum: • Assessment of psychosocial needs • Supportive individual and/or group counseling • Linkages to existing family support systems • Referrals to community-based services AND/OR clinical assessment and medication administration.
Provider Type	• Psychosocial treatment must be provided by physicians, licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed psychiatric clinical nurse specialist, a licensed psychiatric nurse practitioner, a licensed marriage and family therapist, a licensed substance abuse treatment practitioner; or an individual with certification as a substance abuse counselor (CSAC) who is under the direct supervision of one of the licensed practitioners listed above. They receive supervision appropriate to their level of training and experience. • Clinical assessment and medication administration during the induction phase must be provided by a licensed registered nurse. • Medication administration during the maintenance can be provided by a licensed practical nurse under the supervision of a registered nurse
Reimbursement	Can only be billed by providers licensed by DBHDS as Opioid Treatment Programs.
Incentive	400% rate increase
Substance Abuse Case Management	
Description	Includes medical monitoring and coordination of on-site and off-site treatment services, provided as needed. Case managers will also assure the provision of, or referral to, educational and vocational counseling, treatment of psychiatric illness, child care, parenting skills development, primary health care, and other adjunct services, as needed.
Provider Type	• Licensed behavioral health providers including: licensed clinical social worker (LCSW), licensed professional counselor (LPC), licensed psychiatric clinical nurse specialist, a licensed psychiatric nurse practitioner, a licensed marriage and family therapist, licensed clinical psychologist, a licensed substance abuse treatment practitioner; or • Licensed registered nurse or licensed practical nurse with at least one year of clinical experience; or • Individuals with certification as a substance abuse counselor (CSAC) or certification as a substance abuse counselor – assistant (CSAC-A) under the direct supervision of one of the licensed behavioral health providers listed above. • Individuals with at least a bachelor's degree in one of the following fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and has at least one year of substance abuse related clinical experience providing direct services to persons with a diagnosis of mental illness or substance abuse under the under the direct supervision of one of the licensed behavioral health providers listed above .
Reimbursement	Can be only billed by providers licensed by DBHDS for case management
Incentive	50% rate increase
Substance Abuse Care Coordination	
Description	Integrates behavioral health into primary care and specialty care medical settings through interdisciplinary care planning as well as monitoring patient progress and tracking patient outcomes. Supports in-person and telephonic conversations between buprenorphine-waivered physicians and behavioral health providers to develop and monitor individualized and personalized treatment plans that are focused on the best outcomes for the person. Links patients with opioid addiction with community resources (including Alcoholics Anonymous, Narcotics Anonymous, peer recovery supports, etc.) to facilitate referrals and respond to social service needs. Tracks and supports patients when they obtain medical, behavioral health, or social services outside the practice. Follow up with patients within a few days of an emergency room visit or hospital discharge for opioid overdose or any other reason. Communicates test results and care plans to patients and families.
Provider Type	• Licensed behavioral health providers including: licensed clinical social worker (LCSW), licensed professional counselor (LPC), licensed psychiatric clinical nurse specialist, a licensed psychiatric nurse practitioner, a licensed marriage and family therapist, licensed clinical psychologist, a licensed substance abuse treatment practitioner; or • Licensed registered nurse or licensed practical nurse with at least one year of clinical experience; or • Individuals with certification as a substance abuse counselor (CSAC) or certification as a substance abuse counselor– assistant (CSAC-A) under the direct supervision of one of the licensed behavioral health providers listed above. • At least a bachelor's degree in one of the following fields: social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling, and has at least one year of substance abuse related clinical experience providing direct services to persons with a diagnosis of mental illness or substance abuse under the direct supervision of one of the licensed behavioral health providers listed above.
Reimbursement	• This code must be billed with Opioid Use Disorder as the primary diagnosis.

	• Must be billed by buprenorphine-waivered physician who is prescribing buprenorphine and providing the integrated care coordination on-site at his or her practice.
Incentive	New reimbursed service
Screening, Brief Intervention and Referral to Treatment	
Description	A comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. The purpose of SBIRT is to identify individuals who may have alcohol and/or other substance use problems. Following screening, a brief intervention is provided to educate individuals about their use, alert them to possible consequences and, if needed, begin to motivate them to take steps to change their behavior.
Provider Type	• Physician, Pharmacist, Psychologist, Licensed Nurse Practitioner, Licensed Professional Counselor, Licensed Psychiatric Clinical Nurse Specialist, Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, Certified Substance Abuse Counselor (CSAC) under direct supervision. • Health Departments, Federally Qualified Health Centers, Rural Health Clinics, Community Services Boards, Health Systems, Emergency Departments, Pharmacies, Physician Offices, and Outpatient Clinics • Licensed providers, as allowed by their scope of practice, may delegate administration of the tool to other staff (for example Registered Nurses) but must review the tool with the member and provide the counseling. • Providers and delegated staff administering the tool must complete SBIRT training: http://www.integration.samhsa.gov/clinical-practice/sbirt/training-other-resources
Reimbursement	The annual limit is 3 screenings per calendar year, per provider.
Incentive	New types of providers allowed to bill this service

Table 11: MAT Psychosocial Supports

Comprehensive MAT Provider Education and Training

DMAS is partnering with the Virginia Department of Health to develop a comprehensive MAT training curriculum focused on providing buprenorphine in office-based opioid treatment settings. In addition, DBHDS and DMAS will develop reference materials on how to bill for and obtain reimbursement for MAT (methadone and buprenorphine). The training will include three tracks: 1) physicians and other providers; 2) counselors, social workers, care coordinators, case managers, and recovery coaches; and 3) clinic administrators on models for the delivery of and billing for ARTS services incorporating MAT with a focus on buprenorphine. Figure 6 below outlines the proposed training plan.

Phase 1: "Train the Trainers" and Training at Major Provider Conferences July - November 2016

- VDH and contractor will offer special "train the trainer" events to train local physicians, behavioral health providers, and administrators in the new curricula so they are prepared to lead the trainings in their regions in early 2017.
- VDH, DMAS, and contractor will partner with major provider organizations to offer 4-hour CME seminars on MAT aligned with their annual meetings including the PSV and MSV Annual Meetings in October in Roanoke and the Virginia Community Healthcare Association Annual Meeting in October in Metro Richmond. These CME seminars will include an introduction with an overview of the delivery model and business case for addiction treatment followed by break-out sessions with three separate tracks for: 1) physicians/providers - 4 hours of MAT training to help physicians obtain buprenorphine waivers; 2) counselors/social workers/recovery coaches – 4 hours of training on group therapy model and care coordination for MAT; 3) clinic administrators and staff – operationalizing treatment model and billing for MAT.
- The Virginia Commonwealth University research team will disseminate surveys at each training to assess provider satisfaction with the trainings and provide recommendations of any opportunities for improving the curricula.

Phase 2: Train the Providers, January - March 2017

- Trainers trained by VDH and the contractor in the fall will lead trainings in each of the state's major regions including Far Southwest, Roanoke/Allegheny, Halifax/Lynchburg, Charlottesville/Piedmont, Central Virginia, Tidewater, and Northern Virginia/Winchester
- The Virginia Commonwealth University research team will track how many providers are trained at each training and will collect surveys that assess provider satisfaction with the trainings and intention to provide MAT after the training. VCU researchers will follow-up with physicians and providers after the training to evaluate how many are actually offering MAT and any barriers to MAT implementation.

Phase 3: Go Live and Engage Trainer Support Networks, April 2017- April 2018

- VDH will provide ongoing clinical support to physicians and clinic staff who are implementing MAT programs and providing buprenorphine in office-based opioid treatment settings. DMAS and DBHDS will provide ongoing support and guidance on reimbursement to providers.
- DMAS will work with Magellan to develop a Virginia MAT support network for new providers with a hotline to call about difficult patient challenges, regulatory questions, etc.
- The trainers in each region will become regional champions who receive ongoing financial support to serve as a mentor by providing advice to new MAT providers in their region about difficult patient challenges, etc. These regional champions could even also hold weekly or monthly meetings or webinars that serve as case conferences where new MAT providers could bring challenging patient cases and receive advice.

Figure 6: MAT Provider Training Plan

Guidelines for Buprenorphine Providers

The General Assembly during the 2016 session passed legislation that clarified that buprenorphine and other FDA-approved opioid replacement therapy providers are not subject to the same regulatory environment as methadone providers in Virginia. The Virginia Board of Medicine is convening a workgroup to develop guidance on clinical best practices for buprenorphine providers. These guidelines will include evidence-based best practices such as ensuring that counseling and psychosocial supports are offered alongside the buprenorphine medication and requiring that buprenorphine providers check the PMP and random urine drug screens to decrease the risks of diversion and continued substance misuse and abuse. This workgroup includes representatives from DMAS, VDH and DBHDS as well as and the MCOs, who will ensure that these best practices are adopted by DMAS, the MCOs, and Magellan and incorporated into the design and implementation of the MAT benefit.

Services for Adolescents and Youth with a Substance Use Disorder

DMAS will ensure that benefits are covered, services are available, and access is timely for youth and adolescents with a SUD as required under the EPSDT benefit. Care coordination efforts will be dynamic and

include methods to ensure adolescent clinical issues are assessed within the context of the ASAM adolescent placement criteria. The specific focus on distinct care models for adolescents is not necessary in the ASAM model since the criteria account for unique adolescent treatment needs.

At a minimum, assessment and services for adolescents will follow the ASAM adolescent treatment criteria. In addition, the state will identify recovery services through other service systems that are geared towards adolescents, such as those described in the January 26, 2015 CMS Informational Bulletin "Coverage for Behavioral Health Services for Youth with Substance Use Disorder."

DMAS is also exploring adding a family peer support service under the new peer support service that could support adolescents and youth with a SUD. This service could be incorporated into high fidelity wrap services and other evidence-based best practices that DMAS already supports for adolescents and youth with Serious Emotional Disturbance and/or a SUD.

Reporting of Quality Measures

Collection of Quality Measures

DMAS will collect reliable and valid data from the MCOs and Magellan to enable reporting of the ARTS quality measures listed in the table below. These include relevant measures from the Medicaid Adult, and Children's Core Sets for individuals with SUD as well as the Pharmacy Quality Alliance opioid performance measures as specified in the CMS SMD Letter # 15-003. Use of these quality measures in program evaluation is discussed in the Evaluation section of this document.

Source	Measure	Collection Mechanism
NQF #0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Claims/encounter data
NQF # 1664	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge	Electronic clinical data/clinical paper chart review
NQF # 2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	Claims/encounter data
NQF #0648 (modified)	Timely Transmission of Transition Record	Electronic clinical data/clinical paper chart review
PQA	Use of Opioids at High Dosage in Persons Without Cancer (PQA)	Claims/encounter data
PQA	Use of Opioids from Multiple Providers in Persons Without Cancer (PQA)	Claims/encounter data
PQA	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (PQA)	Claims/encounter data

Table 12: Addiction and Recovery Treatment Service Quality Measures

The MCOs and Magellan will collect data through multiple mechanisms, including automated reports from data systems, QI core indicator reports, clinical record audits, provider site visits, and complaints and grievances, etc. Data will be collected from internal sources such as from claims, demographics, pharmacy and lab results, and electronic medical records. Data quality checks will be built into all processes that touch data including data integrity and completeness checks as data are loaded and standardized. Quality checks used to verify data integrity might include comparisons against expected values, domain analysis, and comparisons to standard code sets/values. For reviewing data completeness, quality checks will assess whether all data that came into the system was processed.

Quality Improvement Process

The MCOs and Magellan will leverage, and expand as necessary, their existing quality improvement infrastructures, quality improvement processes, and performance measure data systems to ensure continuous quality improvement of ARTS services. They will use the results of their performance on the ARTS quality measures to improve quality under DMAS supervision and monitoring. Quality improvement processes will include both rapid cycle quality improvement as well as larger system improvements.

At a minimum, quality improvement processes will include the following:

- Monitoring system-wide issues and performance metrics,
- Identifying opportunities for improvement,
- Determining the root cause,
- Exploring alternatives and developing/approving a plan of action, and
- Activating the plan, measuring the results, evaluating effectiveness of actions, and modifying the approach as needed.

Evaluating Care Transitions

The MCOs and Magellan will implement procedures for evaluating successful care transitions between ARTS levels of care as well as linkages with primary care upon discharge. Evaluation of transitions and linkages may be captured via various established activities and processes including the following:

- Collaboration with providers including the setting of expectations for successful transition planning,
- Provider education and training,
- Treatment record reviews to assess coordination with the primary care physician and referring provider(s), as well as discharge planning to appropriate providers,
- Care management and medical necessity review processes, e.g.,
    - Monitoring for appropriate transition of care and avoidance of gaps in service provision.
    - Provider outreach calls to assist in effective transition planning.

Quality Dashboards

DMAS will require the MCOs and Magellan to provide quarterly quality dashboards with the following data:

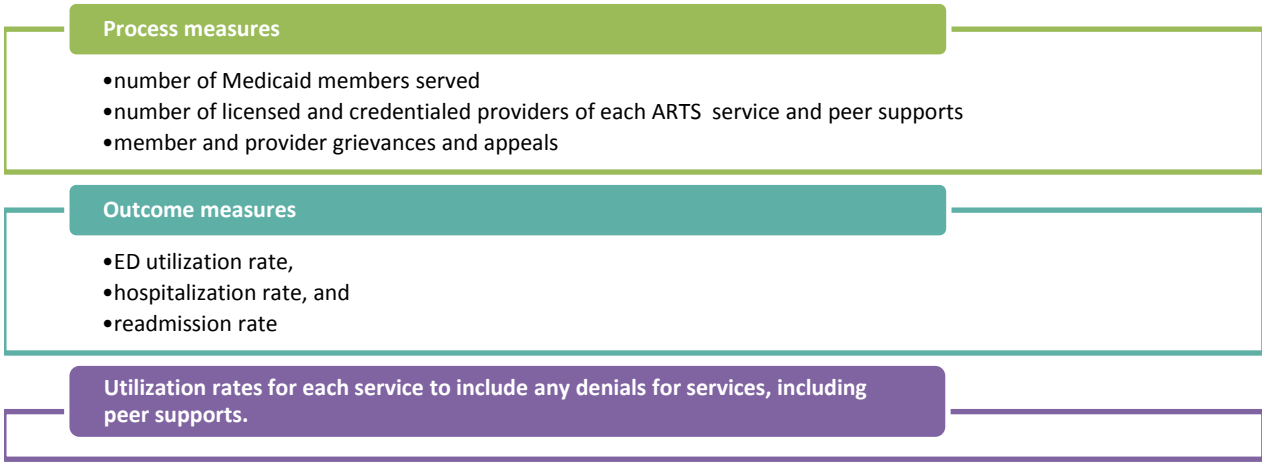


Figure 7: Quarterly Quality Dashboards

Collaboration with Single State Substance Use Disorder Authority

DMAS maintains a close working relationship the Department of Behavioral Health and Developmental Services and has collaborated with the department on all aspects of the design and implementation of the comprehensive Medicaid ARTS benefit and the development of this demonstration. A formal Memorandum of Understanding between the agencies enables the sharing of data, coordination of funding, and alignment of policies and practices.

In addition, DMAS has partnered with additional state agencies including the Department of Health and the Department of Health Professions in the development of this demonstration, most specifically to align provider qualifications and requirements and to develop the MAT provider education and training. Through the ARTS Core Workgroup, DMAS has collaborated with relevant local and state agencies to ensure that they are positioned to respond appropriately to the implementation of this demonstration. Additional coordination efforts will be completed as part of readiness and training initiatives to ensure that state partners are positioned to support the delivery of ARTS services.

Evaluation

An independent evaluation by academic researchers at Virginia Commonwealth University (VCU) will evaluate if the delivery system transformation (i.e., the "carving in" of community-based ARTS services into Managed Care) and services delivered through this demonstration are effective in improving health outcomes and decreasing health care costs and utilization. The researchers will specifically assess the impact of providing the full continuum of ARTS services, especially residential treatment, on Emergency Department utilization,

inpatient hospital utilization, and readmission rates to the same level of care or higher. For a complete description of the waiver evaluation plan, see *Appendix J.*

The VCU researchers will produce the required mid-point evaluation half way through demonstration and final evaluation at the end of demonstration. In addition, they will provide rapid cycle quality improvement data on implementation of the ARTS benefit and on effectiveness of intensive MAT provider education, recruitment, and training in increasing the number of physicians providing MAT.

The evaluation is designed to demonstrate achievement of Virginia's goals, objectives, and metrics for the demonstration. Thus, the specific aims of the evaluation, which align with the demonstration's goals and objectives, are:

1. How does the demonstration affect clinician ARTS services training and ARTS services provision?
   a) To what extent are efforts to prepare and train health care clinicians successful in getting them to appropriately provide ARTS benefits?
   b) How do the new ARTS benefit and waiver affect the number and type of health care clinicians providing ARTS services to Medicaid members with SUD?
2. How does the demonstration affect members' access to and utilization of ARTS services?
   a) To what extent do the new ARTS benefit and waiver increase the percentage of Medicaid members living in communities with an adequate supply of clinicians offering ARTS services to Medicaid members?
   b) How do the new ARTS benefit and waiver affect the type and quantity of ARTS services used by Medicaid members with SUD?
3. How does the demonstration affect patient outcomes and quality of care?
   a) What is the impact of the availability of ARTS residential treatment on emergency department visits, inpatient admissions, and readmissions to the same level of care or higher for ARTS services? (e.g. inpatient admissions, community-based high intensity residential, and community-based low intensity residential).
   b) Are there spillover effects of the new ARTS benefit on utilization and costs for other physical and behavioral health care services, such as emergency department visits, inpatient admissions, and readmissions for non-addiction treatment related services?
   c) What is the impact of the new ARTS benefit on fatal and nonfatal drug overdoses among Medicaid members?
   d) What is the impact of the "carve-in" of ARTS benefits into managed care plans on health care utilization and the coordination of care with other behavioral and physical health problems?
4. How does the ARTS demonstration affect member costs, particularly costs associated with emergency department visits, inpatient stays, and inpatient readmissions?
5. How is the ARTS demonstration related to broader efforts in local communities to address SUD, especially the surge in opioid addiction?
   a) How are ARTS clinicians working with other community organizations (governmental, educational, law enforcement, social service) to help people with SUD?

b) What evidence is there that these "social determinants" are influencing use of ARTS services as well as outcomes, e.g. arrest rates, school attendance and performance, employment?

Budget Neutrality

DMAS assumes that if the waiver services, i.e., addiction and recoverytreatment services in residential facilities with more than 16 beds, were available currently, 150 pregnant women and 820 other low income adults would use these services.

For pregnant women, DMAS assumes two tracks of care,

1. average 10 days of higher intensity care (ASAM 3.3 to 3.7) followed by 75 days of low intensity residential care (ASAM 3.1), or
2. 75 days of low intensity residential care.

All other covered adults are assumed to fall into three tracks of care:

1. just 5 days of higher intensity care,
2. just 25 days of low intensity residential care, or
3. 5 days of higher intensity residential care followed by 25 days of low intensity residential care.

All covered members are expected to continue substance use treatment using non-waiver services such as partial hospitalization, intensive outpatient, medication assistance treatment (MAT) and peer supports.

With the waiver, high intensity residential care (ASAM 3.7) includes some higher cost beds in psychiatric hospitals, but mostly through residential treatment centers. The cost of waiver services is assumed to be higher for pregnant women ($16,000) than for other adults ($5000) as pregnant women are expected to use the waiver services for a longer time per treatment episode and because they are expected to use more of the higher intensity treatment.

DMAS intends to implement the waiver April 1, 2017. The need for substance use services is growing and is expected to continue to grow through the April 1, 2017 start date. DMAS assumes a 10% year growth until the start date and then a slowing of the growth rate in the future. Based on prior experiences in managed care rate setting, DMAS expects the claims payment lag will reduce the expenditures the first year with rate and utilization increases projected to go into effect by State Fiscal Year 2018.

Virginia meets a high bar with addiction and recovery treatment services. Costs for the waiver with the expanded bed capacity are expected to be the same or lower than the benefit costs without the additional bed capacity. Implementation of a standardized ASAM treatment model is expected to result in the same utilization and cost per member. With Waiver costs are hypothetical/pass through costs. Consequently, DMAS has calculated that the With Waiver Per Member Per Month (PMPM) will equal Without Waiver PMPM (see Appendix K).

Appendix

Appendix A: Addiction and Recovery Treatment Services Review Request Form

Appendix B: Addiction and Recovery Treatment Services Reimbursement Structure

Appendix C: Timeline for Draft and Final ARTS Amendments to State Plan, Regulations, and Provider Manuals

Appendix D: Crosswalk ASAM Provider Requirements and Virginia Licensing Requirements

Appendix E: Contract Compliance Enforcement

Appendix F: Draft Scope of Practice for Certified Peer Recovery Specialists

Appendix G: HHR Secretary Letter re. Guideline for Prescribing Opioids for Chronic Pain

Appendix H: Uniform PA Request Form for Buprenorphine/Naloxone or Buprenorphine Initiation

Appendix I: Uniform PA Request Form for Buprenorphine/Naloxone or Buprenorphine Maintenance

Appendix J: Evaluation of Addiction and Recovery Treatment Services Benefit

Appendix K: Budget Neutrality

Clinical Review of Requested Substance Use Disorder Treatment Service

Fax Form to Respective Plan Using Contact Information Below

PLEASE TYPE or WRITE LEGIBLY
or request will be returned as unable to process

MEMBER INFORMATION	
Member Name:	DOB:
Member ID:	If retroactively enrolled, provide enrollment date:

PROVIDER INFORMATION	
Provider Group/Clinic:	Contact:
Phone:	Fax:
Street Address:	City | State | Zip:
Provider ID/NPI:	
ESTIMATED DURATION OF THIS EPISODE OF CARE:	

DIAGNOSES (Primary and any applicable co-occurring diagnoses)
1.
2.
3.
4.

SUBSTANCE USE DISORDER TREATMENT HISTORY
(Describe other ASAM Levels of Care tried in past 12 months)

ASAM Level of Care	Name of Provider	Duration	Approximate Dates	Outcome

ASAM LEVEL OF CARE REQEUSTED					
○	ASAM Level 2.1 | Intensive Outpatient (IOP)	○	ASAM Level 2.5 | Partial Hospitalization (PHP)	○	ASAM Level 3.1 | Clinically Managed Low-Intensity Residential Services
○	ASAM Level 3.3 – 3.5 | Clinically Managed High-Intensity Residential Services	○	ASAM Level 3.7 | Medically Monitored Inpatient Services	○	ASAM Level 4 | Medically Managed Inpatient Services
○	Other				

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MEDICATION		
Please list medications, dosage and frequency below.	Not applicable	
Name	Dosage	Frequency

4/1/16

REQUESTED CODES (Include Amount and Modifier)							
Code		Units/ Visits	Modifier	Code		Units/ Visits	Modifier
○	H0015 Intensive Outpatient			○	Other Code: (please write)		
○	H0018 Short-Term Residential (1-30 days)			○	Other Code: (please write)		
○	H0019 Long-Term Residential (31+ days)			○	Other Code: (please write)		
○	Inpatient Hospitalization			○	Other Code: (please write)		

ASSESSMENT AND SCORING	
DIMENSION 1 | Acute Intoxication and/or Withdrawal Potential	
○	No withdrawal (Move to the next dimension)
○	Moderate withdrawal symptoms not requiring 24-hour intensive or acute hospital setting (Possible referral to RTC)
○	Patient has the potential for life threatening withdrawal (Immediate referral to medically monitored detox)
○	Patient has life threatening withdrawal symptoms, possible or experiencing seizures or DT's or other adverse reactions are imminent (Immediate referral to acute hospital setting)
ASAM Level:	
Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).	
DIMENSION 2 | Biomedical Conditions/Complications	
○	None or very stable (OP)
○	None or not sufficient to distract from treatment (IOP)
○	None or not sufficient to distract from treatment (PHP)
○	None/stable or receiving concurrent treatment – moderate stability (PHP/IOP/Other services)
○	Severe instability requires 24-hour medical care in licensed medical facility. May be the result of life threatening withdrawal or other co-morbidity (Immediate referral to acute care)
ASAM Level:	
Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).	
DIMENSION 3 | Emotional/Behavioral/Cognitive Conditions	
○	None or very stable (OP)
○	Needs structure to focus on recovery as these conditions can distract from recovery efforts (IOP/PHP)
○	Moderate stability, cognitive deficits, impulsive or unstable MH issues (RTC)

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○	Severe instability high safety risk, very unstable may be related to substance use or in addition to substance requires 24-hour acute psychiatric care (Refer to inpatient services)
ASAM Level:	
Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).	

DIMENSION 4 | Readiness to Change	
○	Readiness for recovery but needs motivating and monitoring strategies to strengthen readiness, or needs ongoing monitoring and disease management (OP)
○	Has variable engagement in treatment, lack of awareness of the seriousness of substance use and/or coexisting mental health problems. Requires treatment several times per week to promote change (IOP)
○	Has variable engagement in treatment, lack of awareness of the seriousness of substance use and/or coexisting mental health problems. Requires treatment almost daily to promote change (PHP)
○	Has marked difficulty with treatment or opposition due to functional issues or there has been ongoing dangerous consequences (RTC)
○	Poor impulse control, continues to use substances despite severe negative consequences (medical, physical or situational) and requires a 24-hour structured setting (Rehabilitation)
ASAM Level:	
Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).	

DIMENSION 5 | Relapse, Continued Use or Continued Problem Potential	
○	Minimal support required to control use, needs support to change behaviors (OP)
○	High likelihood of relapse/continued use or addictive behaviors, requires services several times per week (IOP)
○	Intensification of addition and/or mental health issues and has not responded to active treatment provided in a lower levels of care. High likelihood of relapse, requires treatment almost daily to promote change (PHP)
○	Does not recognize the severity of treatment issues, has cognitive and functional deficits (RTC)
○	Unable to control use, requires 24-hour supervision, imminent dangerous consequences (Rehabilitation)
ASAM Level:	
Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).	

DIMENSION 6 | Recovery/Living Environment	
○	Supportive recovery environment and patient has skills to cope with stressors (OP)
○	Not a fully supportive environment but patient has some skills to cope (IOP)
○	Not a supportive environment but can find outside supportive environment (PHP)
○	Environment is dangerous, patient needs 24-hour structure to learn to cope (RTC)
○	Environment is imminently dangerous, patient lacks skills to cope outside of a highly structured environment (Rehabilitation)
ASAM Level:	
Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).	

Based on the clinical review, please indicate the ASAM recommended level of care :							
○	Level 2.1	○	Level 3.1	○	Level 3.7	○	Other
○	Level 2.5	○	Level 3.3 – 3.5	○	Level 4		

Is the ASAM recommended level of care different than what is requested?	○ Yes ○ No
If yes, please provide the reason for the variance and include supporting clinical documentation:	

SIGNATURE

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Reviewer Name (print):	
Signature/Credential:	Date:

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PLEASE FAX FORM TO THE DESIGNATED HEALTHCARE PLAN USING THE CONTACT INFORMATION BELOW

CONTACT INFORMATION				
Managed Care Organization	Contact	Phone Number	Fax Number	E-mail Address
Aetna Better Health	Stephanie Hargan	(800)279-1878	(866)669-2454	hargans@aetna.com
Anthem		(800)901-0020 (for inpatient)	(877)434-7578 (for inpatient) (800)505-1193 (for outpatient)	N/A
INTotal Health	Cheryl Ricciardi	(855)323-5588	(844)462-7376	SUDrequest@inova.org
Kaiser	Linda Bloch	(301)625-6102	(301)625-5560	Linda.l.bloch@kp.org
Magellan		(800)424-4046		
Optima	N/A	(800)648-8420	(844)723-2096 (757)431-7763	N/A
Virginia Premier Complete Care	N/A	(800)727-7536 (toll –free) (804)819-5151 (local)	(877)685-5732 (toll-free) (804)343-0307 (local)	N/A

CONTACT INFORMATION				
Medicare-Medicaid Plan	Contact	Phone Number	Fax Number	E-mail Address
Anthem Healthkeepers	N/A	(800)901-0020 (for inpatient)	(877)434-7578 (for inpatient) (800)505-1193 (for outpatient)	N/A
Humana Integrated Gold	N/A	(855)765-9704		N/A
Virginia Premier Complete Care	N/A	(800)727-7536 (toll –free) (804)819-5151 (local)	(877)685-5732 (toll-free) (804)343-0307 (local)	N/A

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Virginia Medicaid Addiction Treatment Services
Reimbursement Structure

Purple= New Services
Blue = New Rates

Community Based Care							
Billing Code	**Service Name**	**Service Description**	**ASAM Level**	**Unit Lengths Annual Limit (per fiscal year)**	**Rates per Unit**	**Authorization Required**	**Notes**
H0006 (HO)	Alcohol and/or drug services; Case management (Bachelors Level)	Targeted case management services-provided by the CSB's but can be opened to other private providers and used in clinic settings (MAT)	N/A	1 unit = 15 minutes (208 units)	$16.00	No	
H0006 (HD)	Alcohol and/or drug services; Case management (Masters/Licensed Level)	Targeted case management services-provided by the CSB's but can be opened to other private providers and used in clinic settings (MAT)	N/A	1 unit = 15 minutes (208 units)	$24.00	No	
H0038	Peer support services	Self help/Peer Services. Peer provided services to initiate clinical service utilization and self-determination strategies	N/A-may be provided as part of levels 1-4	1 unit = 15 minutes	$13.50	Yes	
S9445	Peer support services Patient education - individual	Patient education; non-physician provider, individual, per session	TBD	1 unit = 15 minutes	Pending	Yes	to be defined later
S9446	Peer support services Patient education - group	Patient education; non-physician provider, group, per session	TBD	1 unit = 15 minutes	Pending	Yes	to be defined later
H0015	Intensive outpatient	Structured program delivering 9-19 hours per week, before/after work/school, in evening and/or weekends to meet complex needs of people with addition and co-occuring conditions.	2.1 and 2WM	1 unit = 1 day	$288.00	Yes, URGENT: Review within 72 hours, PA retroactive	Minimum of 9 hours per week adult Minimum of 6 hours per week adolescent MD visit separate
H0035	Partial Hospitalization	20 or more hours of clinically intensive programming per week with a planned format of individualized and family therapies.	2.5 and 2WM	1 unit = 1 day (6 Hours per day)	$576.00	Yes, URGENT: Review within 72 hours, PA retroactive	Minimum of 20 service hours per week
H0007	*SUD crisis intervention –non-residential*	*Immediate Crisis Intervention Services (No ASAM LOC)*	*Registration*	*1 unit = 15 minutes*	*$25.00*	*Yes*	***SUD Crisis services will be replaced by MH Crisis Intervention***

Medication Assisted Treatment (MAT/OTP) / Opioid Treatment Programs (OTP) / Office Based Opioid Treatment (OBOT) and Withdrawal Management							
Billing Code	**Service Name**	**Service Description**	**ASAM Level**	**Unit Lengths Annual Limit (per fiscal year)**	**Rates per Unit**	**Authorization Required**	**Notes**
G9012 (HO)	(OBOT) Medication Assisted Treatment (MAT) care coordination (Bachelors level)	OBOT Care coordination to manage MAT treatment	OTP/OBOT	1 unit=15 minutes (208 units)	$16.00	No	Used in OBOT setting
G9012 (HD)	(OBOT) Medication Assisted Treatment (MAT) care coordination (Masters/Licensed level)	OBOT Care coordination to manage MAT treatment	OTP/OBOT	1 unit=15 minutes (208 units)	$24.00	No	Used in OBOT setting
H0006 (HO)	Alcohol and/or drug services - Substance abuse case management (Bachelors Level)	Targeted Case Management Services-provided by the CSB's but can be opened to other private providers and used in clinic settings (MAT)	N/A	1 unit=15 minutes (208 units)	$16.00	No	Used in OTP Setting or by Virginia DBHDS licensed providers

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Virginia Medicaid Addiction Treatment Services
Reimbursement Structure

Purple= New Services
Blue = New Rates

Medication Assisted Treatment (MAT) / Opioid Treatment Programs (OTP) / Office Based Opioid Treatment (OBOT) and Withdrawal Management continued							
Billing Code	**Service Name**	**Service Description**	**ASAM Level**	**Unit Lengths Annual Limit (per fiscal year)**	**Rates per Unit**	**Authorization Required**	**Notes**
H0006 (HD)	Alcohol and/or drug services - Substance abuse case management (Masters/Licensed level)	Targeted Case Management Services-provided by the CSB's but can be opened to other private providers and used in clinic settings (MAT)	N/A	1 unit=15 minutes (208 units)	$24.00	No	Used in OTP Setting or by Virginia DBHDS licensed providers
H0020	Opioid treatment services	Opioid Treatment - individual, group counseling and family therapy and medication administration	OTP/OBOT	1 unit=15 minutes (208 units)	$24.00	No	
H0014	Medication Assisted Treatment (MAT) induction	Alcohol and/or drug services; ambulatory detoxification; All non-facility withdrawal management inductions	OTP/OBOT	Per encounter	$140.06	No	
99201-99215	Evaluation and management visit	Physician Services	OTP/OBOT	CPT values		No	CPT rates as of July 1, 2016: Age <21 = $112.14 to 160.35 Age >20 = $97.95 to 140.06
G0477 - G0479	Urine drug screen	Toxicology/Lab	OTP/OBOT	CPT values	$14.96 to 79.25	No	G0477-$14.86, G0478-$19.81, G0479-$79.25
G0480 - G0483	Definitive drug testing	Toxicology/Lab	OTP/OBOT	CPT values	$79.74 to 215.23	No	*Proposed limit of 50/year* G0480-$79.74, G0481-$122.99, G0482-$166.03, G0483-$215.23
S0109 J0571 J0572 J0573 J0574 J0575 J2315	Medication administration in clinic	Medication administration by provider	1WM-2WM and other settings 2.1-3.1	Per Diem- Bundled Services	S0109 $0.26/5 mg *J codes (TBD)*	No*	MD visits, counseling, case management and medical services allowed concurrently. S0109 Methadone oral 5 mg J0571 Buprenorphine, oral, 1 mg J0572 Buprenorphine/naloxone oral <=3 mg J0573 Buprenorphine/naloxone oral >=3 mg but <= 6 mg J0574 Buprenorphine/naloxone oral >=6 mg but <=10 mg J0575 Buprenorphine/naloxone oral >10 mg *Initiation (7 days) – no SA *Maintenance – SA required
Q3014 – GT	Telehealth originating site facility fee		1WM-2WM	Per Visit	$20.00	No	
99211-99215	Evaluation and management services established patient	Evaluation and Management services established patient	1WM-2WM	N/A	$13.48 to 112.14	No	CPT rates as of July 1, 2016: Age <21 = $15.43 to 112.14 Age >20 = $13.48 to 97.95
99201-99205	Evaluation and management services new patient	Evaluation and Management services new patient	1WM-2WM	N/A	$29.84 to 160.35	No	CPT rates as of July 1, 2016: Age <21 = $34.16 to 160.35 Age >20 = $29.84 to 140.06

G0477-G0479	Urine drug screen	Toxicology/Lab	OTP/OBOT 1WM-2WM	CPT values	$14.96 to 79.25	No	G0477-$14.86, G0478-$19.81, G0479-$79.25
G0480-G0483	Definitive drug testing	Toxicology/Lab	OTP/OBOT 1WM-2WM	CPT values	$79.74 to 215.23	No	*Proposed limit of 50/year* G0480-$79.74, G0481-$122.99, G0482-$166.03, G0483-$215.23

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Virginia Medicaid Addiction Treatment Services
Reimbursement Structure

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Medication Assisted Treatment (MAT) / Opioid Treatment Services (OTP) / Office Based Opioid Treatment (OBOT) and Withdrawal Management continued							
Billing Code	**Service Name**	**Service Description**	**ASAM Level**	**Unit Lengths Annual Limit (per fiscal year)**	**Rates per Unit**	**Authorization Required**	**Notes**
90832 – alone or GT (w/o E&M)	Psychotherapy, 30 minutes with patient and/or family member	Outpatient service	1 and 1WM	Varies based on MD face time with patient	$54.67	No	
90833 – alone or GT (w/ E&M)	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service	Outpatient service	1 and 1WM	Varies based on MD face time with patient	$56.51	No	List separately in addition to the code for the primary procedure
90834 – alone or GT (w/o E&M)	Psychotherapy, 45 minutes with patient and/or family member	Outpatient service	1 and 1WM	N/A	$72.69	No	
90836 – alone or GT (w/ E&M)	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service	Outpatient service	1 and 1WM	N/A	$71.78	No	List separately in addition to the code for the primary procedure
90837 – alone or GT (w/o E&M)	Psychotherapy, 60 minutes with patient and/or family member	Outpatient service	1 and 1WM	N/A	$109.04	No	
90838 – alone or GT (w/ E&M)	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service	Outpatient service	1 and 1WM	N/A	$94.68	No	List separately in addition to the code for the primary procedure
90846 alone or GT	Family psychotherapy (without patient present)	Outpatient service	1 and 1WM	45 minutes to 1 hour	$88.27	No	
90847 – alone, GT or HF if SA	Family psychotherapy (with patient present)	Outpatient service	1 and 1WM	45 minutes to 1 hour	$91.32	No	
90853 – alone, GT or HF if SA	Group psychotherapy (other than multi-family)	Outpatient service	1 and 1WM	45 minutes to 1 hour	$21.99	No	Use 90853 in conjunction with 90785 for the specified patient when group psychotherapy includes interactive complexity.
90863 – alone, GT or HF if SA	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	Outpatient service	1 and 1WM	Use in conjunction with 90832, 90834, 90837	$21.99	No	List separately in addition to the code for the primary procedure

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Virginia Medicaid Addiction Treatment Services
Reimbursement Structure

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Residential and Inpatient Treatment							
Billing Code	**Service Name**	**Service Description**	**ASAM Level**	**Unit Lengths Annual Limit (per fiscal year)**	**Rates per Unit**	**Authorization Required**	**Notes**
H2034	Clinically managed low intensity residential services	Alcohol and/or drug abuse halfway house services, per diem. Supportive living environment with 24-hour staff and integration with clinical services; at least 5 hours of low-intensity treatment per week.	3.1	1 unit = 1 day	Urban: $180.00 Rural: $162.00	Yes – ASAM Assessment by Independent Third Party Required URGENT: reviewed within 72 hours	Daily rate includes all services. Additional services consist of IOP or MAT which can be billed separately.
H0010 Rev 1002	Clinically Managed Residential Withdrawal Management	Clinically directed withdrawal management is an organized service managed by clinicians who provide a "Social Detox" program that safely assists patients through withdrawal without the need for readily available on-site medical and nursing personnel.	3.2 WM	1 unit = 1 day	$393.50	Yes – ASAM Assessment by Independent Third Party Required URGENT: reviewed within 72 hours	Per Diem covers all Therapeutic Programming Additional Services that can be billed: • Physician Visits (CPT or E&M Codes) • Drug Screens/Labs • Medications
H0010 Rev 1002	Clinically managed population-specific high intensity residential services	Alcohol and /or drug services; sub-acute detoxification (residential addiction program inpatient). ***Adults only*** - Clinically managed therapeutic rehabilitative facility for adults with cognitive impairment including developmental delay. Staffed by credentialed addiction professionals, physicians/physician extenders, and credentialed MH professionals.	3.3	1 unit = 1 day	$393.50	Yes – ASAM Assessment by Independent Third Party Required URGENT: reviewed within 72 hours	Per Diem covers all Therapeutic Programming Additional Services that can be billed: • Physician Visits (CPT or E&M Codes) • Drug Screens/Labs • Medications
H0010 Rev 1002	Clinically managed high-intensity residential services **(Adult)** Clinically managed medium-intensity residential services **(Adolescent)**	Alcohol and /or drug services; sub-acute detoxification (residential addiction program inpatient). Clinically managed therapeutic community or residential treatment facility providing high intensity services for adults or medium intensity services for adolescents. Staffed by licensed/credentialed clinical staff including addiction counselors, LCSWs, LPCs, physicians/physician extenders, and credentialed MH professionals.	3.5	1 unit = 1 day	$393.50	Yes – ASAM Assessment by Independent Third Party Required URGENT: reviewed within 72 hours	Per Diem covers all Therapeutic Programming Additional Services that can be billed: • Physician Visits (CPT or E&M Codes) • Drug Screens/Labs • Medications

H2036 Rev 1002	Medically Monitored Inpatient Withdrawal Management	Organized service delivered by medical and nursing professionals, which provides for 24 hour evaluation and withdrawal management in a facility with inpatient beds. Services are delivered under a defined set of physician approved policies and physician monitored procedures or clinical protocols.	3.7 WM	1 unit = 1 day	TBD Allowance for separate facility, psychiatric inpatient and RTC rates.	Yes – ASAM Assessment by Independent Third Party Required URGENT: reviewed within 72 hours	Per Diem covers all Therapeutic Programming Additional Services that can be billed: • Physician Visits (CPT or E&M Codes) • Drug Screens/Labs • Medications
H2036 Rev 1002	Medically monitored intensive inpatient services **(Adult)** Medically monitored high intensity inpatient services **(Adolescent)**	Alcohol and/or other drug treatment program, per diem. Planned and structured regimen of 24 hour professionally directed evaluation, observation, medical monitoring and addiction treatment in an inpatient setting consisting of freestanding facility or a specialty unit in a general or psychiatric hospital or other licensed health care facility.	3.7	1 unit = 1 day	TBD *Allowance for separate facility, psychiatric inpatient and RTC rates.*	Yes – ASAM Assessment by Independent Third Party Required URGENT: reviewed within 72 hours	Per Diem covers all Therapeutic Programming Additional Services that can be billed: • Physician Visits (CPT or E&M Codes) • Drug Screens/Labs • Medications

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Virginia Medicaid Addiction Treatment Services
Reimbursement Structure

Purple= New Services
Blue = New Rates

Residential and Inpatient Treatment continued							
Billing Code	**Service Name**	**Service Description**	**ASAM Level**	**Unit Lengths Annual Limit (per fiscal year)**	**Rates per Unit**	**Authorization Required**	**Notes**
H0011 or Rev 1002	Medically Managed Inpatient Withdrawal Management	Inpatient medical service delivered by medical and nursing professionals that provides for 24 hour medically directed evalutation and withdrawal management. Services are delivered under a defined set of physician approved policies and physician monitored procedures or clinical protocols.	4 WM	1 unit = 1 day	DRG	Yes URGENT – Telephonic Approval Within 24 hours (1 calendar day)	Hospital Services Per Diem
H0011 or Rev 1002	Medically managed intensive inpatient services	Alcohol and/or drug services; acute detoxification. Medically Managed Intensive-Inpatient Services consist of 24 hour nursing care and daily physician care for severe, unstable problems in dimensions 1, 2 or 3. Counseling available.	4.0	1 unit = 1 day	DRG	Yes URGENT – Telephonic Approval Within 24 hours (1 calendar day)	Hospital Services Per Diem
Outpatient Treatment							
Billing Code	**Service Name**	**Service Description**	**ASAM Level**	**Unit Lengths Annual Limit (per fiscal year)**	**Rates per Unit**	**Authorization Required**	**Notes**
90791 - alone, GT, or HF if SA	Psychiatric diagnostic evaluation	Outpatient service	1	1 unit per rolling 12 months for same provider	$112.70	No	Use 90785 in conjunction with 90791 or 90792 when the diagnostic evaluation includes interactive complexity services.
90792 - alone or GT	Psychiatric diagnostic evaluation with medical service	Outpatient service	1	1 unit per rolling 12 months for same provider	$124.92	No	Use 90785 in conjunction with 90791 or 90792 when the diagnostic evaluation includes interactive complexity services.
90785 (HF if SA)	Interactive complexity service add-on code to office visits	Outpatient service	1		$11.91	No	List separately in addition to the code for primary procedure.
99408	Alcohol and/or substance (other than tobacco) abuse structured screening: 15 - 30 minutes	Outpatient service	1	1 unit = 1 Assessment 3 screenings per provider, per member	Ages <21=$25.83 >20=$23.82	No	
99409	Alcohol and/or substance (other than tobacco) abuse structured screening: greater than 30 minutes	Outpatient service	1	1 unit = 1 Assessment 3 screenings per provider, per member	Ages <21=$50.35 >20=$46.45	No	
90832-alone or GT (w/o E&M)	Psychotherapy, 30 minutes with patient and/or family member	Outpatient service	1	CPT unit values	$54.67	No	
90833-alone or GT (w/ E&M)	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service	Outpatient service	1	CPT unit values	$56.51	No	List separately in addition to the code for primary procedure.
90834-alone or GT (w/o E&M)	Psychotherapy, 45 minutes with patient and/or family member	Outpatient service	1	CPT unit values	$72.69	No	

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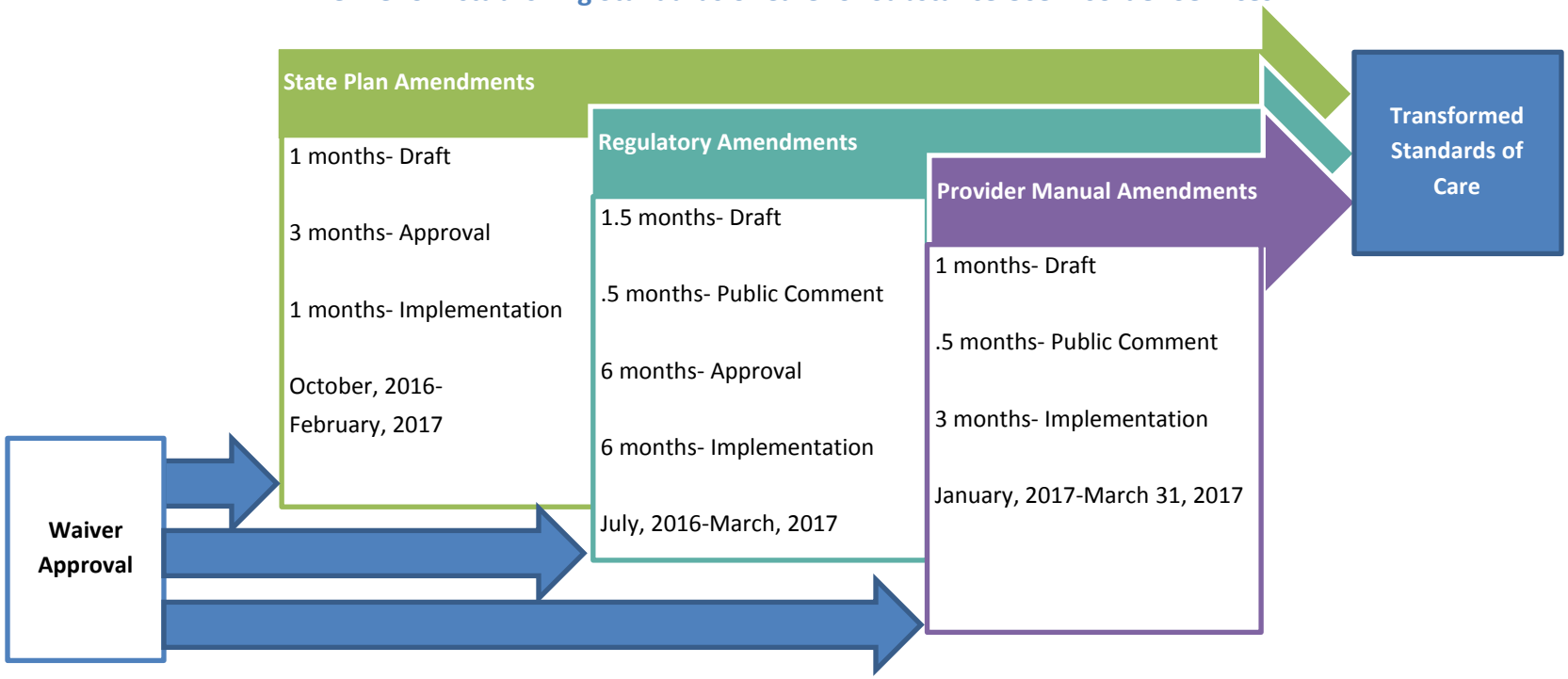
Virginia Medicaid Addiction Treatment Services
Reimbursement Structure

Purple= New Services
Blue = New Rates

Outpatient Treatment continued							
Billing Code	**Service Name**	**Service Description**	**ASAM Level**	**Unit Lengths Annual Limit (per fiscal year)**	**Rates per Unit**	**Authorization Required**	**Notes**
90836-alone or GT (w/ E&M)	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service	Outpatient service	1	CPT unit values	$71.78	No	List separately in addition to the code for primary procedure.
90837-alone or GT (w/o E&M)	Psychotherapy, 60 minutes with patient and/or family member	Outpatient service	1	CPT unit values	$109.04	No	
90838-alone or GT (w/ E&M)	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service	Outpatient service	1	CPT unit values	$94.68	No	List separately in addition to the code for primary procedure.
90846 alone or GT	Family psychotherapy (without patient present)	Outpatient service	1	CPT unit values	$88.27	No	
90847 alone or GT	Family psychotherapy (with patient present)	Outpatient service	1	CPT unit values	$91.32	No	
90853 alone or GT	Group psychotherapy (other than multi-family)	Outpatient service	1	CPT unit values	$21.99	No	Use 90853 in conjunction with 90785 for the specified patient when group psychotherapy includes interactive complexity.
90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	Outpatient service	1WM-2WM	Use in conjunction with 90832, 90834, 90837	$21.99	No	List separately in addition to the code for the primary procedure

Timeline for Establishing Standards of Care for Substance Use Disorder Services



Item 306, 2016 Virginia Appropriation Act

MMMM.1. The Department of Medical Assistance Services, in consultation with the appropriate stakeholders, shall amend the state plan for medical assistance and/or seek federal authority through an 1115 demonstration waiver, as soon as feasible, to provide coverage of inpatient detoxification, inpatient substance abuse treatment, residential detoxification, residential substance abuse treatment, and peer support services to Medicaid individuals in the Fee-for-Service and Managed Care Delivery Systems. The department shall have the authority to implement this change effective upon passage of this Act, and prior to the completion of any regulatory process undertaken in order to effect such change.

2. The Department of Medical Assistance Services shall make programmatic changes in the provision of all Substance Abuse Treatment Outpatient, Community Based and Residential Treatment services (group homes and facilities) for individuals with substance abuse disorders in order to ensure parity between the substance abuse treatment services and the medical and mental health services covered by the department and to ensure comprehensive treatment planning and care coordination for individuals receiving behavioral health and substance use disorder services. The department shall take action to ensure appropriate utilization and cost efficiency, and adjust reimbursement rates within the limits of the funding appropriated for this purpose based on current industry standards. The department shall consider all available options including, but not limited to, service definitions, prior authorization, utilization review, provider qualifications, and reimbursement rates for the following Medicaid services: substance abuse day treatment for pregnant women, substance abuse residential treatment for pregnant women, substance abuse case management, opioid treatment, substance abuse day treatment, and substance abuse intensive outpatient. The department shall have the authority to implement this change effective upon passage of this Act, and prior to the completion of any regulatory process undertaken in order to effect such change.

3. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance and any waivers thereof to include peer support services to children and adults with mental health conditions and/or substance use disorders. The department shall work with its contractors, the Department of Behavioral Health and Developmental Services, and appropriate stakeholders to develop service definitions, utilization review criteria and provider qualifications. The department shall have the authority to implement this change effective upon passage of this Act, and prior to the completion of any regulatory process undertaken in order to effect such change.

DBHDS Licensing and ASAM Level of Care Crosswalk

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ASAM LOC	DBHDS LICENSE	CARE COMPONENT	ASAM REQUIREMENTS	DBHDS REQUIREMENTS
2.1 Intensive Outpatient	Substance Abuse Intensive Outpatient Service For Adults, Children, and Adolescents	Setting	Addiction education and treatment programs offered in any appropriate setting that meets state licensure or certification criteria	Usually in a clinic or similar facility or in another location. Non-residential setting. 12VAC35-105-260. All locations shall be inspected and approved as required by the appropriate building regulatory entity. Documentation of approval shall be a Certificate of Use and Occupancy indicating the building is classified for its proposed licensed purpose.
		Service Delivery Examples	• After-school, day or evening, and/or weekend intensive outpatient programs	• This care and treatment may include counseling, rehabilitation, to individuals on an hourly schedule, on an individual, group, or family basis.
		Admission Criteria	1. The individual has no signs or symptoms of withdrawal, or withdrawal needs can be safely managed. 2. Biomedical problems are stable or are being addressed concurrently and will not interfere with treatment. 3. If emotional, behavioral, or cognitive conditions are present, patient must be admitted to either a co-occurring capable or co-occurring enhanced program. 4. Patient requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another level of care have failed; **OR** patient's perspective inhibits his or her ability to make behavioral changes without repeated, structured, clinically directed motivational interventions 5. Patient is experiencing an intensification of symptoms of the substance-related disorder despite participation in a less intensive level of treatment or there is a high likelihood that the patient will continue to use or relapse to use without close outpatient monitoring and structured therapeutic services • Patient's continued exposure to current school, work, or living environment will render recovery unlikely; **OR** patient lacks skills, social contacts, has unsupportive social contacts that jeopardize recovery.	12VAC35-105-580. • The provider shall admit only those individuals whose service needs are consistent with the service description, for whom services are available, and for which staffing levels and types meet the needs of the individuals served. • The service description for substance abuse treatment services shall address the timely and appropriate treatment of pregnant women with substance abuse (substance use disorders). 12VAC35-105-645. • The provider shall implement policies and procedures for initial contacts and screening, *admissions,* and referral of individuals to other services and designate staff to perform these activities. • The provider shall maintain written documentation of an individual's initial contact and screening prior to his admission including the: 1. Date of contact; 2. Name, age, and gender of the individual; 3. Address and telephone number of the individual, if applicable; 4. Reason why the individual is requesting services; and 5. Disposition of the individual including his referral to other services for further assessment, placement on a waiting list for service, or admission to the service. • The provider shall assist individuals who are not admitted to identify other appropriate services. • The provider shall retain documentation of the individual's initial contacts and screening for six months. Documentation shall be included in the individual's record if the individual is admitted to the service. Individuals admitted may have: • **"Co-occurring disorders"** means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders); brain injury; or developmental disability.

				○ Needing "Co-occurring services" - individually planned therapeutic treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders. • **Substance abuse (substance use disorders)"** means the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual.
		Admission Process	• Patients admitted to this level of care should have been seen in Level 1 services prior to admission; **or** • Direct admission to Level 2 is advisable for the patient based on the biopsychosocial assessment, treatment at a lower level of care is adjudged insufficient to stabilize the patient's condition. ○ Stable bio-medical condition **and** a co-occurring emotional, behavioral, or cognitive condition(s) **and** problems in at least **one** of the following areas: Readiness to Change; Relapse, Continued Use or Continued Problem Potential; or Recovery Environment. • Patient has met treatment objectives at a higher level of care.	12VAC35-105-650. • An assessment shall be initiated prior to or at admission to the service. With the participation of the individual and the individual's authorized representative, if applicable, the provider shall *complete an initial assessment detailed enough to determine whether the individual qualifies for admission* and to initiate an (Individual Service Plan) ISP for those individuals who are admitted to the service. This assessment shall assess immediate service, health, and safety needs, and at a minimum include the individual's: 1. Diagnosis; 2. Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of problems; 3. Current medical problems; 4. Current medications; 5. Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders; and 6. At-risk behavior to self and others. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. Definitions: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans. **"Initial assessment"** means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services.

		Staffing	• Based on daily structured program schedule	12VAC35-105-590. • The provider shall implement a written staffing plan that includes the types, roles, and numbers of employees and contractors that are required to provide the service. This staffing plan shall reflect the: 1. Needs of the individuals served; 2. Types of services offered; 3. The service description; and 4. Number of people to be served at a given time.
		Staff Credentials	• Credentialed addiction treatment professionals & addiction-credentialed physicians who assess and treat SUDs. • A team composed of appropriately trained and credentialed medical, addiction and mental health professionals • Generalist physicians may be involved in providing general medical evaluations and concurrent/integrated general medical care during the provision of Level 2 addiction care.	12VAC35-105-590. • Supervision of mental health, substance abuse, or co-occurring services that are of an acute or clinical nature such as outpatient, inpatient, intensive in-home, or day treatment shall be provided by a licensed mental health professional or a mental health professional who is license-eligible and registered with a board of the Department of Health Professions. • Supervision of mental health, substance abuse, or co-occurring services that are of a supportive or maintenance nature, such as psychosocial rehabilitation, mental health supports shall be provided by a (Qualified Mental Health professional) QMHP. **Definitions:** **"Licensed mental health professional (LMHP)"** means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist. **"Qualified Mental Health Professional-Adult (QMHP-A)"** means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to individuals who have a mental illness; including (i) a doctor of medicine or osteopathy licensed in Virginia; (ii) a doctor of medicine or osteopathy, specializing in psychiatry and licensed in Virginia; (iii) an individual with a master's degree in psychology from an accredited college or university with at least one year of clinical experience; (iv) a social worker: an individual with at least a bachelor's degree in human services or related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling or other degree deemed equivalent to those described) from an accredited college and with at least one year of clinical experience providing direct services to individuals with a diagnosis of mental illness; (v) a person with at least a bachelor's degree from an accredited college in an unrelated field that includes at least 15 semester credits (or equivalent) in a human services field and who has at least three years of clinical experience; (vi) a Certified Psychiatric Rehabilitation Provider (CPRP) registered with the United States Psychiatric Rehabilitation Association (USPRA); (vii) a registered nurse licensed in Virginia with at least one year of clinical experience; or (viii) any other licensed mental health professional. **"Qualified Mental Health Professional-Child (QMHP-C)"** means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to children who have a mental illness. To qualify as a QMHP-C, the individual must have the designated clinical experience and must either (i) be a doctor of medicine or osteopathy licensed in Virginia; (ii) have a master's degree in psychology from an accredited college or university with at least one year of clinical experience with children and adolescents; (iii) have a social work bachelor's or master's degree from an accredited college or university with at least one year of documented clinical experience with children or adolescents; (iv) be a registered nurse

				with at least one year of clinical experience with children and adolescents; (v) have at least a bachelor's degree in a human services field or in special education from an accredited college with at least one year of clinical experience with children and adolescents, or (vi) be a licensed mental health professional.
		Physician Coverage	• Telephone consultation within 24 hours by telephone and within 72 hours in person. • Emergency services available 24/7	12VAC35-105-700. • Providers must establish procedures for immediately accessing appropriate internal and external resources. This shall include a provision for obtaining physician and mental health clinical services if the provider's or service's on-call or back-up physician or mental health clinical services are not available at the time of the emergency. 12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary. 12VAC35-105-530 • The provider shall develop a written emergency preparedness and response plan for all of its services and locations that describes its approach to emergencies throughout the organization or community. • Emergency procedures shall address: Maintaining a 24 hour telephone answering capability to respond to emergencies for individuals receiving services
		Purpose of Treatment	Services provide essential addiction education and treatment components while allowing patients to apply skills with “real world” environments.	Planned individualized interventions intended to reduce or ameliorate mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders).
		Schedule-Clinical Services	Provides 9-19 hours per week of structured programming	Treatment provided in a concentrated manner for two or more consecutive hours per day to groups of individuals in a nonresidential setting. This service is provided over a period of time for individuals requiring more intensive services than an outpatient service can provide.
		Types Clinical Services	Individual and group counseling, medication management, family therapy, psychoeducational	Substance abuse intensive outpatient services may but are not limited to include multiple group therapy sessions during the week, individual and family therapy, individual monitoring, and case management.
		Services	• Biopsychosocial assessment • Individualized treatment planning • occupational & recreational therapies • Motivational interviewing, enhancement, and engagement strategies • Random toxicology testing	Outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services.
		Support Systems	• Direct affiliation with, or close coordination through referral to, more and less intensive levels of care and supportive housing. • Ability to arrange for needed laboratory and toxicology services. • Ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications	Includes Case Management and Coordination of Services; Includes Family Therapy and Individual monitoring; Completion of ISP 12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary.

				12VAC35-105-693. • The provider shall make appropriate arrangements or referrals to all service providers identified in the discharge plan prior to the individual's scheduled discharge date. 12VAC35-105-1250. • Employees or contractors providing case management services shall have knowledge of: Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination; Identifying and documenting how resources, services, and natural supports such as family can be utilized to promote achievement of an individual's personal habilitative or rehabilitative and life goals Definition: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. • A comprehensive assessment shall update and finalize the initial assessment. The timing for completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur no later than 30 days, after admission for providers of mental health and substance abuse services and 60 days after admission for providers of mental retardation (intellectual disability) and developmental disabilities services. It shall address: 1. Onset and duration of problems; 2. Social, behavioral, developmental, and family history and supports; 3. Cognitive functioning including strengths and weaknesses; 4. Employment, vocational, and educational background; 5. Previous interventions and outcomes; 6. Financial resources and benefits; 7. Health history and current medical care needs 8. Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or abuse, and circumstances that increase the individual's risk for mental health or substance use issues; 9. History of abuse, neglect, sexual, or domestic violence, or trauma including psychological trauma; 10. Legal status including authorized representative, commitment, and

				representative payee status; 11. Relevant criminal charges or convictions and probation or parole status; 12. Daily living skills; 13. Housing arrangements; 14. Ability to access services including transportation needs;
ASAM LOC	**DBHDS LICENSE**	**CARE COMPONENT**	**ASAM REQUIREMENTS**	**DBHDS REQUIREMENTS**
2.5 Partial Hospitalization Treatment	Substance Abuse Partial Hospitalization or Substance Abuse/Mental Health Partial Hospitalization	Setting	Addiction education and treatment programs with direct access to psychiatric, medical, and laboratory services offered in any appropriate setting that meets state licensure or certification criteria	*DBHDS Licensing regulations does not specify a specific setting for partial hospitalization programs.* 12VAC35-105-260. • All locations shall be inspected and approved as required by the appropriate building regulatory entity. Documentation of approval shall be a Certificate of Use and Occupancy indicating the building is classified for its proposed licensed purpose.
		Service Delivery Examples	Day treatment programs	Services designed to stabilize and ameliorate acute symptoms, and serve as an alternative to inpatient hospitalization or to reduce the length of a hospital stay.
		Admission Criteria	1. The individual has no signs or symptoms of withdrawal, or withdrawal needs can be safely managed. 2. Biomedical problems are stable or are being addressed concurrently and will not interfere with treatment. 3. If emotional, behavioral, or cognitive conditions are present, patient must be admitted to either a co-occurring capable or co-occurring enhanced program. 4. Patient requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another level of care have failed; **OR** patient's perspective and lack of impulse control inhibit his or her ability to make behavioral changes without repeated, structured, clinically directed motivational interventions. 5. Patient is experiencing an intensification of symptoms of the substance-related disorder despite participation in a less intensive level of treatment; **OR** there is a high likelihood that the patient will continue to use or relapse to use without close outpatient monitoring and structured therapeutic services 6. Patient's continued exposure to current school, work, or living environment will render recovery unlikely. The patient lacks the resources or skills to maintain adequate functioning; **OR** Family member and/or significant others who live with the patient are not supportive of his/her recovery goals, or are passively opposed to his/her treatment.	Individuals with serious mental illness, substance abuse (substance use disorders), or co-occurring disorders at risk of hospitalization or who have been recently discharged from an inpatient setting. 12VAC35-105-580. • The provider shall admit only those individuals whose service needs are consistent with the service description, for whom services are available, and for which staffing levels and types meet the needs of the individuals served. • The service description for substance abuse treatment services shall address the timely and appropriate treatment of pregnant women with substance abuse (substance use disorders). 12VAC35-105-645. • The provider shall implement policies and procedures for initial contacts and screening, *admissions,* and referral of individuals to other services and designate staff to perform these activities. • The provider shall maintain written documentation of an individual's initial contact and screening prior to his admission including the: 1. Date of contact; 2. Name, age, and gender of the individual; 3. Address and telephone number of the individual, if applicable; 4. Reason why the individual is requesting services; and 5. Disposition of the individual including his referral to other services for further assessment, placement on a waiting list for service, or admission to the service. • The provider shall assist individuals who are not admitted to identify other appropriate services. • The provider shall retain documentation of the individual's initial contacts and screening for six months. Documentation shall be included in the individual's record if the individual is admitted to the service. **"Co-occurring disorders"** means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders); brain injury; or developmental disability. ○ Needing "Co-occurring services" - individually planned therapeutic

				treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders. **Substance abuse (substance use disorders)"** means the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual.
		Admission Process	• Patients admitted to this level of care should have been seen in Level 1 services prior to admission; **OR** • Direct admission to Level 2 is advisable for the patient based on the biopsychosocial assessment, treatment at a lower level of care is adjudged insufficient to stabilize the patient's condition. ○ Stable bio-medical condition **and** a co-occurring emotional, behavioral, or cognitive condition(s) **and** problems in at least **one** of the following areas: Readiness to Change; Relapse, Continued Use or Continued Problem Potential; or Recovery Environment. • Patient has met treatment objectives at a higher level of care.	12VAC35-105-650. • An assessment shall be initiated prior to or at admission to the service. With the participation of the individual and the individual's authorized representative, if applicable, the provider shall *complete an initial assessment detailed enough to determine whether the individual qualifies for admission* and to initiate an (Individual Service Plan) ISP for those individuals who are admitted to the service. This assessment shall assess immediate service, health, and safety needs, and at a minimum include the individual's: 1. Diagnosis; 2. Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of problems; 3. Current medical problems; 4. Current medications; 5. Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders; and 6. At-risk behavior to self and others. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. Definitions: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans. **"Initial assessment"** means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services.
		Staffing	• Based on daily structured program schedule	12VAC35-105-590. • The provider shall implement a written staffing plan that includes the

				types, roles, and numbers of employees and contractors that are required to provide the service. This staffing plan shall reflect the: 1. Needs of the individuals served; 2. Types of services offered; 3. The service description; and 4. Number of people to be served at a given time.
		Staff Credentials	• Credentialed addiction treatment professionals & addiction-credentialed physicians who assess and treat SUDs. • A team composed of appropriately trained and credentialed medical, addiction and mental health professionals • Generalist physicians may be involved in providing general medical evaluations and concurrent/integrated general medical care during the provision of Level 2 addiction care.	12VAC35-105-590. • Supervision of mental health, substance abuse, or co-occurring services that are of an acute or clinical nature such as outpatient, inpatient, intensive in-home, or day treatment shall be provided by a licensed mental health professional or a mental health professional who is license-eligible and registered with a board of the Department of Health Professions. • Supervision of mental health, substance abuse, or co-occurring services that are of a supportive or maintenance nature, such as psychosocial rehabilitation, mental health supports shall be provided by a (Qualified Mental Health professional) QMHP. **Definitions:** **"Licensed mental health professional (LMHP)"** means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist. **"Qualified Mental Health Professional-Adult (QMHP-A)"** means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to individuals who have a mental illness; including (i) a doctor of medicine or osteopathy licensed in Virginia; (ii) a doctor of medicine or osteopathy, specializing in psychiatry and licensed in Virginia; (iii) an individual with a master's degree in psychology from an accredited college or university with at least one year of clinical experience; (iv) a social worker: an individual with at least a bachelor's degree in human services or related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling or other degree deemed equivalent to those described) from an accredited college and with at least one year of clinical experience providing direct services to individuals with a diagnosis of mental illness; (v) a person with at least a bachelor's degree from an accredited college in an unrelated field that includes at least 15 semester credits (or equivalent) in a human services field and who has at least three years of clinical experience; (vi) a Certified Psychiatric Rehabilitation Provider (CPRP) registered with the United States Psychiatric Rehabilitation Association (USPRA); (vii) a registered nurse licensed in Virginia with at least one year of clinical experience; or (viii) any other licensed mental health professional. **"Qualified Mental Health Professional-Child (QMHP-C)"** means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to children who have a mental illness. To qualify as a QMHP-C, the individual must have the designated clinical experience and must either (i) be a doctor of medicine or osteopathy licensed in Virginia; (ii) have a master's degree in psychology from an accredited college or university with at least one year of clinical experience with children and adolescents; (iii) have a social work bachelor's or master's degree from an accredited college or university with at least one year of documented clinical experience with children or adolescents; (iv) be a registered nurse with at least one year of clinical experience with children and adolescents; (v) have at

				least a bachelor's degree in a human services field or in special education from an accredited college with at least one year of clinical experience with children and adolescents, or (vi) be a licensed mental health professional.
		Physician Coverage	• Telephone consultation within 8 hours by telephone and within 48 hours in person. • Emergency services available 24/7	12VAC35-105-700. • Providers must establish procedures for immediately accessing appropriate internal and external resources. This shall include a provision for obtaining physician and mental health clinical services if the provider's or service's on-call or back-up physician or mental health clinical services are not available at the time of the emergency. 12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary. 12VAC35-105-530 • The provider shall develop a written emergency preparedness and response plan for all of its services and locations that describes its approach to emergencies throughout the organization or community. • Emergency procedures shall address: Maintaining a 24 hour telephone answering capability to respond to emergencies for individuals receiving services
		Purpose of Treatment	• Services provide essential addiction education and treatment components while allowing patients to apply skills with “real world” environments.	Planned individualized interventions intended to reduce or ameliorate mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders).
		Schedule-Clinical Services	• 20 or more hours of clinically intensive programming per week.	Time-limited active treatment interventions that are more intensive than outpatient services.
		Types Clinical Services	• Individual and group counseling, medication management, family therapy, psychoeducational	Services may include but are not limited to multiple group therapy sessions during the week, individual and family therapy, individual monitoring, and case management.
		Services	• Biopsychosocial assessment • Individualized treatment planning • Occupational & recreational therapies • Motivational interviewing, enhancement, and engagement strategies • Random toxicology testing	May include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services.
		Support Systems	• Direct affiliation with (or close coordination through referral to) more and less intensive levels of care and supportive housing. • Ability to arrange for needed laboratory and toxicology services. • Ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications	Includes Case Management and Coordination of Services; Can includes Family Therapy and Individual monitoring; Completion of ISP 12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary. 12VAC35-105-693. • The provider shall make appropriate arrangements or referrals to all service providers identified in the discharge plan prior to the individual's

				scheduled discharge date. 12VAC35-105-1250. • Employees or contractors providing case management services shall have knowledge of: Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination; Identifying and documenting how resources, services, and natural supports such as family can be utilized to promote achievement of an individual's personal habilitative or rehabilitative and life goals Definition: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. • A comprehensive assessment shall update and finalize the initial assessment. The timing for completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur no later than 30 days, after admission for providers of mental health and substance abuse services and 60 days after admission for providers of mental retardation (intellectual disability) and developmental disabilities services. It shall address: 1. Onset and duration of problems; 2. Social, behavioral, developmental, and family history and supports; 3. Cognitive functioning including strengths and weaknesses; 4. Employment, vocational, and educational background; 5. Previous interventions and outcomes; 6. Financial resources and benefits; 7. Health history and current medical care needs 8. Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or abuse, and circumstances that increase the individual's risk for mental health or substance use issues; 9. History of abuse, neglect, sexual, or domestic violence, or trauma including psychological trauma; 10. Legal status including authorized representative, commitment, and representative payee status; 11. Relevant criminal charges or convictions and probation or parole status; 12. Daily living skills;

				13. Housing arrangements; 14. Ability to access services including transportation needs;
ASAM LOC	**DBHDS LICENSE**	**CARE COMPONENT**	**ASAM REQUIREMENTS**	**DBHDS REQUIREMENTS**
3.1 Clinically Managed Low Intensity Residential Services	Mental Health & Substance Abuse Group Home Service for Adults or Children; Substance Abuse Halfway House for Adults;	Setting	• Provides 24-hour structure and support • Provides a 24-hour supportive living environment	A congregate service providing 24-hour supervision in a community-based home having eight or fewer residents. 12VAC35-105-340. • No more than two individuals shall share a bedroom. Definition(s): **"Residential service"** means providing 24-hour support in conjunction with care and treatment or a training program in a setting other than a hospital or training center. Residential services include residential treatment, **group or community homes,** supervised living, residential crisis stabilization, community gero-psychiatric residential, community intermediate care facility-MR, sponsored residential homes, medical and social detoxification, neurobehavioral services, and substance abuse residential treatment for women and children. **"Group home or community residential service**" means a congregate service providing 24-hour supervision in a community-based home having eight or fewer residents. Services include supervision, supports, counseling, and training in activities of daily living for individuals whose individualized services plan identifies the need for the specific types of services available in this setting.
		Service Delivery Examples	Halfway house, group homes or other supportive living environment with 24-hour staff and close integration with clinical services *Note: This level does not describe or include sober houses, boarding houses, or group homes where treatment services are not provided.*	Services include supervision, supports, counseling, and training in activities of daily living for individuals whose individualized services plan identifies the need for the specific types of services available in this setting. Residential services provide a range of living arrangements from highly structured and intensively supervised to relatively independent requiring a modest amount of staff support and monitoring.
		Admission Criteria	Patient meets specifications in **each** of the six dimensions: 1. The individual has no signs or symptoms of withdrawal, or withdrawal needs can be safely managed. 2. Biomedical problems are stable and the individual is capable of self-administering medication; or the condition requires medical monitoring, which can be provided by the program or through an established arrangement with another provider 3. The individual may not have any significant emotional, behavioral, or cognitive conditions and impairment. However, if any is present, the patient must be admitted to a co-occurring capable or co-occurring enhanced program. 4. The individual acknowledges the existence of a substance use problem and is sufficiently ready to change and cooperative enough to respond to treatment at Level 3.1; **OR** is assessed as appropriately placed at Level 1 or 2 and is receiving Level 3.1 concurrently; **OR** is assessed as not likely to succeed in an OP setting, therefore, requires a 24-hr structured milieu to promote treatment progress and recovery; OR individual's perspective impairs his or her ability to make behavior changes without a structured environment. 5. The individual demonstrates limited coping skills to address relapse triggers and urges and/or deteriorating mental functioning; and, is in imminent danger of relapse without 24-hour structure; **OR** individual	12VAC35-105-580. • The provider shall admit only those individuals whose service needs are consistent with the service description, for whom services are available, and for which staffing levels and types meet the needs of the individuals served. • The service description for substance abuse treatment services shall address the timely and appropriate treatment of pregnant women with substance abuse (substance use disorders). 12VAC35-105-645. • The provider shall implement policies and procedures for initial contacts and screening, *admissions,* and referral of individuals to other services and designate staff to perform these activities. • The provider shall maintain written documentation of an individual's initial contact and screening prior to his admission including the: 1. Date of contact; 2. Name, age, and gender of the individual; 3. Address and telephone number of the individual, if applicable; 4. Reason why the individual is requesting services; and 5. Disposition of the individual including his referral to other services for further assessment, placement on a waiting list for service, or admission to the service. • The provider shall assist individuals who are not admitted to identify other

			understands his or her addiction and/or mental disorder, but is at risk of relapse in a less structured level of care; **OR** individual is at high risk of substance use, addictive behavior or cognitive consequences in the absence of close 24-hour structured support 6. The individual is able to cope, for limited periods of time, outside the 24-hr structure of Level 3.1 in order to pursue clinical, vocational, educational, and community activities; AND has been living in an environment that is characterized by a moderately high risk of initiation or repetition of physical, sexual, or emotional abuse or substance use so endemic that the individual is assessed as being unable to achieve or maintain recovery in an less intensive level of care; **OR** the individual lacks social contacts or has high-risk social contacts; **OR** individual's social network involves living in an environment so highly invested in alcohol or other drug use that the individual's recovery goals are assessed as unachievable **OR** continued exposure to the individual's school, work, or living environment makes recovery unlikely, and individual has insufficient resources and skills to maintain an adequate level of functioning outside of a 24-hr supportive environment; **OR** the patient is in danger of victimization by another and, thus, requires 24-hr supervision.	appropriate services. • The provider shall retain documentation of the individual's initial contacts and screening for six months. Documentation shall be included in the individual's record if the individual is admitted to the service. • **"Co-occurring disorders"** means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders); brain injury; or developmental disability. o Needing "Co-occurring services" - individually planned therapeutic treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders. **Substance abuse (substance use disorders)"** means the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual.
		Admission Process	• Patients admitted to this level of care should have been seen in Level 1 or 2 services prior to admission for multidimensional assessment and differential diagnosis	12VAC35-105-650. • An assessment shall be initiated prior to or at admission to the service. With the participation of the individual and the individual's authorized representative, if applicable, the provider shall *complete an initial assessment detailed enough to determine whether the individual qualifies for admission* and to initiate an (Individual Service Plan) ISP for those individuals who are admitted to the service. This assessment shall assess immediate service, health, and safety needs, and at a minimum include the individual's: 1. Diagnosis; 2. Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of problems; 3. Current medical problems; 4. Current medications; 5. Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders; and 6. At-risk behavior to self and others. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. Definitions: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs

				and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans. **"Initial assessment"** means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services.
		Staffing	• 24 hour staff	Provides 24-hour supervision of residents
		Staff Credentials	• Allied health professional staff, such as counselor aides or group living workers who are on-site 24/7, or as required by licensing standards • Clinical staff who are knowledgeable about the biological and psychosocial dimensions of SUDs and their treatment and who are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation • A team composed of appropriately trained and credentialed medical, addiction and mental health professionals	12VAC35-105-590. • The provider shall implement a written staffing plan that includes the types, roles, and numbers of employees and contractors that are required to provide the service. This staffing plan shall reflect the: 1. Needs of the individuals served; 2. Types of services offered; 3. The service description; and 4. Number of people to be served at a given time.
		Physician Coverage	• Telephone or in-person consultation with a physician and emergency services available 24/7 • An addiction physician should review admission decisions to confirm the clinical necessity of services	12VAC35-105-700. • Providers must establish procedures for immediately accessing appropriate internal and external resources. This shall include a provision for obtaining physician and mental health clinical services if the provider's or service's on-call or back-up physician or mental health clinical services are not available at the time of the emergency. 12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary. 12VAC35-105-530 • The provider shall develop a written emergency preparedness and response plan for all of its services and locations that describes its approach to emergencies throughout the organization or community. • Emergency procedures shall address: Maintaining a 24 hour telephone answering capability to respond to emergencies for individuals receiving services
		Purpose of Treatment	• Services facilitate the application of recovery skills, relapse prevention, and emotional coping strategies • They promote personal responsibility and reintegration of the individual into the network systems of work, education and family life	Planned individualized interventions intended to reduce or ameliorate mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders).
		Schedule-Clinical Services	• 5 hours of planned, clinical activities of professionally directed treatment per week	Not specified in DBHDS Licensure requirements
		Types Clinical Services	• Treatment is characterized by services such as individual, group and family therapy; medication management; and psychoeducation	Services include supervision, supports, counseling, and training in activities of daily living for individuals whose individualized services plan identifies the need for the specific types of services available in this setting.
		Services	• Clinically directed treatment • Addiction pharmacotherapy	Services include supervision, supports, counseling, and training in activities of daily living for individuals whose individualized services plan identifies the need for the specific types of services available in this setting.

			• Random drug screening • Motivational enhancement and engagement strategies • Counseling and clinical monitoring • Regular monitoring of patient's medication adherence • Recovery support services • Services for the patient's family and significant others, as appropriate • Opportunities for the patient to be introduced to the potential benefits of addiction pharmacotherapy as a tool to manage his or her addictive disorder • Self-help meetings are available on-site, or easily accessible in the local community	
		Support Systems	• Direct affiliations with other levels of care, or close coordination through referral to more and less intensive services (such as IOP, vocational, literacy training and adult education) • Ability to arrange for needed procedures, including laboratory and toxicology tests • Ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications	12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary. 12VAC35-105-693. • The provider shall make appropriate arrangements or referrals to all service providers identified in the discharge plan prior to the individual's scheduled discharge date. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. • A comprehensive assessment shall update and finalize the initial assessment. The timing for completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur no later than 30 days, after admission for providers of mental health and substance abuse services and 60 days after admission for providers of mental retardation (intellectual disability) and developmental disabilities services. It shall address: 1. Onset and duration of problems; 2. Social, behavioral, developmental, and family history and supports; 3. Cognitive functioning including strengths and weaknesses; 4. Employment, vocational, and educational background; 5. Previous interventions and outcomes; 6. Financial resources and benefits; 7. Health history and current medical care needs 8. Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or abuse, and circumstances that increase the individual's risk for mental health or substance use issues; 9. History of abuse, neglect, sexual, or domestic violence, or trauma including psychological trauma; 10. Legal status including authorized representative, commitment, and representative payee status; 11. Relevant criminal charges or convictions and probation or parole status;

				12. Daily living skills; 13. Housing arrangements; 14. Ability to access services including transportation needs; Definition: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans.
ASAM LOC	**DBHDS LICENSE**	**CARE COMPONENT**	**ASAM REQUIREMENTS**	**DBHDS REQUIREMENTS**
3.3 Clinically Managed Population-Specific High Intensity Residential Services for special populations with cognitive disabilities	Supervised Residential Treatment Services for Adults; Substance Abuse Residential Treatment for Adults	Setting	• Provides 24-hour service and supports • Freestanding, appropriately licensed facility located within a community setting or a specialty licensed health care facility	In a residential setting, other than an inpatient service or private family home; publicly or privately operated facility. Definition(s): **"Residential service"** means providing 24-hour support in conjunction with care and treatment or a training program in a setting other than a hospital or training center. Residential services include residential treatment, group or community homes, supervised living, residential crisis stabilization, community gero-psychiatric residential, community intermediate care facility-MR, sponsored residential homes, medical and social detoxification, neurobehavioral services, and **substance abuse residential treatment for women and children.**
		Service Delivery Examples	• Therapeutic rehabilitation facility or a traumatic brain injury program	Providing an intensive and highly structured mental health, substance abuse, or neurobehavioral service, or services for co-occurring disorders
		Admission Criteria	Patient meets specifications in **each** of the six dimensions: 1. The individual has no signs or symptoms of withdrawal, or withdrawal needs can be safely managed. 2. Biomedical problems are stable and the individual is capable of self-administering medication; or the condition requires medical monitoring, which can be provided by the program or through an established arrangement with another provider. 3. If significant emotional, behavioral, or cognitive conditions and impairment are present, the patient must be admitted to a co-occurring capable or co-occurring enhanced program. 4. The intensity and chronicity of the SUD or the patient's cognitive impairment is such that he or she has little awareness of the need for treatment or continuing care; **OR** despite experiencing consequences of the SUD or mental health problem the patient has marked difficulty understanding the relationship between his or her SUD, addiction, mental health or life problems and impaired coping; **OR** the patient's continued us poses a danger of harm to self or others, and he or she demonstrates no awareness of the need to address the severity of his or her addiction or recognize the need for treatment; **OR** the patient's perspective impairs his or her ability to make	12VAC35-105-580. • The provider shall admit only those individuals whose service needs are consistent with the service description, for whom services are available, and for which staffing levels and types meet the needs of the individuals served. • The service description for substance abuse treatment services shall address the timely and appropriate treatment of pregnant women with substance abuse (substance use disorders). 12VAC35-105-645. • The provider shall implement policies and procedures for initial contacts and screening, *admissions,* and referral of individuals to other services and designate staff to perform these activities. • The provider shall maintain written documentation of an individual's initial contact and screening prior to his admission including the: 1. Date of contact; 2. Name, age, and gender of the individual; 3. Address and telephone number of the individual, if applicable; 4. Reason why the individual is requesting services; and 5. Disposition of the individual including his referral to other services for further assessment, placement on a waiting list for service, or admission to

			behavior changes without repeated, structured, clinically motivated interventions developed in a 24-hour milieu. 5. Patient does not recognize relapse triggers and has little awareness of the need for continuing care. He or she is in imminent danger of continued substance use or mental health problems without 24-hour monitoring and structure; **OR** patient is experiencing an intensification of symptoms of his or her substance SUD or mental disorder, and his or her level of functioning is deteriorating despite an amendment to the treatment plan; **OR** patient's cognitive impairment has limited his or her ability to identify and cope with relapse triggers and high-risk situations. Patient requires relapse prevention activities that are delivered at a slower pace, more concretely, and more repetitively, in a setting that provides 24-hour structure and support; **OR** Despite recent, active participation in treatment at a less intensive level of care, the patient continues to use substances or to deteriorate psychiatrically with imminent consequences. 6. Patient has been living in an environment that is characterized by a moderately high risk of initiation or repetition of physical, sexual, or emotional abuse or substance use so endemic that the individual is assessed as being unable to achieve or maintain recovery in an less intensive level of care; **OR** significant danger of victimization and thus requires 24-hour supervision; **OR** individual's social network involves living in an environment so highly invested in alcohol or other drug use that the individual's recovery goals are assessed as unachievable; **OR** patient need staff monitoring to assure his or her safety and well-being.	the service. • The provider shall assist individuals who are not admitted to identify other appropriate services. • The provider shall retain documentation of the individual's initial contacts and screening for six months. Documentation shall be included in the individual's record if the individual is admitted to the service. • **"Co-occurring disorders"** means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders); brain injury; or developmental disability. ○ Needing "Co-occurring services" - individually planned therapeutic treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders. **Substance abuse (substance use disorders)"** means the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual.
		Admission Process	• Patients admitted to this level of care meet diagnostic criteria for moderate or severe SUD	12VAC35-105-650. • An assessment shall be initiated prior to or at admission to the service. With the participation of the individual and the individual's authorized representative, if applicable, the provider shall *complete an initial assessment detailed enough to determine whether the individual qualifies for admission* and to initiate an (Individual Service Plan) ISP for those individuals who are admitted to the service. This assessment shall assess immediate service, health, and safety needs, and at a minimum include the individual's: 1. Diagnosis; 2. Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of problems; 3. Current medical problems; 4. Current medications; 5. Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders; and 6. At-risk behavior to self and others. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. 12VAC-35-105-740 • A physical examination shall be administered within 24 hours of an

				individual's admission. The physical examination shall include, at minimum: o General physical condition (history and physical); o Evaluation of communicable diseases; o Recommendations for further diagnostic tests and treatment, if appropriate; o Other examinations that may be indicated; and o The date of examination and signature of a qualified practitioner Definitions: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans. **"Initial assessment"** means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services.
		Staffing	24 hour staff	Provider assumes responsibility for management of the physical environment of the residence, and staff supervision and monitoring are daily and available on a 24-hour basis
		Staff Credentials	• Physicians • Allied health professional staff, such as counselor aides or group living workers who are on-site 24/7, or as required by licensing standards. One or more clinicians with competence in the treatment of substance use disorders are available on-site or by telephone 24 hours a day. • Clinical staff who are knowledgeable about the biological and psychosocial dimensions of SUDs and their treatment and who are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation • A team composed of appropriately trained and credentialed medical, addiction and mental health professionals	12VAC35-105-590. • The provider shall implement a written staffing plan that includes the types, roles, and numbers of employees and contractors that are required to provide the service. This staffing plan shall reflect the: 1. Needs of the individuals served; 2. Types of services offered; 3. The service description; and 4. Number of people to be served at a given time.
		Physician Coverage	• Telephone or in-person consultation with a physician and emergency services available 24/7	12VAC35-105-700. • Providers must establish procedures for immediately accessing appropriate internal and external resources. This shall include a provision for obtaining physician and mental health clinical services if the provider's or service's on-call or back-up physician or mental health clinical services are not available at the time of the emergency. 12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary.

				12VAC35-105-530 • The provider shall develop a written emergency preparedness and response plan for all of its services and locations that describes its approach to emergencies throughout the organization or community. • Emergency procedures shall address: Maintaining a 24 hour telephone answering capability to respond to emergencies for individuals receiving services
		Purpose of Treatment	Services address the effects of the substance use or a co-occurring disorder that has resulted in cognitive impairment and the impact on the individual's life is so significant, and the resulting level of impairment so great, that outpatient motivational and/or relapse prevention strategies are not feasible or effective.	Planned individualized interventions intended to reduce or ameliorate mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders).
		Schedule-Clinical Services	• Daily • Individualized based on the extent of reduced cognitive functioning	Not Specified in DBHDS Licensing Regulations
		Types Clinical Services	Treatment is characterized by services such as individual, group and family therapy; medical and nursing; physical therapy; medication management; and psychoeducation	Services are provided based on the needs of the individual in areas such as food preparation, housekeeping, medication administration, personal hygiene, treatment, counseling, and budgeting
		Services	• Biopsychosocial assessment • Individualized treatment planning • Clinically directed treatment • Addiction pharmacotherapy • Random drug screening • Art, music or movement therapies • Vocational rehabilitation • Cognitive and behavioral therapies • Counseling and clinical monitoring • Regular monitoring of patient's medication adherence • Recovery support services • Services for the patient's family and significant others, as appropriate • Opportunities for the patient to be introduced to the potential benefits of addiction pharmacotherapy as a tool to manage his or her addictive disorder	Services are provided based on the needs of the individual in areas such as food preparation, housekeeping, medication administration, personal hygiene, treatment, counseling, and budgeting.
		Support Systems	• Direct affiliations with other levels of care, or close coordination through referral to more and less intensive services (such as IOP, vocational, literacy training and adult education) • Ability to arrange for needed procedures, including laboratory and toxicology tests • Medical, psychiatric, psychological services available through consultation or referral.	12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary. 12VAC35-105-693. • The provider shall make appropriate arrangements or referrals to all service providers identified in the discharge plan prior to the individual's scheduled discharge date. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24

				hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. • A comprehensive assessment shall update and finalize the initial assessment. The timing for completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur no later than 30 days, after admission for providers of mental health and substance abuse services and 60 days after admission for providers of mental retardation (intellectual disability) and developmental disabilities services. It shall address: 1. Onset and duration of problems; 2. Social, behavioral, developmental, and family history and supports; 3. Cognitive functioning including strengths and weaknesses; 4. Employment, vocational, and educational background; 5. Previous interventions and outcomes; 6. Financial resources and benefits; 7. Health history and current medical care needs 8. Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or abuse, and circumstances that increase the individual's risk for mental health or substance use issues; 9. History of abuse, neglect, sexual, or domestic violence, or trauma including psychological trauma; 10. Legal status including authorized representative, commitment, and representative payee status; 11. Relevant criminal charges or convictions and probation or parole status; 12. Daily living skills; 13. Housing arrangements; 14. Ability to access services including transportation needs; Definition: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans.

ASAM LOC	DBHDS LICENSE	CARE COMPONENT	ASAM REQUIREMENTS	DBHDS REQUIREMENTS
3.5 Clinically-Managed, Medium/High Intensity Residential Treatment	Substance Abuse Residential Treatment Services for Adults or Children; or Psychiatric Unit	Setting	• Provides 24-hour service and structured support • Freestanding, appropriately licensed facility located within a community setting or a specialty licensed health care facility • Prisons or secure community settings for inmates released from prison as a step down	In a residential setting, other than an inpatient service or private family home; publicly or privately operated facility. Definition(s): **"Residential service"** means providing 24-hour support in conjunction with care and treatment or a training program in a setting other than a hospital or training center. Residential services include residential treatment, group or community homes, supervised living, residential crisis stabilization, community gero-psychiatric residential, community intermediate care facility-MR, sponsored residential homes, medical and social detoxification, neurobehavioral services, and **substance abuse residential treatment for women and children.** **"Children's residential facility" or "facility"** means a publicly or privately operated facility, other than a private family home, where 24-hour per day care is provided to children separated from their legal guardians and is required to be licensed or certified by the Code of Virginia **Acute psychiatric hospital** "Special hospital" means institutions as defined by § 32.1-123 of the Code of Virginia that provide care for a specialized group of patients or limit admissions to provide diagnosis and treatment for patients who have specific conditions (e.g., tuberculosis, orthopedic, pediatric, maternity). (12VAC5-410-10) **Psychiatric unit within an acute care general hospital or Acute psychiatric hospital –** An intensive 24-hour medical, nursing, and treatment services provided to individuals with mental illness or substance abuse (substance use disorders) in a hospital as defined in §32.1-123 of the Code of Virginia or in a special unit of such a hospital. (12VAC35-105-20)
		Service Delivery Examples	• Residential treatment center or a therapeutic community	Providing an intensive and highly structured mental health, substance abuse, or neurobehavioral service, or services for co-occurring disorders Free standing psychiatric or substance abuse hospital, or an acute care facility with a specialized psychiatric or substance use treatment unit. An intensive 24-hour medical, nursing, and treatment services provided to individuals with mental illness or substance abuse (substance use disorders) in a hospital as defined in §32.1-123 of the Code of Virginia or in a special unit of such a hospital. (12VAC35-105-20) In a residential setting, other than an inpatient service or private family home; publicly or privately operated facility.
		Admission Criteria	Patient meets specifications in **each** of the six dimensions: 1. The individual has no signs or symptoms of withdrawal, or withdrawal needs can be safely managed; **OR** current biomedical condition is not severe enough to warrant inpatient treatment, but warrants medical monitoring, which can be provided by the program or through an established arrangement with another provider.	12VAC35-105-580. • The provider shall admit only those individuals whose service needs are consistent with the service description, for whom services are available, and for which staffing levels and types meet the needs of the individuals served. • The service description for substance abuse treatment services shall address the timely and appropriate treatment of pregnant women with substance abuse

			2. Biomedical problems are stable and the individual is capable of self-administering medication; or the condition requires medical monitoring, which can be provided by the program or through an established arrangement with another provider. 3. If significant emotional, behavioral, or cognitive conditions and impairment are present, the patient must be admitted to a co-occurring capable or co-occurring enhanced program. 4. The intensity and chronicity of the SUD or the patient's mental health problems are such that he or she has limited insight or little awareness of the need for treatment or continuing care; **OR** despite experiencing consequences of the SUD or mental health problem the patient has marked difficulty understanding the relationship between his or her SUD, addiction, mental health or life problems and impaired coping, or blaming others for his or her addiction problem; **OR** patient demonstrates passive or active opposition to addressing the severity of his or her mental or addiction problem, or does not recognize the need for treatment; **OR** patient requires structured therapy and a 24-hours programmatic milieu to promote treatment progress and recovery, because motivation interventions have not succeeded at less intensive levels of care; **OR** patient's perspective impairs his or her ability to make behavior changes without repeated, structured, clinically motivated interventions developed in a 24-hour milieu; **OR** despite recognition of a SUD and understanding the relationship between his or her use, addiction, life problems, the patient expresses little to no interest in changing; **OR** Patient attributes his or her alcohol, drug, addictive, or mental problem to other persons or external events, rather than to a substance use or addictive or mental disorder. 5. The patient requires 24-hour monitoring and structured support. Patient does not recognize relapse triggers and has little awareness of the need for continuing care and is, therefore, not committed to treatment. His or her continued substance use poses an imminent danger of harm to self or others in the absence of 24-hour monitoring and structured support; **OR** patient's psychiatric condition is stabilizing; however, patient is unable to control his or her use of alcohol, other drugs, and/or antisocial behaviors. The patient has limited ability to interrupt the relapse process or to use peer supports when at risk for relapse; **OR** patient is experiencing psychiatric or addiction symptoms, insufficient ability to postpone immediate gratification and other drug-seeking behaviors. Poses an imminent danger of harm to self or others in the absence of 24-hour monitored support; **OR** patient is in danger of relapse or continued use, with dangerous emotional, behavioral, or cognitive consequences, as a result of a crisis situation; **OR** Despite recent, active participation in treatment at a less intensive level of care, the patient continue to use alcohol or other drugs, or to deteriorate psychiatrically, with imminent serious consequences; **OR** patient demonstrates a lifetime history of repeated incarceration with a pattern of relapse to substances and uninterrupted use outside of incarceration, with imminent risk of relapse to addiction or mental health problems and recidivism to criminal behavior. The patient's imminent danger of relapse is accompanied by an uninterrupted cycle of relapse-reoffending-incarceration-release-relapse without the opportunity for treatment.	(substance use disorders). 12VAC35-105-645. • The provider shall implement policies and procedures for initial contacts and screening, *admissions,* and referral of individuals to other services and designate staff to perform these activities. • The provider shall maintain written documentation of an individual's initial contact and screening prior to his admission including the: 1. Date of contact; 2. Name, age, and gender of the individual; 3. Address and telephone number of the individual, if applicable; 4. Reason why the individual is requesting services; and 5. Disposition of the individual including his referral to other services for further assessment, placement on a waiting list for service, or admission to the service. • The provider shall assist individuals who are not admitted to identify other appropriate services. • The provider shall retain documentation of the individual's initial contacts and screening for six months. Documentation shall be included in the individual's record if the individual is admitted to the service. • **"Co-occurring disorders"** means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders); brain injury; or developmental disability. o Needing "Co-occurring services" - individually planned therapeutic treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders. **Substance abuse (substance use disorders)"** means the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual. 12VAC35-46-640. (Children's Residential Regulations) • The facility shall have written criteria for admission that shall include: 1. A description of the population to be served; 2. A description of the types of services offered; 3. Intake and admission procedures; 4. Exclusion criteria to define those behaviors or problems that the facility does not have the staff with experience or training to manage; and 5. Description of how educational services will be provided to the population being served. • The facility shall accept and serve only those children whose needs are compatible with the services provided through the facility unless a child's admission is ordered by a court of competent jurisdiction.

			6. Patient has been living in an environment that is characterized by a moderately high risk of initiation or repetition of physical, sexual, or emotional abuse or substance use so endemic that the individual is assessed as being unable to achieve or maintain recovery in an less intensive level of care; **OR** individual's social network includes regular users of alcohol, tobacco, and/or other drugs, such that the individual's recovery goals are assessed as unachievable; **OR** patient's social network involves living with an individual who is a regular user, addicted user or dealer of alcohol and/or other drugs, or the living environment is so invested in alcohol and/or other drug use that his or her recovery goals are assessed as unachievable; **OR** patient is unable to cope, for even limited periods of time, outside of 24-hour care.	
		Admission Process	• Patients admitted to this level of care meet diagnostic criteria for moderate or severe SUD • Patients have multiple limitations such as psychological problems, impaired functioning, and demonstrate antisocial behaviors. • Patients have a pattern of relapse-reoffending-incarceration-release-relapse • Patients to this level of care should have been seen in Level 1 or 2 services prior to admission for multidimensional assessment and differential diagnosis	**Psychiatric unit within a general hospital and acute psychiatric hospital** An initial individualized services plan (ISP) shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs. (12VAC35-105-660 B) 12VAC35-105-650. • An assessment shall be initiated prior to or at admission to the service. With the participation of the individual and the individual's authorized representative, if applicable, the provider shall *complete an initial assessment detailed enough to determine whether the individual qualifies for admission* and to initiate an (Individual Service Plan) ISP for those individuals who are admitted to the service. This assessment shall assess immediate service, health, and safety needs, and at a minimum include the individual's: 1. Diagnosis; 2. Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of problems; 3. Current medical problems; 4. Current medications; 5. Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders; and 6. At-risk behavior to self and others. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. (12VAC-35-105-740) • A physical examination shall be administered within 24 hours of an individual's admission. The physical examination shall include, at minimum: ○ General physical condition (history and physical); ○ Evaluation of communicable diseases; ○ Recommendations for further diagnostic tests and treatment, if appropriate; ○ Other examinations that may be indicated; and ○ The date of examination and signature of a qualified

				practitioner 12VAC35-46-10 (Children Residential Regulations) • The service provides active treatment or training beginning at admission related to the resident's principle diagnosis and admitting symptoms. 12VAC35-46-630. (Children Residential Regulations) • Acceptance of children. Children shall be accepted only by court order or by written placement agreement with legal guardians. 12VAC35-46-710. (Children Residential Regulations) • Admission shall be based on evaluation of an application for admission. The requirements of this section do not apply to court-ordered placements or transfer of a resident between residential facilities located in Virginia and operated by the same sponsor. • Providers shall develop, and fully complete prior to acceptance for care, an application for admission that is designed to compile information necessary to determine: 1. The educational needs of the prospective resident; 2. The mental health, emotional, and psychological needs of the prospective resident; 3. The physical health needs, including the immunization needs, of the prospective resident; 4. The protection needs of the prospective resident; 5. The suitability of the prospective resident's admission; 6. The behavior support needs of the prospective resident; 7. Family history and relationships; 8. Social and development history; 9. Current behavioral functioning and social competence; 10. History of previous treatment for mental health, mental retardation, substance abuse, brain injury, and behavior problems; and 11. Medication and drug use profile. • Each facility shall develop and implement written policies and procedures to assess each prospective resident as part of the application process to ensure that: 1. The needs of the prospective resident can be addressed by the facility's services; 2. The facility's staff are trained to meet the prospective resident's needs; and 3. The admission of the prospective resident would not pose any significant risk to (i) the prospective resident or (ii) the facility's residents or staff. 12VAC35-46-750. (Children Residential Regulations) • An individualized service plan shall be developed and placed in the resident's record within 30 days following admission and implemented immediately thereafter. • Individualized service plans shall describe in measurable terms the: 1. Strengths and needs of the resident; 2. Resident's current level of functioning; 3. Goals, objectives, and strategies established for the resident; 4. Projected family involvement; 5. Projected date for accomplishing each objective; and 6. Status of the projected discharge plan and estimated length of stay, except that this requirement shall not apply to a facility that discharges only upon receipt of the

				order of a court of competent jurisdiction. Definitions: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans. **"Initial assessment"** means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services.
		Staffing	24-hour staff	Provider assumes responsibility for management of the physical environment of the residence, and staff supervision and monitoring are daily and available on a 24-hour basis
		Staff Credentials	• Licensed or credentialed clinical staff (addiction counselors, social workers, and licensed professional counselors) who work with the allied health professional staff in an interdisciplinary team approach. • Allied health professional staff, such as counselor aides or group living workers who are on-site 24/7, or as required by licensing standards. One or more clinicians with competence in the treatment of substance use disorders are available on-site or by telephone 24 hours a day. • Clinical staff who are knowledgeable about the biological and psychosocial dimensions of SUDs and their treatment and who are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation	12 VAC35-105-1080. • The provider shall document staff training in the areas of: 1. Management of withdrawal; and 2. First responder training. • Untrained employees or contractors shall not be solely responsible for the care of individuals. 12VAC35-105-590. • The provider shall implement a written staffing plan that includes the types, roles, and numbers of employees and contractors that are required to provide the service. This staffing plan shall reflect the: 1. Needs of the individuals served; 2. Types of services offered; 3. The service description; and 4. Number of people to be served at a given time. 12VAC35-46-625. (Children's Residential Regulations) • The provider shall have and implement written policies and procedures that address the provision of: 1. Psychiatric care; 2. Family therapy; and 3. Staffing appropriate to the needs and behaviors of the residents served. 12VAC35-46-370 (Children Residential Regulations) • Child care supervisors shall have responsibility for the: 1. Development of the daily living program within each child care unit; and 2. Orientation, training, and supervision of direct care workers. 12VAC35-46-380. (Children Residential Regulations) • The child care worker shall have responsibility for guidance and supervision of the children. 12VAC35-46-390. (Children Residential Regulations)

				• Qualified relief staff shall be employed as necessary to meet the needs of the programs and services offered and to maintain a structured program of care 12VAC35-46-350. (Children Residential Regulations) • Program Director-The facility's program shall be directed by one or more qualified persons. • Persons directing programs shall be responsible for the development and implementation of the programs and services offered by the facility, including overseeing assessments, service planning, staff scheduling, and supervision. **Definitions:** **"Licensed mental health professional (LMHP)"** means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist. **"Qualified Mental Health Professional-Adult (QMHP-A)"** means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to individuals who have a mental illness; including (i) a doctor of medicine or osteopathy licensed in Virginia; (ii) a doctor of medicine or osteopathy, specializing in psychiatry and licensed in Virginia; (iii) an individual with a master's degree in psychology from an accredited college or university with at least one year of clinical experience; (iv) a social worker: an individual with at least a bachelor's degree in human services or related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling or other degree deemed equivalent to those described) from an accredited college and with at least one year of clinical experience providing direct services to individuals with a diagnosis of mental illness; (v) a person with at least a bachelor's degree from an accredited college in an unrelated field that includes at least 15 semester credits (or equivalent) in a human services field and who has at least three years of clinical experience; (vi) a Certified Psychiatric Rehabilitation Provider (CPRP) registered with the United States Psychiatric Rehabilitation Association (USPRA); (vii) a registered nurse licensed in Virginia with at least one year of clinical experience; or (viii) any other licensed mental health professional. **"Qualified Mental Health Professional-Child (QMHP-C)"** means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to children who have a mental illness. To qualify as a QMHP-C, the individual must have the designated clinical experience and must either (i) be a doctor of medicine or osteopathy licensed in Virginia; (ii) have a master's degree in psychology from an accredited college or university with at least one year of clinical experience with children and adolescents; (iii) have a social work bachelor's or master's degree from an accredited college or university with at least one year of documented clinical experience with children or adolescents; (iv) be a registered nurse with at least one year of clinical experience with children and adolescents; (v) have at least a bachelor's degree in a human services field or in special education from an accredited college with at least one year of clinical experience with children and adolescents, or (vi) be a licensed mental health professional.
		Physician Coverage	Telephone or in-person consultation with a physician and emergency services available 24/7	12VAC35-105-700. • Providers must establish procedures for immediately accessing appropriate internal and external resources. This shall include a provision for obtaining physician and mental health clinical services if the provider's or service's on-call

				or back-up physician or mental health clinical services are not available at the time of the emergency. 12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary. 12VAC35-105-530 • The provider shall develop a written emergency preparedness and response plan for all of its services and locations that describes its approach to emergencies throughout the organization or community. • Emergency procedures shall address: Maintaining a 24 hour telephone answering capability to respond to emergencies for individuals receiving services 12VAC35-46-820. (Children Residential Regulations) • The provider shall develop and implement written policies and procedures for a crisis or clinical emergency that shall include: 1. Procedures for crisis or clinical stabilization, and immediate access to appropriate internal and external resources, including a provision for obtaining physician and mental health clinical services if on-call physician back-up or mental health clinical services are not available; and 2. Employee or contractor responsibilities.
		Purpose of Treatment	• Services are for individuals whose addiction is so out of control that they need a 24-hour supportive treatment environment. • The treatment community is a therapeutic agent.	Services to eliminate or reduce the effects of alcohol or other drugs in the individual's body. Planned individualized interventions intended to reduce or ameliorate mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders). 12VAC35-46-10 (Children Residential Regulations) • Designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, or training needs of a child or adolescent in order to prevent or minimize the need for more intensive inpatient treatment.
		Schedule-Clinical Services	Daily	24-hour support in conjunction with care and treatment or a training program. 12VAC35-46-625. (Children's Residential Regulations) • The provider shall have and implement written policies and procedures for the on-site provision of a structured program of care or treatment of residents with mental illness, mental retardation, substance abuse, or brain injury. The provision, intensity, and frequency of mental health, mental retardation, substance abuse, or brain injury interventions shall be based on the assessed needs of the resident. B. Each provider shall have formal arrangements for the evaluation, assessment, and treatment of the mental health or brain injury needs of the resident.

		Types Clinical Services	Treatment is characterized by services such as individual, group and family therapy using a range of evidence-based practices; medical and nursing; physical therapy; medication management; and psychoeducation	Intensive and highly structured mental health, substance abuse, or neurobehavioral service, or services for co-occurring disorders in a residential setting, other than an inpatient service. 12VAC35-46-625. (Children's Residential Regulations) • Interventions, applicable to the population served, shall include, but are not limited to: 1. Individual counseling; 2. Group counseling; 3. Training in decision making, family and interpersonal skills, problem solving, self-care, social, and independent living skills; 4. Training in functional skills; 5. Assistance with activities of daily living (ADL's); 6. Social skills training in therapeutic recreational activities, e.g., anger management, leisure skills education and development, and community integration; 7. Providing positive behavior supports; 8. Physical, occupational, and/or speech therapy; 9. Substance abuse education and counseling; and 10. Neurobehavioral services for individuals with brain injury.
		Services	• Biopsychosocial assessment • Individualized treatment planning • Clinically directed treatment • Addiction pharmacotherapy • Random drug screening • Motivational enhancement and engagement strategies • Occupational or recreational activities • Counseling and clinical monitoring • Regular monitoring of patient's medication adherence • Planned community reinforcement to foster community living skills • Recovery support services • Services for the patient's family and significant others, as appropriate • Opportunities for the patient to be introduced to the potential benefits of addiction pharmacotherapy as a tool to manage his or her addictive disorder • Self-help meetings are available on-site, or easily accessible in the local community	Intensive and highly structured mental health, substance abuse, or neurobehavioral service, or services for co-occurring disorders. 12VAC35-46-10 (Children Residential Regulations) • Services include, but shall not be limited to, assessment and evaluation, medical treatment (including medication), individual and group counseling, neurobehavioral services, and family therapy necessary to treat the child.
		Support Systems	• Direct affiliations with other levels of care, or close coordination through referral to more and less intensive services (such as IOP, vocational, literacy training and adult education) • Ability to arrange for needed procedures, including laboratory and toxicology tests • Medical, psychiatric, psychological services available through consultation or referral.	12VAC35-105-693. • The provider shall make appropriate arrangements or referrals to all service providers identified in the discharge plan prior to the individual's scheduled discharge date. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. • A comprehensive assessment shall update and finalize the initial assessment. The

				timing for completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur no later than 30 days, after admission for providers of mental health and substance abuse services and 60 days after admission for providers of mental retardation (intellectual disability) and developmental disabilities services. It shall address: 1. Onset and duration of problems; 2. Social, behavioral, developmental, and family history and supports; 3. Cognitive functioning including strengths and weaknesses; 4. Employment, vocational, and educational background; 5. Previous interventions and outcomes; 6. Financial resources and benefits; 7. Health history and current medical care needs 8. Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or abuse, and circumstances that increase the individual's risk for mental health or substance use issues; 9. History of abuse, neglect, sexual, or domestic violence, or trauma including psychological trauma; 10. Legal status including authorized representative, commitment, and representative payee status; 11. Relevant criminal charges or convictions and probation or parole status; 12. Daily living skills; 13. Housing arrangements; 14. Ability to access services including transportation needs; 12VAC35-46-750. (Children Residential Regulations) The initial individualized service plan shall be reviewed within 60 days of the initial plan and within each 90-day period thereafter and revised as necessary. 12VAC35-46-360. Case managers shall have the responsibility for coordination of all services offered to each resident. Definition: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans.

ASAM LOC	DBHDS LICENSE	CARE COMPONENT	ASAM REQUIREMENTS	DBHDS REQUIREMENTS
3.7 Medically Monitored Intensive Inpatient Services	• Psychiatric Unit within an acute care general hospital – with a detox license • Acute/freestanding psychiatric hospital –with a Medical Detox license; Substance Abuse Residential Treatment Services for Adults or Children with a detox license; Residential Crisis Stabilization Units with a detox license	Setting	24 hour professionally-directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting.	**Psychiatric Unit within an acute care general hospital** "Special care unit" means an appropriately equipped area of the hospital where there is a concentration of physicians, nurses, and others who have special skills and experience to provide optimal medical care for patients assigned to the unit. (12VAC5-410-10) **Acute psychiatric hospital** "Special hospital" means institutions as defined by § 32.1-123 of the Code of Virginia that provide care for a specialized group of patients or limit admissions to provide diagnosis and treatment for patients who have specific conditions (e.g., tuberculosis, orthopedic, pediatric, maternity). (12VAC5-410-10) **Psychiatric unit within an acute care general hospital or Acute psychiatric hospital –** An intensive 24-hour medical, nursing, and treatment services provided to individuals with mental illness or substance abuse (substance use disorders) in a hospital as defined in §32.1-123 of the Code of Virginia or in a special unit of such a hospital. (12VAC35-105-20) **"Medical detoxification"** means a service provided in a hospital or other 24-hour care facility under the supervision of medical personnel using medication to systematically eliminate or reduce effects of alcohol or other drugs in the individual's body. **"Residential service"** means providing 24-hour support in conjunction with care and treatment or a training program in a setting other than a hospital or training center. Residential services include residential treatment, group or community homes, supervised living, residential crisis stabilization, community gero-psychiatric residential, community intermediate care facility-MR, sponsored residential homes, medical and social detoxification, neurobehavioral services, and **substance abuse residential treatment for women and children.** **"Children's residential facility" or "facility"** means a publicly or privately operated facility, other than a private family home, where 24-hour per day care is provided to children separated from their legal guardians and is required to be licensed or certified by the Code of Virginia
		Service Delivery Examples	Freestanding, appropriately licensed facility located within a the context of an acute care hospital or acute psychiatric unit of a freestanding Level 3.5 residential facility	Free standing psychiatric or substance abuse hospital, or an acute care facility with a specialized psychiatric or substance use treatment unit. An intensive 24-hour medical, nursing, and treatment services provided to individuals with mental illness or substance abuse (substance use disorders) in a hospital as defined in §32.1-123 of the Code of Virginia or in a special unit of such a hospital. (12VAC35-105-20) In a residential setting, other than an inpatient service or private family home; publicly or privately operated facility.
		Admission Criteria	Patient meets specifications in at least **two** of the six dimensions, at least **one** of which is in Dimension 1, 2, or 3: 1. Patient needs withdrawal management protocol 2. Interaction of the patient's biomedical condition and	12VAC35-105-580. • The provider shall admit only those individuals whose service needs are consistent with the service description, for whom services are available, and for which staffing levels and types meet the needs of the individuals served.

			continued alcohol and/or other drug use places the patient at significant risk of serious damage to physical health or concomitant biomedical conditions; **OR** a current biomedical condition requires 24-hour nursing and medical monitoring or active treatment, but not the full resources of an acute care hospital. 3. If significant emotional, behavioral, or cognitive conditions and impairment are present, the patient must be admitted to a co-occurring capable or co-occurring enhanced program. 4. Despite experiencing serious consequences or effects of the addictive disorder and/or behavioral health problem, the patient does not accept or relate the addictive disorder to the severity of the presenting problem; **OR** patient is in need of intensive motivating strategies, activities, and processed available only in a 24-hour structured, medically monitored setting; **OR** ongoing 24-hour psychiatric monitoring to assure follow through with the treatment regimen, and to deal with issues such as ambivalence about adherence to psychiatric medications and a recovery program. 5. Patient is experiencing an acute psychiatric or substance use crisis, marked by intensification of symptoms of his or her addictive or mental disorder, which poses a serious risk of harm to self or others in the absence of 24-hour monitoring and structured support; **OR** patient is experiencing an escalation of relapse behaviors and/or reemergence of acute symptoms, which places the patient at serious risk to self or others in the absence of the type of 24-hour monitoring and structured support found in a medically monitored setting; **OR** the intensity or modality of treatment protocols to address relapse require that the patient receive Level 3.7 program, to safely and effectively initiate antagonist therapy, or agonist therapy. 6. Patient requires continuous medical monitoring while addressing his or her substance use and/or psychiatric symptoms because his or her current living situation is characterized by a high risk or initiation or repetition or physical, sexual, or emotional abuse, or active substance abuse, such that the patient is assessed as being unable to achieve or maintain recovery at a less intensive level of care; **OR** family members or significant others living with the patient are not supportive of his or her recovery goals and are actively sabotaging treatment, or their behavior jeopardizes recovery efforts; **OR** patient is unable to cope, for even limited periods of time, outside of 24-hour care.	• The service description for substance abuse treatment services shall address the timely and appropriate treatment of pregnant women with substance abuse (substance use disorders). 12VAC35-105-645. • The provider shall implement policies and procedures for initial contacts and screening, *admissions,* and referral of individuals to other services and designate staff to perform these activities. • The provider shall maintain written documentation of an individual's initial contact and screening prior to his admission including the: 1. Date of contact; 2. Name, age, and gender of the individual; 3. Address and telephone number of the individual, if applicable; 4. Reason why the individual is requesting services; and 5. Disposition of the individual including his referral to other services for further assessment, placement on a waiting list for service, or admission to the service. • The provider shall assist individuals who are not admitted to identify other appropriate services. • The provider shall retain documentation of the individual's initial contacts and screening for six months. Documentation shall be included in the individual's record if the individual is admitted to the service. 12VAC35-46-640. (Children's Residential Regulations) • The facility shall have written criteria for admission that shall include: 1. A description of the population to be served; 2. A description of the types of services offered; 3. Intake and admission procedures; 4. Exclusion criteria to define those behaviors or problems that the facility does not have the staff with experience or training to manage; and 5. Description of how educational services will be provided to the population being served. • The facility shall accept and serve only those children whose needs are compatible with the services provided through the facility unless a child's admission is ordered by a court of competent jurisdiction. • **"Co-occurring disorders"** means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders); brain injury; or developmental disability. o Needing "Co-occurring services" - individually planned therapeutic treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders. **Substance abuse (substance use disorders)"** means the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual.
		Admission Process	• Patients admitted to this level of care meet diagnostic	**Psychiatric unit within a general hospital and acute psychiatric hospital**

			criteria for moderate or severe SUD • Patients have functional limitations in one of the following areas: acute intoxication and/or withdrawal potential, biomedical conditions and complications; or emotional, behavioral, or cognitive conditions and complications **AND** functional limitations in at least one other dimension.	An initial individualized services plan (ISP) shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs. (12VAC35-105-660 B) A physical examination shall be administered within 24 hours of an individual's admission. The physical examination shall include, at minimum: • General physical condition (history and physical); • Evaluation of communicable diseases; • Recommendations for further diagnostic tests and treatment, if appropriate; • Other examinations that may be indicated; and • The date of examination and signature of a qualified practitioner (12VAC-35-105-740) In addition, for individuals treated for managed withdrawal, providers shall: • Identify individuals with a high-risk for medical complications or who may pose a danger to themselves or others: • Assess substances used an time of last use; • Determine time of last meal; • Administer a urine screen; • Analyze blood alcohol content or administer a breathalyzer; and • Record vital signs (12VAC35-105-1110) Unless the individual refuses, the provider shall take vital signs; • At admission and discharge; • Every four hours for the first 24 hours and every with hours thereafter; and • As frequently as necessary, until signs and symptoms stabilize for individuals with a high-profile. (12VAC35-105-1120) 12VAC35-105-645 E. An assessment shall be initiated prior to or at admission to the services. An initial assessment shall determine whether the individual qualifies for admission and at minimum shall include the individual's: • Diagnosis; • Presenting needs; • Current medical problems; • Current medications; Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders; and • At risk behaviors to self and others. 12VAC35-105-650. An assessment shall be initiated prior to or at admission to the service. With the participation of the individual and the individual's authorized representative, if applicable, the provider shall *complete an initial assessment detailed enough to determine whether the individual qualifies for admission* and to initiate an (Individual Service Plan) ISP for those individuals who are admitted to the service. This assessment shall assess immediate service, health, and safety needs, and at a minimum include the individual's: 1. Diagnosis; 2. Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of problems;

				3. Current medical problems; 4. Current medications; 5. Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders; and 6. At-risk behavior to self and others. 12VAC35-46-10 (Children Residential Regulations) The service provides active treatment or training beginning at admission related to the resident's principle diagnosis and admitting symptoms. 12VAC35-46-630. (Children Residential Regulations) • Acceptance of children. Children shall be accepted only by court order or by written placement agreement with legal guardians. • 12VAC35-46-710. (Children Residential Regulations) • Admission shall be based on evaluation of an application for admission. The requirements of this section do not apply to court-ordered placements or transfer of a resident between residential facilities located in Virginia and operated by the same sponsor. • Providers shall develop, and fully complete prior to acceptance for care, an application for admission that is designed to compile information necessary to determine: 1. The educational needs of the prospective resident; 2. The mental health, emotional, and psychological needs of the prospective resident; 3. The physical health needs, including the immunization needs, of the prospective resident; 4. The protection needs of the prospective resident; 5. The suitability of the prospective resident's admission; 6. The behavior support needs of the prospective resident; 7. Family history and relationships; 8. Social and development history; 9. Current behavioral functioning and social competence; 10. History of previous treatment for mental health, mental retardation, substance abuse, brain injury, and behavior problems; and 11. Medication and drug use profile. • Each facility shall develop and implement written policies and procedures to assess each prospective resident as part of the application process to ensure that: 1. The needs of the prospective resident can be addressed by the facility's services; 2. The facility's staff are trained to meet the prospective resident's needs; and 3. The admission of the prospective resident would not pose any significant risk to (i) the prospective resident or (ii) the facility's residents or staff. 12VAC35-46-750. (Children Residential Regulations) • An individualized service plan shall be developed and placed in the resident's record within 30 days following admission and implemented immediately thereafter. • Individualized service plans shall describe in measurable terms the: 1. Strengths and needs of the resident; 2. Resident's current level of functioning; 3. Goals, objectives, and strategies established for the resident;

				4. Projected family involvement; 5. Projected date for accomplishing each objective; and 6. Status of the projected discharge plan and estimated length of stay, except that this requirement shall not apply to a facility that discharges only upon receipt of the order of a court of competent jurisdiction. Definitions: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans. **"Initial assessment"** means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services.
		Staffing	24-hour	24-hour care facility under the supervision of medical personnel using medication to systematically eliminate or reduce effects of alcohol or other drugs in the individual's body.
		Staff Credentials	• An interdisciplinary staff (including physicians, nurses, addiction counselors, and behavioral health specialists), who are able to assess and treat the patient and to obtain and interpret information regarding the patient's psychiatric and substance use disorder. • Clinical staff who are knowledgeable about the biological and psychosocial dimensions of addiction and other behavioral health disorders, and with specialized training in behavior management techniques and evidence-based practices. • A licensed physician to oversee the treatment process and assure the quality of care. Physicians perform physical examinations for al patients admitted to this level or care.	As above and the psychiatric service shall be under the supervision of a physician, licensed by the Board of Medicine, who meets the qualifications of the medical staff bylaws. Medical, nursing, and treatment services (12VAC35-105-20) The provider shall implement a written staffing plan that includes the types, roles, and numbers of employees and contractors that are required to provide the service. This staffing plan shall reflect the: • Needs of the individuals served; • Types of services offered; • The service description; and • Number of people to be served at a given time. (12VAC35-105-590 A) Supervision of staff shall be provided by a licensed mental health professional or mental health professional who is license-eligible and registered with a board of the Department of Health Professions. (12VAC35-105-590 C.5) 12VAC35-46-625. (Children's Residential Regulations) • The provider shall have and implement written policies and procedures that address the provision of: 1. Psychiatric care; 2. Family therapy; and 3. Staffing appropriate to the needs and behaviors of the residents served.

				12VAC35-46-370 (Children Residential Regulations) Child care supervisors shall have responsibility for the: 1. Development of the daily living program within each child care unit; and 2. Orientation, training, and supervision of direct care workers. 12VAC35-46-380. (Children Residential Regulations) The child care worker shall have responsibility for guidance and supervision of the children. 12VAC35-46-390. (Children Residential Regulations) • Qualified relief staff shall be employed as necessary to meet the needs of the programs and services offered and to maintain a structured program of care 12VAC35-46-350. (Children Residential Regulations) • Program Director-The facility's program shall be directed by one or more qualified persons. • Persons directing programs shall be responsible for the development and implementation of the programs and services offered by the facility, including overseeing assessments, service planning, staff scheduling, and supervision. **Definitions:** **"Licensed mental health professional (LMHP)"** means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist. **"Qualified Mental Health Professional-Adult (QMHP-A)"** means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to individuals who have a mental illness; including (i) a doctor of medicine or osteopathy licensed in Virginia; (ii) a doctor of medicine or osteopathy, specializing in psychiatry and licensed in Virginia; (iii) an individual with a master's degree in psychology from an accredited college or university with at least one year of clinical experience; (iv) a social worker: an individual with at least a bachelor's degree in human services or related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling or other degree deemed equivalent to those described) from an accredited college and with at least one year of clinical experience providing direct services to individuals with a diagnosis of mental illness; (v) a person with at least a bachelor's degree from an accredited college in an unrelated field that includes at least 15 semester credits (or equivalent) in a human services field and who has at least three years of clinical experience; (vi) a Certified Psychiatric Rehabilitation Provider (CPRP) registered with the United States Psychiatric Rehabilitation Association (USPRA); (vii) a registered nurse licensed in Virginia with at least one year of clinical experience; or (viii) any other licensed mental health professional. **"Qualified Mental Health Professional-Child (QMHP-C)"** means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to children who have a mental illness. To qualify as a QMHP-C, the individual must have the designated clinical experience and must either (i) be a doctor of medicine or osteopathy licensed in Virginia; (ii) have a master's degree in psychology from an accredited college or university with at least one year of clinical experience with children and adolescents; (iii) have a social work bachelor's or

				master's degree from an accredited college or university with at least one year of documented clinical experience with children or adolescents; (iv) be a registered nurse with at least one year of clinical experience with children and adolescents; (v) have at least a bachelor's degree in a human services field or in special education from an accredited college with at least one year of clinical experience with children and adolescents, or (vi) be a licensed mental health professional.
		Physician Coverage	In-person assessment within 24-hours of admission and thereafter as medically necessary.	12VAC35-105-700. • Providers must establish procedures for immediately accessing appropriate internal and external resources. This shall include a provision for obtaining physician and mental health clinical services if the provider's or service's on-call or back-up physician or mental health clinical services are not available at the time of the emergency. 12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary. 12VAC35-105-530 • The provider shall develop a written emergency preparedness and response plan for all of its services and locations that describes its approach to emergencies throughout the organization or community. • Emergency procedures shall address: Maintaining a 24 hour telephone answering capability to respond to emergencies for individuals receiving services 12 VAC35-105-1090. In detoxification service locations, at least two employees or contractors shall be on duty at all times. If the location is within or contiguous to another service location, at least one employee or contractor shall be on duty at the location with trained backup employees or contractors immediately available. In other managed withdrawal settings the number of staff on duty shall be appropriate for the services offered and individuals served. 12VAC35-46-820. (Children Residential Regulations) • The provider shall develop and implement written policies and procedures for a crisis or clinical emergency that shall include: 1. Procedures for crisis or clinical stabilization, and immediate access to appropriate internal and external resources, including a provision for obtaining physician and mental health clinical services if on-call physician back-up or mental health clinical services are not available; and 2. Employee or contractor responsibilities.
		Purpose of Treatment	Services are provided to patient whose subacute biomedical and emotional, behavioral, or cognitive problems are so severe that they require inpatient treatment	The provider shall develop a written mission statement that clearly identifies its philosophy, purpose, and goals. (12VAC35-105-570) Planned individualized interventions intended to reduce or ameliorate mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders).

				To systematically eliminate or reduce effects of alcohol or other drugs in the individual's body.
		Schedule-Clinical Services	Daily	Intensive 24-hour medical, nursing, and treatment service 12VAC35-46-625. (Children's Residential Regulations) • The provider shall have and implement written policies and procedures for the on-site provision of a structured program of care or treatment of residents with mental illness, mental retardation, substance abuse, or brain injury. The provision, intensity, and frequency of mental health, mental retardation, substance abuse, or brain injury interventions shall be based on the assessed needs of the resident. B. Each provider shall have formal arrangements for the evaluation, assessment, and treatment of the mental health or brain injury needs of the resident.
		Types Clinical Services	Treatment is characterized by services such as individual, group and family therapy using a range of evidence-based practices; medical and nursing management of any acute symptoms; physical therapy; medication management; and psychoeducation	24-hour care facility under the supervision of medical personnel using medication to systematically eliminate or reduce effects of alcohol or other drugs in the individual's body. 2VAC35-105-1055. • In the service description the provider shall describe the level of services and the medical management provided. 12VAC35-46-625. (Children's Residential Regulations) • Interventions, applicable to the population served, shall include, but are not limited to: 1. Individual counseling; 2. Group counseling; 3. Training in decision making, family and interpersonal skills, problem solving, self-care, social, and independent living skills; 4. Training in functional skills; 5. Assistance with activities of daily living (ADL's); 6. Social skills training in therapeutic recreational activities, e.g., anger management, leisure skills education and development, and community integration; 7. Providing positive behavior supports; 8. Physical, occupational, and/or speech therapy; 9. Substance abuse education and counseling; and 10. Neurobehavioral services for individuals with brain injury. Not further specified in licensure requirements
		Services	• Biopsychosocial assessment • Individualized treatment planning • Clinically directed treatment • Psychiatric stabilization • Addiction pharmacotherapy • Random drug screening • Motivational enhancement and engagement strategies • Health education • Counseling and clinical monitoring • Regular monitoring of patient's medication adherence • Recovery support services • Services for the patient's family and significant others, as	The provider shall prepare a written description of each service it offers. Elements of each service description shall include: • Service goals; • A description of care, treatment, or other supports provided; • Characteristics and needs of individuals to be served; • Contract services, if any; • Eligibility requirements and admission, continued stay, and exclusion criteria; • Service termination and discharge or transition criteria; and • Type and role of employees or contractors. (12VAC35-105-580 C1 – C7) The service description for substance abuse treatment services shall address the timely and appropriate treatment of pregnant women with substance abuse

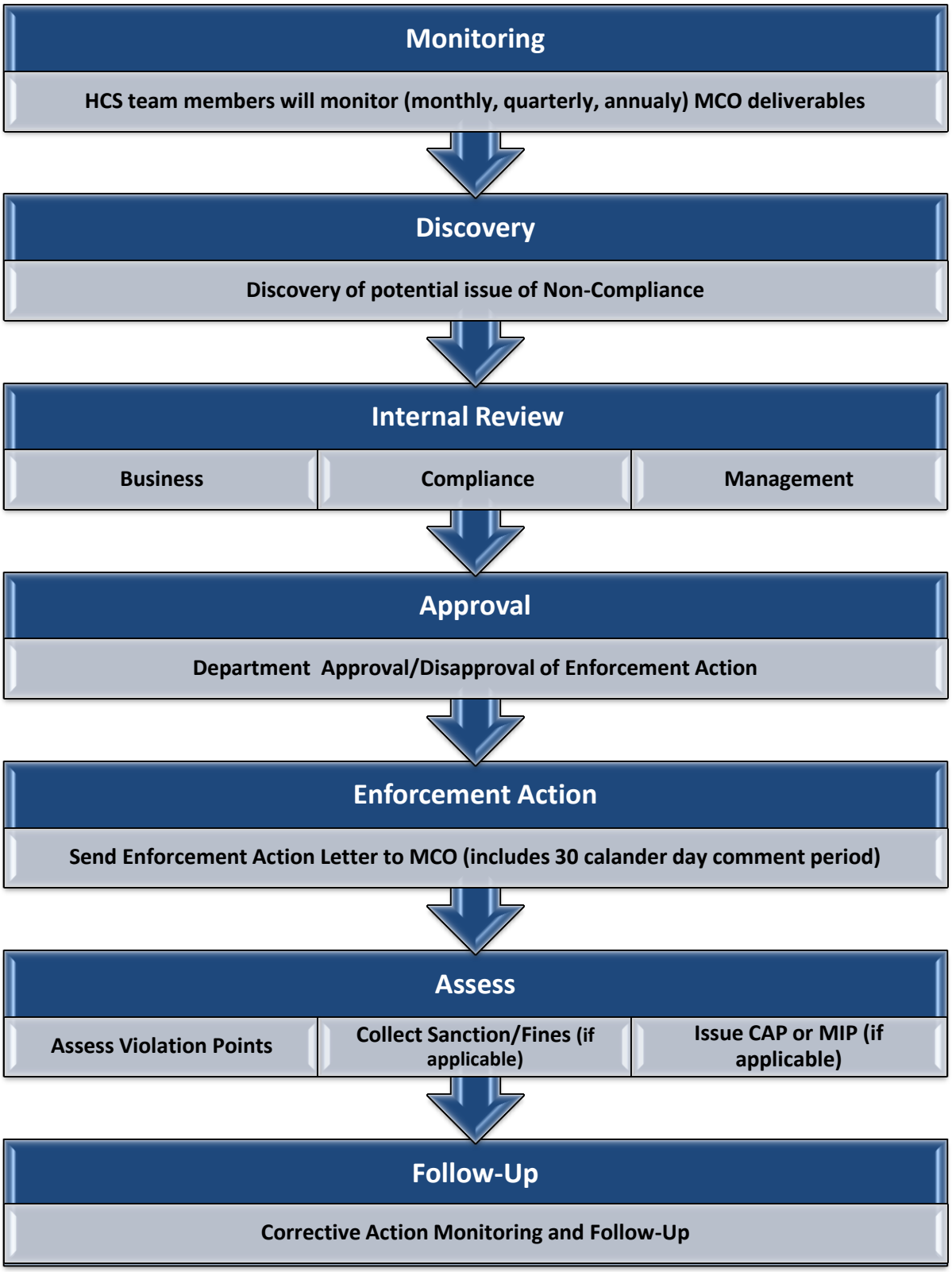
			appropriate • Opportunities for the patient to be introduced to the potential benefits of addiction pharmacotherapy as a tool to manage his or her addictive disorder	(substance use disorders). (12VAC-35-105-580 H.) 12VAC35-46-10 (Children Residential Regulations) Services include, but shall not be limited to, assessment and evaluation, medical treatment (including medication), individual and group counseling, neurobehavioral services, and family therapy necessary to treat the child.
		Support Systems	• A registered nurse conducts an alcohol or other drug-focused nursing assessment at the time of admission. • Additional medical specialty consultation, psychological, laboratory, and toxicology services are available on-site, through consultation or referral. • Coordination of necessary services or other levels of care are available through direct affiliation or referral processes. • Psychiatric services are available on-site, through consultation or referral. Serves are to be available within 8 hours by telephone or 24 hours in person.	12VAC35-105-1055. • In the service description, the provider shall describe the level of services and the medical management provided. 12VAC35-105-1060. The provider shall establish cooperative agreements with other community agencies to accept referrals for treatment, including provisions for physician coverage if not provided on-site, and emergency medical care. The agreements shall clearly outline the responsibility of each party. 12VAC35-105-720. • Providers of residential or inpatient services shall provide or arrange for the provision of appropriate medical care. Providers of other services shall define instances when they shall provide or arrange for appropriate medical and dental care and instances when they shall refer the individual to appropriate medical care. 12VAC35-105-590. • The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals being served in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary. 12VAC35-105-693. • The provider shall make appropriate arrangements or referrals to all service providers identified in the discharge plan prior to the individual's scheduled discharge date. 12VAC35-105-645 • The provider shall develop an initial person-centered ISP for the first 60 days for mental retardation (intellectual disability) and developmental disabilities services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first. • A comprehensive assessment shall update and finalize the initial assessment. The timing for completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur no later than 30 days, after admission for providers of mental health and substance abuse services and 60 days after admission for providers of mental retardation (intellectual disability) and developmental disabilities services. It shall address: 1. Onset and duration of problems; 2. Social, behavioral, developmental, and family history and supports; 3. Cognitive functioning including strengths and weaknesses;

				4. Employment, vocational, and educational background; 5. Previous interventions and outcomes; 6. Financial resources and benefits; 7. Health history and current medical care needs 8. Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or abuse, and circumstances that increase the individual's risk for mental health or substance use issues; 9. History of abuse, neglect, sexual, or domestic violence, or trauma including psychological trauma; 10. Legal status including authorized representative, commitment, and representative payee status; 11. Relevant criminal charges or convictions and probation or parole status; 12. Daily living skills; 13. Housing arrangements; 14. Ability to access services including transportation needs; Definition: **"Individualized services plan" or "ISP"** means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans.
ASAM LOC	**DBHDS LICENSE**	**CARE COMPONENT**	**ASAM REQUIREMENTS**	**DBHDS REQUIREMENTS**
4.0 Medically Managed Intensive Inpatient Services	Acute care general hospital - 12-VAC5-410	Setting	• Acute care medical facility • Medically-directed care • 24-hour treatment • Offers addition treatment services along with intensive biomedical and/or psychiatric services • **Must offer medically direct acute withdrawal management, emergency life support care and treatment** – either directly or through transfer of patient to another service within the facility, or to another medical facility equipped to provide such care.	Hospitals to be licensed shall be classified as general hospitals, special hospitals or outpatient hospitals defined by 12VAC5-410-10.
		Service Delivery Examples	• Acute care general hospital • Acute psychiatric hospital • Psychiatric unit within an acute care general hospital	**Acute care general hospital** - Not specified in DBHDS licensure requirements
		Admission Criteria	Patient meets specifications in at least **one** Dimensions 1, 2, or 3: 1. Patient needs withdrawal management 2. Biomedical complications of the addictive disorder require medical management and skilled nursing care; **OR** a concurrent biomedical illness or pregnancy requires stabilization and daily medical management with daily primary nursing interventions; **OR** patient has a concurrent biomedical condition(s) in which continued alcohol or other drug use presents an imminent danger to the life or severe danger to health; **OR** patient is experiencing recurrent or multiple seizures; **OR** patient is experiencing a disulfiram-alcohol reaction; **OR** patient has life-threatening symptoms that are related to use of alcohol, tobacco, and/or other drugs; **OR** changes in the patient's medical status, such as	**Acute care general hospital** - Not specified in DBHDS licensure requirements

			significant worsening of a medical condition, make abstinence imperative; **OR** significant improvement in a previously unstable medical condition allows the patient to respond to addiction treatment; **OR** patient has (an)other biomedical problem(s) that requires 24-hour observation and evaluation. 3. Patient whose status is characterized by stabilized emotional, behavioral, or cognitive condition is appropriately assessed as in need of Level 4 co-occurring capable program services; **OR** if the patient's emotional, behavioral, or cognitive conditions symptoms are so severe as to require admission to a Level 4 program, then only a co-occurring enhanced program is sufficient to meet the patient's needs. 4. Only a patient who meets criteria in Dimensions 1, 2, or 3 is appropriately placed in a Level 4 program. 5. Only a patient who meets criteria in Dimensions 1, 2, or 3 is appropriately placed in a Level 4 program. 6. Only a patient who meets criteria in Dimensions 1, 2, or 3 is appropriately placed in a Level 4 program.	
		Admission Process	• Meet diagnostic criteria for a SUD • Patients have functional limitations in one of the following areas: acute intoxication and/or withdrawal potential, biomedical conditions and complications; or emotional, behavioral, or cognitive conditions and complications	**Acute care general hospital** - Not specified in DBHDS licensure requirements
		Staffing	• 24-hour	**Acute care general hospital** - Not specified in DBHDS licensure requirements
		Staff Credentials	• An interdisciplinary staff of appropriately credential clinical staff (including addiction-credentialed physicians, nurse practitioners, physician assistants, nurses, counselors, psychologists, and social workers), who assess and treat patients with severe substance use disorders, or addicted patients with concomitant acute biomedical, emotional, or behavioral disorders. Facility approved addition counselors or licensed, certified, or registered addiction clinicians who administer planned interventions according to the assessed needs of the patient.	**Acute general hospital** An organized medical staff; with permanent facilities that include inpatient beds; and with medical services, including physician services, dentist services and continuous nursing services, to provide diagnosis and treatment for patients who have a variety of medical and dental conditions that may require various types of care, such as medical, surgical, and maternity. (12VAC5-410-10)
		Physician Coverage	• In-person 24 hours a day, and professional consultation 16 hours a day	**Acute care general hospital** - Not specified in DBHDS licensure requirements
		Purpose of Treatment	• Services are provided to patients whose acute biomedical, emotional, behavioral, and cognitive problems are so severe that they require primary medical and nursing care.	**Acute care general hospital** - Not specified in DBHDS licensure requirements
		Schedule-Clinical Services	• Individualized • 24-hours	**Acute care general hospital** - Not specified in DBHDS licensure requirements
		Types Clinical Services	• Individualized array of treatment services for SUDs, as well as any concurrent biomedical, emotional, behavioral, or cognitive problems delivered by an interdisciplinary team	**Acute care general hospital** - Not specified in DBHDS licensure requirements
		Services	• Biopsychosocial assessment • Individualized treatment planning • Biomedical treatment • Psychiatric stabilization and treatment • Addiction pharmacotherapy	**Acute care general hospital** - Not specified in licensure requirements

			• Motivational enhancement and engagement strategies • Health education • Individualized treatment activities to monitor mental health, and to address the interaction of the mental health problems and SUD • Regular monitoring of patient's medication adherence • Services for the patient's family and significant others, as appropriate • Opportunities for the patient to be introduced to the potential benefits of addiction pharmacotherapy as a tool to manage his or her addictive disorder	
		Support Systems	• A full range of acute care services, specialty consultation, and intensive care.	**Acute care general hospital** - Not specified in DBHDS licensure requirements

Contract Compliance Enforcement Process



As of 7.2015

Department of Behavioral Health Developmental Services
Office of Recovery Services

Scope of Practice for Certified Peer Recovery Specialists

Certified Peer Recovery Specialists (CPRS) provide non-clinical, person-centered, strengths based, wellness focused, and trauma-informed support while helping to ensure the person's wellness-recovery plan reveals the needs and preferences of the person being served to complete their measurable and personalized goals. CPRSs serve adults with behavioral health challenges. Certified Peer Recovery Specialists also serve parent peers and family members who provide support to parents and children who experience behavioral health challenges.

The type and intensity of services provided must be determined on an individual basis, taking into account the acuity of the situation for the person(s) receiving services, as well as the experience of the CPRS. The foundational value that Certified Peer Recovery Specialists support is always received on a voluntary basis and must be the foundation of all relationships. CPRSs share their first-hand experiences that inspire and support individuals in their responses, choices and management of behavioral challenges. They assist people in expressing and achieving personal goals for wellness, recovery, resiliency and self-advocacy. CPRSs provide and advocate for effective recovery and wellness oriented services.

Certified Peer Recovery Specialists:

1) ***Provide face to face interaction that supports an individual achieving their self-identified level of recovery, wellness, independence or personal strength.***

    a. Serve as a role model for recovery and wellness and self-advocacy. Provide feedback and insight into the value of every individual's unique recovery experience.
    b. Assist an individual or family receiving services with writing and communicating their personal recovery-wellness plans and to identify ways to reach those goals using a person-centered, individual recovery-wellness plan.
    c. Increase the individual's resiliency by assisting them in recognizing and augmenting personal strengths in skill areas related to handling problems encountered in daily life; such as self-awareness, resource discovery, and self-responsibility. Assist in gaining/regaining control of their lives through recovery and/or wellness based activities, concepts, and understandings.
    d. Share effective and positive strategies for developing coping skills and wellness tools related to overcoming the effects of having a trauma, a substance use disorder, or a mental health challenge.
    e. Clarify and enhance self-advocacy skills. Encourage peers to develop independent behavior that is based on informed choice; assisting peers in developing empowerment skills through self-advocacy.
    f. Establish and maintain a peer relationship based on mutuality rather than a hierarchical relationship. Partner with the other person to facilitate recovery dialogues and other evidence-based and/or best practice methods
    g. Assist peers in selecting behavioral health services that suit each person's individual recovery and wellness needs; Inform peers about community based and natural supports and how to utilize these in the recovery process.
    h. Provide education on wellness and/or recovery
    i. Assist in developing a psychiatric advance directive
    j. Assist individuals and families of children in creating crisis recovery response plans.
    k. Accompany people through the behavioral health service intake process and the discharge process, with person to person, face-to-face follow up after discharge of person. Help people identify and implement service exit strategies.
    l. Provide outreach to people who have frequent inpatient experiences. Provide outreach to people who have failed to engage with the behavioral health system.

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2) ***Provide trained peer-to-peer support in groups encouraging and supporting participation and self-directed participation.***

a. Serve as a role model for recovery and wellness and self-advocacy. Provide feedback and insight into the value of every individual's unique recovery experience.
b. Assist in developing skills needed to identify a variety of groups that may be helpful and available in the community.
c. Facilitate peer-to -peer evidence-based practices or best practices, such as WRAP, Dual Recovery, 12-Step groups, WHAM, High Fidelity Wraparound, etc.
d. Facilitate non-clinical peer to peer recovery education and wellness coaching through group activities in topics such as stress management, healthy leisure activities, wellness, alternative treatment options, recovery, focusing on individual health and wellness strengths and needs, self-affirmation, treatment management techniques, community involvement strategies, etc.
e. Increase the individual's resiliency by assisting them in recognizing and augmenting personal strengths in skill areas related to handling problems encountered in daily life; such as self-awareness, resource discovery, and self-responsibility. Assist in gaining/regaining control of their lives through recovery and/or wellness based activities, concepts, and understandings.
f. Share effective and positive strategies for developing coping skills and wellness tools related to overcoming the effects of having a trauma, a substance use disorder, or a mental health challenge.
g. Clarify and enhance self-advocacy skills. Encourage peers to develop independent behavior that is based on informed choice; assisting peers in developing empowerment skills through self-advocacy.
h. Establish and maintain a peer relationship based on mutuality rather than a hierarchical relationship. Partner with the other person to facilitate recovery dialogues and other evidence-based and/or best practice methods.
i. Assist peers in selecting behavioral health services that suit each person's individual recovery and wellness needs; Inform peers about community based and natural supports and how to utilize these in the recovery process.
j. Provide education on wellness and/or recovery.
k. Assist in developing a psychiatric advance directive.
l. Assist individuals and families of children in creating crisis recovery response plans.
m. Accompany people through the behavioral health service intake process and the discharge process, with person to person face to face follow up after discharge of person. Help people identify and implement service exit strategies.
n. Provide outreach to people who have frequent inpatient experiences. Provide outreach to people who have failed to engage with the behavioral health system.

3) ***Mentor community integration activities (one-to-one or in groups)***

a. Provide community networking and linkage with social, recreational, spiritual, volunteer, educational or vocational resources. Assist the person in identifying traditional and non-traditional community based supports that sustain a healthy life style. Provide opportunities to practice socialization, interaction and engagement abilities in the community. Support, encourage, and enhance the development of natural support systems and independent choice and participation.
b. Assist in the development of a community integration plan that sets milestones for an increased independent community involvement, showing a decrease of dependency on the CPRS
c. Support for day-to-day problem solving related to integration/reintegration into the positive community of choice.

d. Enhance the person's/family's ability to navigate the systems of service delivery related to the person's written wellness-recovery plan or individual service plan. Provide, when available, time-limited transportation focusing on increasing the individual's transportation independence through access to natural or formal resources.
e. Assist other behavioral healthcare service providers in identifying program and service environments that are conducive to recovery.

4) Provide emotional support during the acquisition, exploration and sustaining of employment and/or educational services.

a. Support the vocational and educational choices of peers and assist them in developing strategies for overcoming educational or job-related behavioral health challenges that lead to independence.

5) Attend treatment team and program development meetings.

a. Promote the use of self-directed recovery and wellness tools in individualized treatment planning. Facilitate the inclusion of the person being served in all meetings that relate to the delivery of services. Promote the inclusion of the individual in all treatment plans related to their healthcare.
b. The CPRS will share his or her unique perspective on recovery from mental illness or substance use disorder with non-peer staff. Assist non-peer staff in identifying programs and environments that are advantageous to supporting recovery and wellness outcomes.

COMMONWEALTH of VIRGINIA

Office of the Governor

William A. Hazel, Jr., MD
Secretary of Health and Human Resources

May 10, 2016

Dear Colleague,

There is an opioid overdose crisis in the United States. In 2014 there were 18,893 prescription drug overdose deaths and 10,574 heroin deaths, and there is broad agreement that a key ingredient to solving this problem is proper prescribing for pain management.

Accordingly, in March 2016 the Center for Disease Control released the Guideline for Prescribing Opioids for Chronic Pain. This guideline, which is summarized below, addresses 1) when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use. The CDC has a number of related resources, such as a 2-page summary, a prescribing checklist and recommended non-opioid treatments, on their website. If you are a prescriber of opioids, I ask you to please review the full guideline, which contains background, documentation and rationale for the following recommendations:

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Providers should only consider adding opioid therapy if expected benefits for both pain and function are anticipated to outweigh risks to the patient.

2. Before starting opioid therapy for chronic pain, providers should establish treatment goals with all patients, including realistic goals for pain and function. Providers should not initiate opioid therapy without consideration of how therapy will be discontinued if unsuccessful. Providers should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, providers should discuss with patients known risks and realistic benefits of opioid therapy and patient and provider responsibilities for managing therapy.

4. When starting opioid therapy for chronic pain, providers should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5. When opioids are started, providers should prescribe the lowest effective dosage. Providers should use caution when prescribing opioids at any dosage, should implement

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additional precautions when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should generally avoid increasing dosage to ≥90 MME/ day.

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, providers should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three or fewer days usually will be sufficient for most nontraumatic pain not related to major surgery.

7. Providers should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Providers should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, providers should work with patients to reduce opioid dosage and to discontinue opioids.

8. Before starting and periodically during continuation of opioid therapy, providers should evaluate risk factors for opioid-related harms. Providers should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, or higher opioid dosages (≥50 MME), are present.

9. Providers should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving high opioid dosages or dangerous combinations that put him or her at high risk for overdose. Providers should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10. When prescribing opioids for chronic pain, providers should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11. Providers should avoid prescribing opioid pain medication for patients receiving benzodiazepines whenever possible.

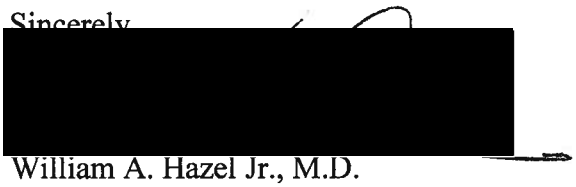
12. Providers should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

These recommendations are aligned with initiatives that we are implementing as a result of the Governor's Task Force on Prescription Drug and Heroin Abuse. Prescribers are now automatically registered with Virginia's Prescription Monitoring Program, and starting July 1 will be required to check the PMP for most prescriptions lasting more than 14 days. The

Board of Medicine is now allowed to require CME in opiate-related areas (beginning with 2018 renewals), and is convening a workgroup on buprenorphine.

Thank you for your attention to this critical issue. Together we will find ways to effectively manage our patients' pain while also preventing addiction, misuse and overdose.

Sincerely,



William A. Hazel Jr., M.D.

Uniform SA Request Form for Initiation of Buprenorphine/Naloxone or Buprenorphine

GUIDELINES:

1. ***Coverage Policy*:** Buprenorphine/naloxone and buprenorphine will be covered for the treatment of Opioid Use Disorder when all of the following conditions are met:
    a. Individual has a diagnosis of Opioid Use Disorder AND
    b. Individual is 16 years of age or older AND
    c. Prescriber's personal DEA and X DEA Number are provided AND
    d. Individual is participating in psychosocial counseling (individual or group) at least once per week during first 3 months of initiation.
2. ***Induction:*** A one-time 7-day quantity of buprenorphine/naloxone (or buprenorphine if a member is pregnant or transitioning from methadone) will be allowed without a SA.
3. ***Buprenorphine:*** Buprenorphine monotherapy will only be covered for pregnant women for a maximum of 9 months. Documentation and date of positive pregnancy test must be provided.
4. ***Initial Authorization:*** Initial request will be authorized for 3 months. Additional service authorizations will not be required for dose adjustments. After 3 months, the provider must submit the SA Request Form for Buprenorphine or Buprenorphine/Naloxone Maintenance.
5. ***Dose Maximum:*** Maximum of 16 mg per day will be covered unless compelling clinical rationale for exceeding this dose with written documentation is provided. Dose greater than 24 mg per day will not be approved.
6. ***Lock In Policy***: Upon approval, the patient will be automatically locked in for buprenorphine or buprenorphine/naloxone to the requesting physician and to the dispensing pharmacy.
7. ***Concurrent Medications:*** The following medications will NOT be allowed to be prescribed or taken concurrently: benzodiazepines, tramadol (Ultram), carisoprodol (Soma), other opiates, or stimulants due to the increased risks of adverse events including fatal overdoses.
8. ***Reasons for Non-Coverage:***
    a. Requests for any diagnosis other than Opioid Use Disorder.
    b. Concurrent use of benzodiazepines, tramadol (Ultram), carisoprodol (Soma), other opiates, or stimulants
    c. Lack of participation in psychosocial counseling at least once per week.

I. PHYSICIAN INFORMATION

1. Name and Address, NPI Number
2. Physician DEA Number
3. Physician DATA waiver ID number (X DEA Number)

II. PATIENT INFORMATION

1. Name, Address, ID#, DOB, Gender, Phone Number, Date of Rx
2. Is patient 16 years of age or greater? Yes or No
3. Does patient meet criteria for a diagnosis of Opioid Use Disorder (defined by DSM 5: http://pcssmat.org/wp-content/uploads/2014/02/5B-DSM-5-Opioid-Use-Disorder-Diagnostic-Criteria.pdf)? Yes or No
4. List any medical conditions patient has that could impact recovery or choice of medication (such as mental illness, seizure disorder, etc.)
5. Has patient been screened for tuberculosis, HIV, Hepatitis B, or Hepatitis C?
6. Is the patient pregnant? If yes, provide documentation and date of positive pregnancy test.

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III. TREATMENT INFORMATION

1. Buprenorphine/naloxone or buprenorphine dose, directions, and quantity.
2. If requesting dose of greater than 16 mg per day, provide clinical rationale including documentation of why this higher dose is medically necessary for patient.
3. Can you confirm that the patient is NOT prescribed or taking any of the following medications: benzodiazepines, tramadol (Ultram), carisoprodol (Soma), other opiates, or stimulants? Yes or No
4. Is patient receiving psychosocial counseling (individual or group) at least once per week? Yes or No*
5. Provide name and phone number of counselor.

If provider answers no to any questions in red → request will not be approved

*Note: Health plans and Magellan may review claims data to confirm that patient is receiving counseling. If provider is not billing for counseling, please provide the most recent addiction counseling note and/or interdisciplinary patient-centered treatment plan that includes the psychosocial supports for this patient.

DRAFT

Uniform SA Request Form for Maintenance of Buprenorphone/Naloxone or Buprenorphine

GUIDELINES:

1. ***Coverage Policy*:** Buprenorphine/naloxone and buprenorphine will be covered for the treatment of Opioid Use Disorder when all of the following conditions are met:
    - Individual has a diagnosis of Opioid Use Disorder AND
    - Individual is 16 years of age or older AND
    - Prescriber's personal DEA and X DEA Number are provided AND
    - Individual is participating in psychosocial counseling (individual or group) at least once per month during maintenance.
2. ***Buprenorphine:*** Buprenorphine monotherapy will only be covered for pregnant women for a maximum of 9 months. Documentation and date of positive pregnancy test must be provided.
3. ***Initial Authorization:*** Initial request will be authorized for 3 months.
4. ***Renewal Authorizations for Maintenance***: The second and subsequent requests will be authorized for 6 months. Additional service authorizations will not be required for dose adjustments. Before approving the maintenance request, the health plan will:
    - Verify continued participation in psychosocial counseling using claims data.
    - Review documentation from provider that urine drug screens confirm no concurrent opioids and patient is taking buprenorphine.
5. ***Dose Maximum:*** Maximum of 16 mg per day will be covered unless compelling clinical rationale for exceeding this dose with written documentation is provided. Dose greater than 24 mg per day will not be approved.
6. ***Duration:*** There is no set time limit or maximum duration of treatment. Risk of relapse related to treatment discontinuation should be weighed against the risk of continued medication use on an individual patient basis. Duration of treatment should be individualized to meet the patient's needs. There is evidence that longer treatment duration is associated with decreased risk of relapse. Discontinuation should be a mutual discussion between the physician and patient, after the treatment goals are reached. If the physician and patient decide to discontinue treatment, the daily dose should be decreased gradually over a predetermined period at a rate determined by the patient and physician together.
7. ***Concurrent Medications:***
    - The following medications will NOT be allowed to be prescribed or taken concurrently: benzodiazepines, tramadol (Ultram), carisoprodol (Soma), other opiates, or stimulants.
8. ***Reasons for Non-Coverage:***
    - Requests for any diagnosis other than Opioid Use Disorder.
    - Concurrent use of other opiates, stimulants, benzodiazepines, carisoprodol (Soma), or tramadol (Ultram).
    - Lack of participation in psychosocial counseling at least once per month.
    - Required documentation of urine drug screens is not provided.
    - Urine drug screen is negative for buprenorphine/norbuprenorphine or positive for another substance and documentation of steps being taken to address possible diversion of buprenorphine/naloxone or buprenorphine and/or ongoing use of other substances is not provided.
    - Provider has not checked the PMP on the date of the request

    .

DRAFT

I. PHYSICIAN INFORMATION

1. Name and Address, NPI Number
2. Physician DEA Number
3. Physician DATA waiver ID number (X DEA Number)

II. PATIENT INFORMATION

1. Name, Address, ID#, DOB, Gender, Phone Number, Date of Rx
2. Is patient 16 years of age or greater? Yes or No
3. Does patient meet criteria for a diagnosis of Opioid Use Disorder (defined by DSM 5: http://pcssmat.org/wp-content/uploads/2014/02/5B-DSM-5-Opioid-Use-Disorder-Diagnostic-Criteria.pdf)? Yes or No
4. List any medical conditions patient has that could impact recovery or choice of medication (such as mental illness, seizure disorder, etc.)
5. Has patient been screened for tuberculosis, HIV, Hepatitis B, or Hepatitis C?
6. Is patient pregnant? If yes, provide documentation and date of positive pregnancy test.

III. TREATMENT INFORMATION

1. Buprenorphine/naloxone or Buprenorphine dose, directions, and quantity.
2. Can you confirm that the patient is NOT taking any of the following medications: tramadol (Ultram), benzodiazepines, carisoprodol (Soma), other opiates, or stimulants? Yes or No
3. Is this patient receiving psychosocial counseling (individual or group) at least once per month? Yes or No*
4. Provide name and phone number of counselor.

IV. MONITORING

1. Is prescriber checking random urine drug screens at least 4 times per 6 months? Yes or No
2. Do the urine drug screens check for buprenorphine/norbuprenorphine, methadone, oxycodone, benzodiazepines, amphetamine/methamphetamine, cocaine, heroin, THC, and other prescription opiates? Yes or No
3. Provide last 2 urine drug screens (with at least 1 of these screenings within past month). **Copies must be provided for approval.**
4. Are 2 urine drug screens attached? Yes or No
5. Is the date of at least one of these screens within the past month? Yes or No
6. Are all urine drug screens positive for buprenorphine/norburpenorphine? Yes or No
7. Are all urine drug screens negative for all other substances? Yes or No
8. If a drug screen is negative for buprenorphine/norbuprenorphine and/or positive for another substance, provide written documentation of steps being taken to address patient's possible diversion of buprenorphine and/or ongoing use of other substances including intensifying the counseling that patient is receiving and/or considering referral to higher level of care (such as intensive outpatient, partial hospitalization, or residential treatment).
9. Has the prescriber reviewed the Virginia Prescription Monitoring Program on the date of this request? Yes or No

If provider answers no to any questions in red → request will not be approved

*Note: Health plans and Magellan may review claims data to confirm that patient is receiving counseling. If provider is not billing for counseling, please provide the most recent addiction counseling note and/or interdisciplinary patient-centered treatment plan that includes the psychosocial supports for this patient.

DRAFT

VCU Health
VCU School of Medicine

Health Behavior and Policy
One Capital Square
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PO Box 980149
Richmond, VA 23298-0149

Proposed VCU Independent Evaluation of Virginia Medicaid Addiction and Recovery Treatment Services Benefit and Waiver Required by CMS

May 12, 2016
Rev Aug 4, 2016

Background

The Commonwealth of Virginia is transforming the delivery system for Medicaid members with Substance Use Disorders (SUD). The new Medicaid Addiction and Recovery Treatment Services (ARTS) Benefit positions the Commonwealth to apply to CMS for a Medicaid Section 1115 waiver. The ARTS waiver will require an evaluation of the effectiveness of the services delivered in terms of clinician ARTS training and service provision as well as Medicaid member health outcomes, health care costs, and service utilization. To that end, a team of researchers from the Virginia Commonwealth University School of Medicine is proposing to conduct a robust evaluation of the new ARTS benefit and waiver.

Evaluation Aims

The evaluation has the following aims:

1. How do the new ARTS benefit and waiver affect clinician ARTS training and ARTS service provision?
   a) To what extent are efforts to prepare and train health care clinicians successful in getting them to appropriately provide ARTS benefits?
   b) How do the new ARTS benefit and waiver affect the number and type of health care clinicians providing ARTS services to Medicaid members with SUD?
2. How do the new ARTS benefit and waiver affect members' access to and utilization of ARTS services?
   a) To what extent do the new ARTS benefit and waiver increase the percentage of Medicaid members living in communities with an adequate supply of clinicians offering ARTS treatment services to Medicaid members?
   b) How do the new ARTS benefit and waiver affect the type and quantity of ARTS treatment services used by Medicaid members with SUD?
3. How do the new ARTS benefit and waiver affect patient outcomes and quality of care?
   a) What is the impact of the availability of substance abuse residential treatment on emergency department visits, inpatient admissions, and readmissions to the same level

of care or higher for ARTS (e.g. inpatient detox, community-based high intensity residential, and community-based low intensity residential)?

b) Are there spillover effects of the new ARTS benefit and waiver on utilization and costs for other physical and behavioral health care services, such as emergency department visits, inpatient admissions, and readmissions for other conditions such as chronic diseases and serious mental illness?
c) What is the impact of the new ARTS benefit and waiver on fatal and nonfatal drug overdoses among Medicaid members?
d) What is the impact of the "carve-in" of ARTS treatment into managed care plans on health care utilization and the coordination of care with other behavioral and physical health services?

4. How do the new ARTS benefit and waiver affect member costs, particularly costs associated with emergency department visits, inpatient stays, and inpatient readmissions?
5. How is the new ARTS benefit and waiver related to broader efforts in local communities to address SUD, especially the surge in opioid addiction?
   a) How are ARTS clinicians working with other community organizations (governmental, educational, law enforcement, social service) to help people with SUD?
   b) What evidence is there that these "social determinants" are influencing use of ARTS services as well as outcomes (e.g. arrest rates, school attendance and performance, employment?)
6. Does the ARTS waiver achieve the waiver goals, objectives, hypotheses, and metrics approved by CMS in the waiver application evaluation plan?

Specific evaluation activities

1. Analysis of claims data from Magellan and Medicaid managed care plans

We will use claims data from the Medicaid health plans to examine how member access, utilization, outcomes, and costs related to SUD change following implementing of the new Medicaid ARTS benefit and waiver on April 1, 2017 (relevant to Aims 2, 3 and 4). We will require a baseline period of approximately two years, from April 1, 2015 through March 31, 2017. DMAS will need to request health plans and Magellan to provide claims data for all members dating back to April 1, 2015. Specifically, the project will require (1) all emergency department and inpatient hospitalization claims for all members from the health plans; (2) all claims data on outpatient visits from the health plans, including for primary care, specialist visits for physical health, behavioral health, and SUD; all claims data on community-based substance abuse treatment services from Magellan; all prescription drug utilization claims data from the health plans and Medicaid fee-for-service.

Measures of access and outcomes

Figure 1 shows the access and outcome measures constructed from *claims data* that will be used to assess the impact of the new ARTS benefit, and how these measures relate to the major provisions of the new benefit.

Access Measures: Examining changes in the number of physicians providing ARTS treatment to Medicaid members, as well as the percent of members living in counties with no physicians providing ARTS treatment will provide an early indication of whether the increase in payment rates for ARTS services, as well as education and training efforts have been successful in increasing the supply and availability of ARTS practitioners to Medicaid members. NQF measures on the timely transmission of transition record (#0648), ARTS treatment provided or offered at inpatient discharge (#1664), and ARTS follow-up after discharge from the emergency department (#2605) will indicate whether efforts to improve care coordination and transition between acute care settings and ARTS treatment services are successful.

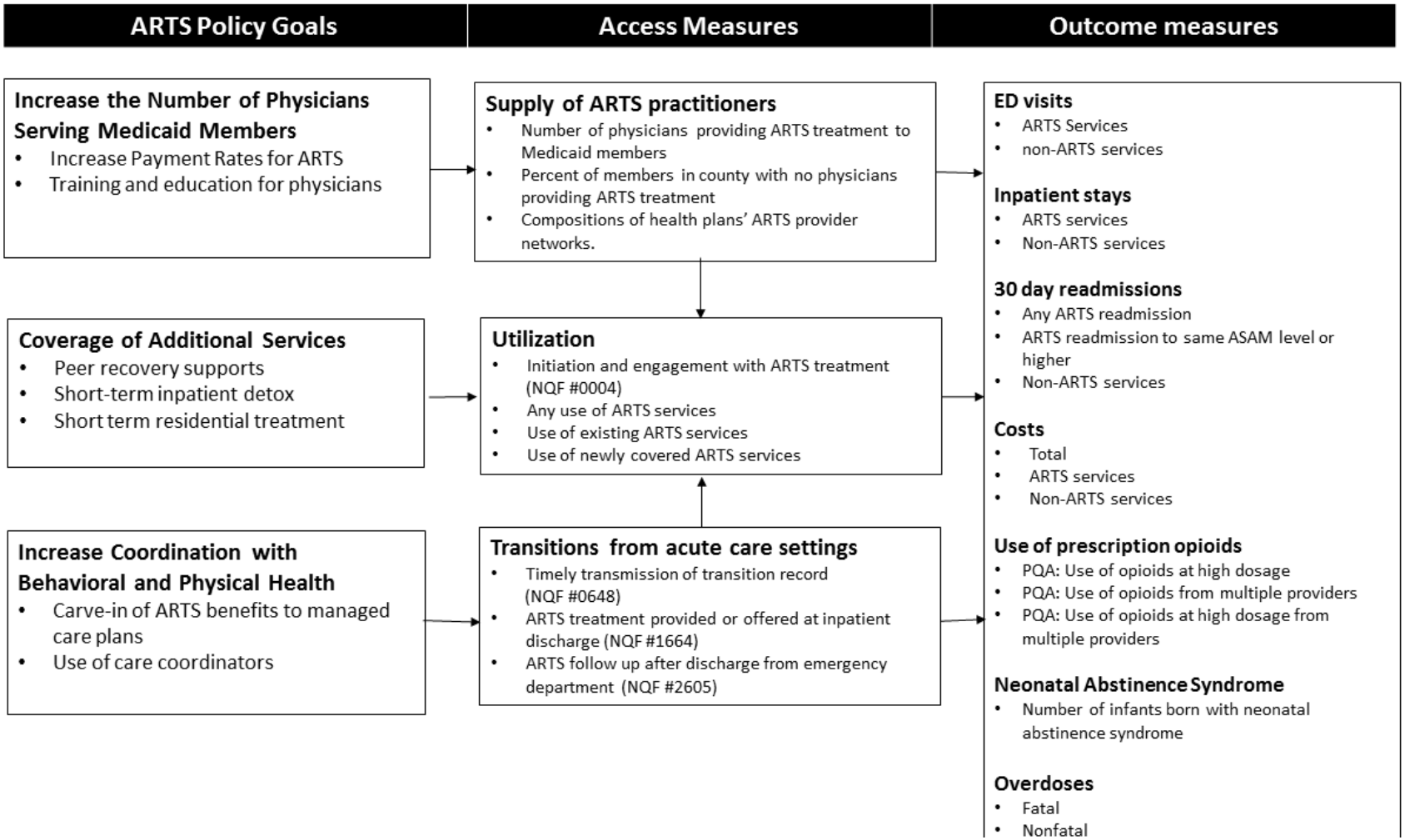
Increased supply of ARTS practitioners as well as improved care transitions should result in greater utilization of ARTS services, especially initiation and engagement with ARTS treatment (NQF #0004). This should also result in greater use of services, especially for the additional ARTS services covered by the new benefit.

Outcome Measures: Greater access to and use of ARTS services should lead to improved outcomes, including fewer emergency department visits, inpatient admissions, and 30 day readmission rates for SUD conditions. Greater access to ARTS treatment and greater care coordination between SUD, mental health, and physical health problems should also lead to reductions in acute-care hospital use for other (non-SUD) health conditions (i.e. spillover effects). Less use of acute-care hospitals should lower the overall costs of care for Medicaid members engaging in ARTS treatment. Use of prescription opioids among Medicaid members should decrease along with greater treatment of ARTS. Further, we expect the number of infants born with neonatal abstinence syndrome to decrease with greater access to ARTS treatment for Medicaid members. Most importantly, it is expected that the new benefit will ultimately lead to decreases in fatal and nonfatal overdoses.

Identifying control groups

Since implementation of the new benefit occurs statewide on April 1, 2017, one of the challenges for this evaluation will be to identify a control group of people who are similar to Medicaid members eligible for ARTS treatment, but are unaffected by the new benefit. A control group strengthens the evaluation by allowing us to assess how much of the change in access and outcomes for Medicaid members is likely due to the new benefit, and how much of the change may be due to other changes that are more broadly affecting people in the Commonwealth of Virginia.

FIGURE 1: ACCESS AND OUTCOME MEASURES INCLUDED IN EVALUATION OF ARTS WAIVER



Given that the implementation occurs statewide on the same date, it is unlikely that we will be able to identify an ideal control group. Depending on how the rollout of the new benefit progresses, we propose two potential strategies for constructing control groups from existing claims data that leverage either variation in ARTS benefit implementation or matching Medicaid members to privately insured individuals.

Differences in ARTS Benefit Implementation: It is likely that there will be variation across the state in how rapidly ARTS provider networks are established and members begin using services. We can use the regions that are slower in setting up ARTS provider networks as a comparison group for the regions that have been quicker to implement the new benefit. Similarly, since the new ARTS services will be provided through the health plans serving Medicaid members, there may be variation between health plans in how they implement the new benefit. Such variation between plans could also be exploited for the purposes of identifying control groups.

Matching Medicaid Members and Privately Insured Individuals: We will also consider using people in Virginia with private insurance coverage as a control group. Data on privately insured people can be obtained from Virginia's All Payer Claims Database (APCD), or possibly from the health plans in Virginia that serve both privately insured and Medicaid members. Aetna, Anthem, Optima, and Kaiser Permanente are Virginia health insurance companies that offer plans to both privately insured and Medicaid members.

Analysis to assess impact of the new ARTS benefit on access and outcomes

Regardless of the control group(s) that are selected for the analysis, they will likely differ from the "treatment" group (i.e. Medicaid members for whom we are observing the impact of the new ARTS benefit) in ways that may affect the measures of access and outcomes used in the analysis, such as differences in age, gender, race/ethnicity, income, community characteristics, and co-morbid mental and physical health problems. In examining the impact of the new ARTS benefit, we will assess two different methods for controlling for these covariates.

Difference-in-Difference Analysis: The regression-based difference-in-differences analysis may be more appropriate if the control group consists of regions of the state that are slower to implement the new benefit. The method essentially estimates the net change in access and outcome measures for one group compared to another group, while also adjusting for differences in the characteristics of people between the two groups. An example of how such an analysis would be specified for this project is as follows:

$$Y_i = \beta_0 + \beta_1 REGION_i + \beta_2 POST_i + \beta_3(REGION_i * POST_i) + \beta_4 X_i + \gamma_c + \varepsilon_i.$$

Y_i represents one of the measures of access and outcomes identified in Figure 1, observed for each Medicaid member ($_i$) included in the analysis. REGION is a binary measure reflecting whether the Medicaid member lived in an area of the state that was rapidly implementing the new ARTS benefit or whether they lived in an area that was slower in implementation. POST is a binary measure reflecting the time period before and after April 1, 2017 (the implementation date). X_i refers to a set of covariates reflecting individual sociodemographic and health characteristics. γ_c represents county fixed effects that control for time-invariant county characteristics, and ε_i is the error term.

The key parameter of interest is β_3, the difference-in-differences coefficient that reflects the net change in the outcome measure for Medicaid members in regions that are rapidly implementing the new ARTS benefit relative to Medicaid members in regions that have been slower to implement the benefit. The analysis controls for other sociodemographic, co-morbid health, and community characteristics that may also be correlated with access and outcomes.

<u>Propensity Score Matching:</u> If we use privately insured persons as a comparison group, Propensity Score Matching is one method that could be used to control for observed differences between Medicaid members and privately insured persons. Propensity Score Matching is a method that essentially identifies a control group of people who have similar characteristics to the "treatment" group. In other words, we would identify a subsample of privately insured people who are most similar to Medicaid members based on their sociodemographic, health, and community characteristics to serve as a control group. Sociodemographic and health data for people would be obtained directly from the claims data, while information on community characteristics could be obtained from the American Community Survey and the Area Health Resource File, both of which provide detailed small area data on population and health system characteristics.

Once the matched control group has been identified, we will compute the change in access and outcomes from before and after the implementation of the new ARTS benefit for both Medicaid members as well as the control group (privately insured people who most closely resemble Medicaid members). The effect of the new ARTS benefit will reflect the difference between the change for Medicaid members and the change for the control group.

2. Analysis of clinician training and preparations for new ARTS benefit

Relevant to Aim #1, the VCU Department of Family Medicine qualitative research team will conduct a rapid cycle quality improvement evaluation of ARTS training activities and implementation processes. Data collection and analysis will assess the implementation process in the context of on-the-ground, practice specific settings, with a focus on: 1) describing the ARTS benefit and waiver's impact on practice activities and patient quality of life; 2) identifying on-the-ground challenges and facilitators; 3) generating timely and actionable strategies and solutions to inform subsequent phases of provider training and education.

Data collection will consist of key stakeholder interviews, including ARTS trainers, clinicians and patients. Practice surveys will be distributed at baseline to obtain descriptive data on practice and patient panel characteristics, use of registries and clinical decision support systems, and existing practice efforts pertaining to delivery of ARTS treatment services. Practice site visits will allow for collecting data on practice specific, on-the-ground, conditions and other contextual factors that affect implementation and provider participation.

Baseline data collection will begin in October 2016, with initial provider training expected to take place during meetings of the Psychiatric Society of Virginia in Roanoke, the Medical Society of Virginia in Roanoke, and the Virginia Community Healthcare Association in Richmond. These initial observations will be used to inform the more expansive statewide training, which is expected to begin in January, 2017. A second round of more intensive data collection will occur between January and March, 2017, when statewide training begins. To the extent that additional training occurs later in the year, or subsequent years, then we will consider a third round of data collection.

3. Case studies of selected communities (relevant to Aim #5) – contingent on VCU securing additional funding

Understand community responses to the new ARTS benefit; coordination between health practitioners and other community organizations in addressing the SUD problem; how the social determinants of health are related to access to and utilization of ARTS services, patient outcomes, and costs.

Select 4-5 communities representing diverse areas of the state. Communities will be selected based on strong potential for addressing social determinants of health, availability of data on social determinants, and in consultation with DMAS.

Conduct interviews with community organizations and groups involved with ARTS treatment and prevention, including major health care providers (e.g. hospitals), CSBs, local health departments, schools, law enforcement. Interviews will be designed to elicit information on perceptions of the SUD problem; the impact of the new Medicaid ARTS benefit;

community-wide efforts designed to address the crisis; and the key social determinants related to SUD.

Obtain quantitative data on social determinants in the community related to SUD, and examine changes since the implementation of the new benefit.

Timeline of activities

October 1, 2016 to December, 2016

- Qualitative evaluation of initial provider training activities at three provider conferences.
- Begin developing databases and measures to be used for analysis of claims data.

Jan. 2 to June 30, 2017

- Qualitative evaluation of statewide training
- Analysis of baseline claims data from Magellan and health plans

July 1, 2017 to December 31, 2017

- Planning for case studies of the social determinants
- Additional data collection for provider training, if needed.
- Analysis of Medicaid claims data for assessment of changes in provider participation, utilization, costs and patient outcomes during the first 6 months of the new benefit.

Jan. 2 to Sept. 30, 2018

- Conduct case studies to assess social determinants
- Analysis of Medicaid claims data for assessment of changes in provider participation, utilization, costs, and patient outcomes during the first year of the new benefit.

April 1, 2019 to Sept. 30, 2019

- Analysis of Medicaid claims data for assessment of changes in provider participation, utilization, costs, and patient outcomes during the first two years of the new benefit.

April 1, 2020 to Sept. 30, 2020

- Analysis of Medicaid claims data for assessment of changes in provider participation, utilization, costs, and patient outcomes during the first three years of the new benefit.

April 1, 2021 to Sept. 30, 2021

- Analysis of Medicaid claims data for assessment of changes in provider participation, utilization, costs, and patient outcomes during the first four years of the new benefit.

April 1, 2022 to Sept. 30, 2022

- Analysis of Medicaid claims data for assessment of changes in provider participation, utilization, costs, and patient outcomes during the first five years of the new benefit.

Major Deliverables

- **January 31, 2017.** Report on provider training activities during Fall 2016
- **July 31, 2017.** Report on statewide provider training
- **July 31, 2017.** Report on baseline analysis of utilization, costs, and provider participation before implementation of ARTS benefit and waiver
- **January 2, 2018:** Preliminary report on changes in ARTS utilization, access, costs, and provider participation during the first 6 months of the new ARTS benefit and waiver for Virginia General Assembly.
- **July 31, 2018.** Report on case studies of the social determinants.
- **September 30, 2018.** Report on changes in ARTS utilization, access, costs, and provider participation during the first year of the new ARTS benefit and waiver for DMAS and Virginia General Assembly.
- **September 30, 2019.** Midterm Evaluation Report required by CMS on changes in ARTS utilization, access, costs, and provider participation during the first two years of the new ARTS benefit and waiver.
- **September 30, 2020.** Report on changes in ARTS utilization, access, costs, and provider participation during the first three years of the new ARTS benefit and waiver for DMAS and General Assembly.
- **September 30, 2021.** Report on changes in ARTS utilization, access, costs, and provider participation during the first four years of the new ARTS benefit and waiver for DMAS and General Assembly, and submission to CMS during negotiations of waiver extension.
- **September 30, 2022.** Final Evaluation Report required by CMS on changes in ARTS utilization, access, costs, and provider participation during all five years of the new ARTS benefit and waiver.

Key Project Staff from Virginia Commonwealth University, School of Medicine

Peter Cunningham, Ph.D., Dept. of Health Behavior and Policy. Dr. Cunningham will be the Principal Investigator for this project, and will have overall responsibility for project management, oversight of the project budget, and preparation of deliverables. He will also focus on the analysis of Medicaid claims data, and in directing the case studies.

Andrew Barnes, Ph.D., Dept. of Health Behavior and Policy. Dr. Barnes will be a Co-investigator, and will lead the analysis of Medicaid claims data. He is a health economist with experience evaluating the cost impact of substance abuse treatment.

Bassam Dahman, Ph.D., Dept. of Health Behavior and Policy. Dr. Dahman is a biostatistician and will provide statistical and analytical support in the overall evaluation design and in the analysis of claims data.

Rebecca Etz, Ph.D., Department of Family Medicine and Population Health. Dr. Etz will be a Co-investigator, and will lead the qualitative data collection and analysis. She is a medical anthropologist with experience interviewing Medicaid-covered individuals with serious mental illness and substance abuse and working with primary care practices and communities.

Sebastian Tong, M.D., M.P.H., Department of Family Medicine and Population Health. Dr. Tong will be a Co-investigator, and will provide clinical guidance on all aspects of the project. He is a buprenorphine-waivered physician who provides treatment for opioid addiction in primary care and advised DMAS on the design of the Medicaid ARTS benefit.

F. Gerard Moeller, M.D., Department of Pharmacology and Toxicology. Dr. Moeller will serve as a consultant for this project. He is an addiction psychiatrist and recognized national expert in research on the clinical aspects of substance abuse treatment.

	A	B	C	D	E	F	G
1	**5 YEARS OF HISTORIC DATA**						
2							
3	**SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:**						
4							
5		**SFY 2010**	**SFY 2011**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**5-YEARS**
6	**TOTAL EXPENDITURES**						
7	**ELIGIBLE MEMBER MONTHS**						
8	**PMPM COST**						
9	**TREND RATES**						**5-YEAR**
10							**AVERAGE**
11	TOTAL EXPENDITURE						
12	ELIGIBLE MEMBER MONTHS						
13	PMPM COST						
14							
15							
16	**Other Data**	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
17	**TOTAL EXPENDITURES**						
18	**ELIGIBLE MEMBER MONTHS**						
19	**PMPM COST**						
20	**TREND RATES**						**5-YEAR**
21				**ANNUAL CHANGE**			**AVERAGE**
22	TOTAL EXPENDITURE						
23	ELIGIBLE MEMBER MONTHS						
24	PMPM COST						

	A	B	C	D	E	F	G	H	I	J	K	L
1	**DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS**											
2												
3												
4	**ELIGIBILITY**	**TREND**	**MONTHS**	**BASE YEAR**	**TREND**	**DEMONSTRATION YEARS (DY)**					**TOTAL**	
5	**GROUP**	**RATE 1**	**OF AGING**	**DY 00 (CY14)**	**RATE 2**	**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**	**WOW**	
6												
7	**Medicaid-Eligible Adults in Need of Residential SUD Services**											
8	**Pop Type:**	**Medicaid**										
9	Eligible Member Months					1,105	1,233	1,296	1,350	1,393		
10	PMPM Cost					$6,374.50	$6,724.51	$6,860.55	$6,996.94	$7,136.22		
11	Total Expenditure					$ 7,043,817	$ 8,291,321	$ 8,891,269	$ 9,445,864	$ 9,940,755	$ 43,613,026	
12												
13												
14												
15												
16												
17												
18												
19												

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

ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
Medicaid-Eligible Adults in Need of Residential SUD Services								
Pop Type:	**Medicaid**							
Eligible Member Months		0.0%	-	-	-	-	-	
PMPM Cost		0.0%	$ -	$ -	$ -	$ -	$ -	
Total Expenditure			$ -	$ -	$ -	$ -	$ -	$ -
SUD Waiver Services Recipients								
Pop Type:	**Expansion**							
Eligible Member Months			1,105	1,233	1,296	1,350	1,393	
PMPM Cost			$ 6,374.50	$ 6,724.51	$ 6,860.55	$ 6,996.94	$ 7,136.22	
Total Expenditure			$ 7,043,817	$ 8,291,321	$ 8,891,269	$ 9,445,864	$ 9,940,755	$ 43,613,026

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Medicaid-Eligible Adults in Need of Residential SUD Services	$ 7,043,817	$ 8,291,321	$ 8,891,269	$ 9,445,864	$ 9,940,755	$ 43,613,026
TOTAL	$ 7,043,817	$ 8,291,321	$ 8,891,269	$ 9,445,864	$ 9,940,755	$ 43,613,026

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Medicaid-Eligible Adults in Need of Residential SUD Services	$ -	$ -	$ -	$ -	$ -	$ -
Expansion Populations						
SUD Waiver Services Recipients	$ 7,043,817	$ 8,291,321	$ 8,891,269	$ 9,445,864	$ 9,940,755	$ 43,613,026
TOTAL	$ 7,043,817	$ 8,291,321	$ 8,891,269	$ 9,445,864	$ 9,940,755	$ 43,613,026

VARIANCE	$ -	$ -	$ -	$ -	$ -	$ -

Population Status Drop-Down
Medicaid
Hypothetical
Expansion

Panel 1: Historic DSH Claims for the Last Five Fiscal Years:

RECENT PAST FEDERAL FISCAL YEARS	20__	20__	20__	20__	20__
State DSH Allotment (Federal share)					
State DSH Claim Amount (Federal share)					
DSH Allotment Left Unspent (Federal share)	$ -	$ -	$ -	$ -	$ -

Panel 2: Projected Without Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)						
State DSH Claim Amount (Federal share)						
DSH Allotment Projected to be Unused (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 3: Projected With Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
State DSH Claim Amount (Federal share)						
Maximum DSH Allotment Available for Diversion (Federal share)						
Total DSH Alltoment Diverted (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Available for DSH Diversion Less Amount Diverted (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Projected to be Unused (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 4: Projected DSH Diversion Allocated to DYs

DEMONSTRATION YEARS		DY 01	DY 02	DY 03	DY 04	DY 05
DSH Diversion to Leading FFY (total computable)						
FMAP for Leading FFY						
DSH Diversion to Trailing FFY (total computable)						
FMAP for Trailing FFY						
Total Demo Spending From Diverted DSH (total computable)		$ -	$ -	$ -	$ -	$ -

Virginia Department of Medical Assistance Services
Public Notice Process for Virginia's Section 1115 Medicaid Demonstration
GAP Amendment for Addiction and Recovery Treatment Services (ARTS)

Background

Virginia recognizes it has an important role as a payor for services provided to individuals with Substance Use Disorders SUD. On September 26, 2014, Virginia Governor, Terry McAuliffe, put Executive Order 29 into place, creating the Governor's Task Force on Prescription Drug and Heroin Abuse. Dovetailing with Virginia's concern, in July of 2015, CMS issued CMS letter, SMD # 15-003 to Medicaid directors, highlighting CMS' new service delivery opportunities for Medicaid members with SUD. The information contained in that letter significantly aligned with Virginia's belief that prescription drug and heroin overdoses are a public health and public safety crisis that is indiscriminately taking the lives of Virginians. Fully believing that there is work to be accomplished in this area, The Department of Medical Assistance Services (DMAS) began the planning process to seek CMS waiver authority using the guidance found in the CMS letter and the recommendations created by the Governor's Task Force to strengthen how Virginia: educates individuals, providers, and communities; treats those identified with SUD; collects and monitors data and health outcomes pertaining to these individuals; and enforces new policies and practices in the treatment of individuals with substance use disorders.

Public Input at the State Level Prior to Submission to CMS:

Public Comment was used to help DMAS identify key areas for SUD reform beginning in September, 2015 until June, 2016 using multiple modalities that included the Commonwealth's administrative record, the Virginia Regulatory Town Hall and a variety of electronic and face to face methods all of which were supported by electronic communications provided to interested stakeholders. DMAS held two public hearings on January 5, 2016 in the Richmond Area and on January 7, 2016 in the Far Southwest region in Abingdon, Virginia. The public forms allowed for discussion of DMAS initiatives to improve Medicaid service benefits and delivery systems for individuals with substance use disorders (SUD). The public meetings were posted online through the Virginia Regulatory Town Hall as well as posted on the DMAS website and distributed through an electronic distribution list which included key stakeholders from managed care, the provider community, provider associations and the advocates.

In addition to the web based communication and public hearings a comprehensive workgroup was convened to develop the benefit program structure in collaboration with stakeholders. The SUD/ARTS Workgroup consists of Managed Care Organizations, the DMAS Behavioral Health Service Administrator, public and private behavioral health providers, health systems, provider associations, member advocacy organizations, peer support representatives, community service boards, hospital associations, physician and psychiatric societies as well as staff from DMAS, the Department of Behavioral Health and Developmental Services (DBHDS), the Virginia Department of Health Professions (DHP), and the Virginia Department of Health (VDH). All workgroup activity has been summarized and posted to the DMAS website for review by stakeholders and interested individuals. Information on the workgroup and program design can be found on the DMAS website at: http://www.dmas.virginia.gov/Content_Pgs/bh-sud.aspx.

DMAS posted the draft concept paper on its website and provided notice through the Virginia Regulatory Town Hall on July 1,
2016: http://townhall.virginia.gov/L/ViewNotice.cfm?gnid=566.

DMAS contacted the Chief of the Pumunkey Indian Tribe via letter to meet the federal rule to provide a 30-day tribal comment period for the ARTS benefit transformation. This letter was mailed on June 16, 2016. The Agency did not receive any feedback by Chief Robert Gray.

DMAS posted another public notice online through the Commonwealth's administrative record, the Virginia Regulatory Town Hall on July 1, 2016 as well as posted the notice on the DMAS website and distributed through the electronic distribution list. This notice further sought public comments for a 30 day period on the ARTS Waiver "Concept Paper" which incorporated feedback from the earlier public hearings. The ARTS Waiver "Concept Paper" was the draft application to amend the 1115 GAP Waiver. DMAS requested public comments on the entire Addiction and Recovery Treatment Services benefit delivery system design.

All feedback was considered and as appropriate incorporated in the 1115 Waiver amendment which was submitted to the Centers for Medicare and Medicaid Services (CMS) on August 5, 2016.

A summary of public comment and DMAS actions related to those comments is presented in the following pages based on the public comment opportunities in September-October, 2015 and July 1-August 1, 2016. Note: Reference to FAMIS (Virginia's Children's Health Insurance Program [CHIP]) includes FAMIS MOMS (Virginia's Pregnant Women's' Program for women over the Medicaid federal poverty level (FPL) up to 200% FPL) unless otherwise noted.

Addiction, Recovery and Treatment Services (ARTS)
Virginia Department of Medical Assistance Services
Substance Use Disorder Benefit
Themes from the Public Comment Period
September 21, 2015 to October 21, 2015

Advocates (24 comments) /Providers (15 comments) /Health Plans (2 comments)

Program Recommendations/Benefit Design	
Comment Received	**DMAS Response**
Develop a secured centralized behavioral and medical data base.	Due to the complexities of HIPAA and 42 CFR Part 2 privacy limitations DMAS is not yet able to develop a centralized database that all providers are able to use. Instead, the Health Plans, Magellan and DMAS manage PHI in accordance with provider contract limitations and usage in accord with applicable federal law.
Include the credentials/qualifications currently being used for QSAP in the Community Mental Health Rehabilitation Services regulations.	The provider credentials will be aligned to match state practice act standards and ASAM criteria. The current QSAP definitions will be abandoned to match ASAM requirements for provider credentials and qualifications upon implementation of the new ARTS benefit.
Provide Integrated Care to strengthen the coordination of primary and behavioral healthcare for individuals with SUD.	ARTS benefits will be managed using an integrated care approach by the DMAS contracted health plans and Magellan. The ARTS benefits will be carved into Managed Care and CCC/MLTSS coverage which will allow integration of physical and behavioral health care for individuals with SUD.
Expand Medicaid coverage for medically supervised detoxification to strengthen the coordination of primary and behavioral healthcare for individuals with SUD.	The ARTS benefits will be aligned to match ASAM criteria. All ASAM levels of care including medically

	supervised detoxification will be provided in the ARTS benefit. The ARTS benefit already expanded coverage for medically supervised detoxification to all currently eligible Medicaid and FAMIS members.
Targeted use of incentives.	The ARTS benefits will be aligned to match ASAM criteria. Incentives such as higher reimbursement rates are targeted to support providers in expanding their addiction treatment to Medicaid and FAMIS patients. All ASAM levels of care will be provided in the ARTS benefit.
Support the adoption and use of the ASAM Criteria.	The ARTS benefits will be aligned to match ASAM criteria. All ASAM levels of care will be provided in the ARTS benefit. DBHDS will offer 2-day workshops on ASAM throughout the state to train providers and health plans in how to adopt and use the ASAM criteria in patient placement decisions.
Expand Medication Assisted Treatment (MAT) statewide. **Allow for MAT to be provided concurrently with other levels of care.**	All ASAM levels of care including MAT will be provided in the ARTS benefit, and MAT will be allowed to be provided concurrently with other levels of care. To expand MAT statewide, the reimbursement rate for counseling that supports MAT was increased by 400% under the ARTS benefit approved by the General Assembly. Also, DMAS is creating a new substance abuse care coordination code to support integrated MAT in physician's offices and a "Gold Card Office Based Opioid Treatment (OBOT)" program to support providers in expanding MAT. Finally, VDH will offer statewide MAT education and training to physicians, behavioral health providers, and clinic staff to expand access to MAT in Fall 2016 through Spring 2017.
Encourage waiver of the IMD requirement.	DMAS is seeking an 1115 waiver to

	allow for service delivery in IMD settings.
Eliminate any remaining prohibitions against reimbursement for any services delivered to the children of mothers in treatment for SUDs.	The ARTS benefits will be aligned to match ASAM criteria. All ASAM levels of care will be provided in the ARTS benefit. All prohibitions against Medicaid and FAMIS reimbursement for services delivered to the children of mothers in treatment for SUDs have been removed.
Extend Medicaid coverage for women during the postpartum period.	This action is not supported in the current Virginia Budget. Medicaid coverage can only be expanded by the Virginia General Assembly.
Covered services should include residential treatment, detoxification in Crisis Stabilization Environments, and Peer Support at rates that reflect the costs to provide these services.	The ARTS benefits will be aligned to match ASAM criteria. All ASAM levels of care will be provided in the ARTS benefit. Reimbursement rates have been approved by the General Assembly to support effective ASAM standards of care for all covered services including residential treatment and detoxification and to develop new Peer Support services.
Effective and carefully planned community integration.	The SUD/ARTS workgroup extensively discussed how to integrate the ARTS benefit into communities. DMAS will also be providing in-person regional trainings across the state to inform communities about the ARTS benefit and support communities in developing the full continuum of integrated addiction treatment.
Collaboration with Single State Agency for Substance Abuse.	DMAS has collaborated very closely with DBHDS, the single state agency for substance abuse, to design the ARTS benefit and develop provider requirements in accord with DBHDS and DHP standards.

Medication Recommendations	
Comment Received	**DMAS Response**
Provide a medication therapy management program that uses a network of retail pharmacists that will meet with members face-to-face to provide medication reviews.	A medication therapy management program is beyond the scope of the ARTS benefit and waiver. Pharmacists were engaged in the design of the ARTS benefit. DMAS will reimburse pharmacies for face-to-face SBIRT screenings provided by pharmacists.
Remove the duration limits on the use of buprenorphine.	Medicaid and FAMIS Fee-for-Service and the health plans have all agreed to remove the duration limits on the use of buprenorphine as part of the ARTS benefit. This will also be mandated in the health plans' contracts.
Use Buprenorphine as the primary evidence-based medication.	All evidence-based medications recommended by ASAM and SAMHSA for MAT for opioid addiction including methadone, buprenorphine, and naltrexone injections will be supported by the ARTS benefit. DMAS has designed payment incentives specifically to expand access to MAT with buprenorphine including a new substance abuse care coordination code to support counseling and psychosocial supports delivered by clinics with buprenorphine-waivered physicians and a "Gold Card OBOT" program to support high quality buprenorphine providers.
Expand Medicaid coverage for Suboxone, as current treatment plans using Suboxone are limited to a maximum of two years.	Medicaid and FAMIS Fee-for-Service and the health plans have all agreed to remove the duration limits on the use of buprenorphine as part of the ARTS benefit. This will also be mandated in the health plans' contracts.

Network Development

Comment Received	DMAS Response
Create a strong network development plan.	ARTS benefits will be managed using an integrated care approach by the DMAS-contracted health plans and Magellan. The ARTS benefits will be carved into Managed Care and CCC/MLTSS coverage and will benefit from comprehensive network development plans.
The inclusion of pediatricians in network development.	See above. Pediatricians will be encouraged to participate in the statewide VDH training and obtain their buprenorphine waivers so they can deliver MAT in clinic settings..

Billing and Reimbursement Concerns/Recommendations	
Comment Received	**DMAS Response**
Medicaid reimbursement rates for SUD services need to be increased.	Significant Medicaid and FAMIS reimbursement rate increases from 50% to 400% were approved by the General Assembly to support effective ASAM standards of care.
Require necessary infrastructure cost setting, to include the direct and overhead expenses to support cost of physicians, pharmacists, nurses, laboratory, drug screening and counseling services, efficient eHR billing, and reporting systems. SUD rates have not been adjusted since 2007.	Significant Medicaid and FAMIS reimbursement rate increases from 50% to 400% were approved by the General Assembly to support effective ASAM standards of care. Medicaid and FAMIS rates for certain SUD services will be higher than commercial rates. The new rates for all services reflect the costs required to deliver services designed based on ASAM criteria which include the providers, support systems, and therapies required by ASAM for each level of care.
Bundle the service reimbursement rate.	Bundling of services does not enhance reimbursement and does not allow for effective service delivery oversight by

	payers. MAT models have been redesigned to incentivize ASAM care models and ensure comprehensive patient management occurs for all cases based on the individual medical necessity.
Increase reimbursement rates for Substance Abuse Case Management (SACM).	Significant Medicaid and FAMIS reimbursement rate increases from 50% to 400% were approved by the General Assembly to support effective ASAM standards of care. The ARTS benefit increased rates for substance abuse case management by 50%.
Reimburse DBHDS Certified Peer Recovery Specialists (CPRS) as a distinct service through Medicaid.	The ARTS benefit approved by the General Assembly added certified peer recovery specialists for Medicaid members with mental illness and/or a SUD as a distinct service that can be reimbursed by Medicaid.
In addition to Licensed Mental Health Professionals (LMHP), the Certified Substance Abuse Counselor (CSAC) be added to the list of people who can bill for Substance Use Disorder services.	The provider credentials will be aligned to match state practice act standards and ASAM criteria. CSACs were added to the list of providers who can be reimbursed by Medicaid and FAMIS for delivering SUD treatment. The Virginia Community College System developed a CSAC curriculum that will be offered online throughout Virginia starting in Fall 2016. Please review the August 10, 2016 ARTS Medicaid Memo for more detail on ARTS provider requirements including the CSAC requirement and training opportunities.
Inclusion of coverage for drug screenings, which are a vital part of the treatment of SUDs.	Urine drug screenings have always been covered by Medicaid and FAMIS Fee-for-Service and the Managed Care plans and will continue to be covered under the ARTS benefit.

Allow reimbursement for MAT and concurrent clinical treatment services for opiate dependent pregnant and parenting women as well as other opiate dependent individuals who seek treatment.	The ARTS benefit will allow reimbursement for MAT delivered concurrently with other ASAM levels of care and services for all currently eligible Medicaid and FAMIS members including opioid dependent pregnant and parenting women and other individuals with opioid dependence.
Reimburse for court ordered SUDS services if medical necessity can be clearly supported in the clinical documentation.	The ARTS benefit will allow reimbursement for court-ordered SUD services if the services are included in the benefit and if the individual is covered by Medicaid and FAMIS.
Reimburse for transportation to treatment and medical appointments.	Transportation has always been covered by Medicaid and FAMIS MOMS Fee-for-Service and the Managed Care plans and will continue to be covered under the ARTS benefit. FAMIS enrollees are not eligible for transportation services for routine access to and from providers of covered medical services.
Allow people to maintain their Medicaid coverage while incarcerated and reimburse for medical and SUDS services while incarcerated.	CMS prohibits states to provide Medicaid/CHIP coverage during periods of incarceration. Therefore, Virginia Medicaid and FAMIS cannot reimburse for medical and SUD services that incarcerated individuals receive.
Reimburse OB-GYN physicians who are willing to treat women with SUDS at a higher rate to provide incentive for their participation.	This action is not supported in the current Virginia Budget approved by the Governor and General Assembly.
Have a central assessment site such as the local Office on Youth or Community Services Board where DMAS reimburses for the assessment, much like the current VICAP system.	ARTS benefits will be managed using an integrated care approach by the DMAS contracted health plans and Magellan. The ARTS benefits will be carved into managed Care and CCC/MLTSS coverage to allow for centralized administrative supports and to allow for treatment providers to access SUD specific care

	coordination.
Case rates (at targeted and whole population groups) tied to performance.	This action is not supported in the current Virginia Budget approved by the Governor and General Assembly.

Reporting of Quality Measures	
Comment Received	**DMAS Response**
Filing of annual cost reports by IMDs, to include annual audited financial statements of the individual facility and home office cost report for those facilities with a shared parent corporation; and public reporting of costs, utilization, outcomes and quality indicators for facility-based SUD services.	This action is not supported in the current Virginia Budget approved by the Governor and General Assembly. .

Addiction and Recovery Treatment Services (ARTS)
Virginia Department of Medical Assistance Services
Substance Use Disorder Benefit
Themes from the Public Comment Period: July 1, 2016 to August 1, 2016

Public Comments Received:
Advocates (3) / Associations (4) / Providers (5) / Health Plans (3)

Program Recommendations / Benefit Design	
Comment Received	**DMAS Response**
Increase funding to the Community Services Board (CSB) to expand mental health treatment services to prevent/reduce impact of individuals self-medicating.	Significant Medicaid and FAMIS reimbursement rate increases from 50% to 400% were approved by the General Assembly to support effective ASAM standards of care by all eligible providers including Community Service Board.
Increasing resources for mental health treatment should be primary focus and serve as prevention measure for substance abuse.	This action is not supported in the current Virginia Budget approved by the Governor and General Assembly.
Allow non-Medicaid recipients to participate in Peer Support Service Group sessions along with Medicaid members.	Peer support services may be delivered in group sessions using a variety of funding supports. However, Medicaid can only provide reimbursement for peer support services delivered to Medicaid members. Non-Medicaid members can participate in the peer support service groups but providers cannot bill for the services provided to the non-Medicaid members.
Support for the expansion of addiction treatment services and using the American Society of Addiction Medicine (ASAM) Criteria.	The ARTS benefit expanded Medicaid coverage (and FAMIS/FAMIS MOMS where eligible) of the full continuum of addiction treatment services defined by the ASAM criteria including ASAM Levels 0.5, 1.0, 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, and 4.0. All addiction treatment services will be aligned to match ASAM criteria. All ASAM levels of care will be provided in the ARTS benefit. Significant increases in reimbursement rates were approved by the General Assembly to support

	effective ASAM standards of care at all levels of care
Include the standard practice of assessing/treating members who are using substances for communicable diseases (i.e., HPV, HIV, HCV).	This practice will be included as a standard of care for all ASAM service levels as part of an integrated care approach.
Expand Screening, Brief Intervention and Referral to Treatment (SBIRT) provider types to include Pharmacists.	DMAS consulted with the Board of Pharmacy and will allow pharmacists to provide SBIRT in accordance with the state practice act. The pharmacies will be reimbursed for the SBIRT services.
Expand Pharmacist's role by allowing them to prescribe naloxone in crisis situations and coordinating with other prescribers.	Pharmacists are already allowed to dispense naloxone based on an oral, written, or standing order to a person in a crisis situation experiencing a life threatening opioid overdose under state legislation that went into effect in July 2015.
Apply the same rule of being "at-risk for harming self or others" to individuals who abuse substances.	Clinical discretion must be applied on a case by case basis in Temporary Detention Order (TDO) situations that apply the rule of being "at risk for haring self or others" and when delivering crisis services.
Longer treatment time frames are needed in an inpatient setting of at least 30 days and up to twelve months for individuals who test positive for opiates over a 3 month period. Long term treatment options are critical.	The ARTS benefit was developed based on the CMS Letter to State Medicaid Directors from July 27, 2015 on "New Service Delivery Opportunities for Individuals with SUD." Based on the guidance from CMS, the ARTS benefit included reimbursement for inpatient detoxification up to 15 days and for residential treatment for an average length of stay of 30 days for Medicaid members. This coverage was approved by the General Assembly and the Governor and funding based on these treatment durations was included in the Virginia Budget.

Support for the expansion and increased reimbursement of opiate treatment/Medication Assisted Treatment (MAT).	To expand MAT statewide, the reimbursement rate for counseling that supports MAT was increased by 400% under the ARTS benefit approved by the General Assembly. Also, DMAS is creating a new substance abuse care coordination code to support integrated MAT in physician's offices and a "Gold Card OBOT" program to support providers in expanding MAT. Finally, VDH and DMAS will offer statewide MAT education and training to physicians, behavioral health providers, and clinic staff to expand access to MAT.

Medication Recommendations	
Comments Received	**DMAS Response**
Reimburse for the FDA approved buprenorphine implant which has been utilized in other States.	Since the buprenorphine implant is an FDA-approved medication, Medicaid and FAMIS Fee-for-Service and the Medicaid/FAMIS Managed Care plans will reimburse for it. However, after reviewing the evidence for the buprenorphine implant with the addiction psychiatrists and Board-certified addiction medicine physicians on the ARTS workgroup, DMAS determined that there was not compelling evidence that the implant is more effective than the buprenorphine/naloxone films and tablets that are currently the preferred medication covered by Fee-for-Service and the health plans.
Discharge individuals from hospital/ED settings who have a substance use diagnosis or presented with opiate overdose with naloxone.	DMAS Fee-for-Service and Managed Care plans have all agreed that a PA will not be required for naloxone and will work with the hospitals and EDs to provide naloxone to all individuals with a SUD diagnosis or who present with opioid overdose. DMAS is also working with the health plans to implement the *CDC Guidelines for*

	Prescribing Opioids for Chronic Pain, which include encouraging prescribers to co-prescribe naloxone for any individuals taking greater than 50 MME of opioids.

Network Development	
Comments Received	**DMAS Response**
Concern over the lack of skilled professionals to handle the demand for services. Inclusion of "qualified" and "credentialed" professionals working together to provide services.	ARTS Services will be delivered using ASAM level of care criteria and delivered by licensed and certified staff in accordance with the state practice act. Licensed behavioral health providers and CSACs will be required to deliver all services based on the provider types defined by ASAM at each level of care. To support "qualified" professionals in obtaining the required CSAC credential, the Virginia Community College System is offering an affordable, online CSAC curriculum starting in Fall 2016 that will prepare "qualified" professionals to take the CSAC exam by April 2017.
Concern with network capacity and Hospitals meeting the State licensing requirements for ASAM levels of care. Systems/Providers will need assistance in meeting the licensing requirements.	DMAS has shared licensing guidance from DBHDS and VDH to help facilities better understand the licensing requirements for delivering SUD services. DMAS will be presenting licensing requirements in webinars and at in-personal informational sessions held around the state beginning in early September, 2016.
Allow pharmacist to assist with monitoring drug abuse by working with the Prescription Monitoring Program (PMP).	Pharmacists are already required to assist with monitoring drug abuse by working with the PMP.
Pharmacists are integral component to multidisciplinary team and should have integral role in MAT in an Opiate Treatment Program (OTP).	Virginia's MAT clinical and payment model was designed with input from a psychiatric pharmacist and includes pharmacists as integral members of the multidisciplinary team that will provide MAT.

Billing and Reimbursement Concerns/Recommendations	
Comments Received	**DMAS Response**
DMAS should reimburse for all levels of care to include individual and group counseling provided by a Licensed Mental Health Professional or Certified Substance Abuse Counselor, Intensive Outpatient therapy, detoxification, MAT, inpatient, recovery coaching, and half way houses.	Under the ARTS benefit approved by the General Assembly, DMAS will provide Medicaid (and FAMIS where eligible) reimbursement for services delivered by LMHPs and CSACs at all ASAM levels of care including inpatient and outpatient detoxification/withdrawal management, residential treatment, partial hospitalization, intensive outpatient programs, outpatient treatment including MAT as well as SBIRT and peer recovery coaching.
Concern over the financial strain on providers for the injectable medications-buy-and-bill program.	To decrease the financial strain on providers, DMAS is exploring working with the manufacturer of injectable naltrexone to arrange for the medication to be provided free up-front to providers, who can inject it and then bill Magellan or the managed care plans before having to reimburse the manufacturer. .
Support for increase in rate reimbursements.	Significant reimbursement rates ranging from 50% to 400% for all addiction treatment services were approved by the General Assembly to support effective ASAM standards of care.
Allow reimbursement for residential facilities.	The ARTS benefit will allow Medicaid reimbursement for residential treatment for an average length of stay of 30 days for all Medicaid members.

Education	
Comments Received	**DMAS Response**
Provide resources to staff in office settings (i.e., doctor office) to assist individuals in need of services.	DMAS developed a substance abuse care coordination code to support psychosocial supports delivered in office settings by buprenorphine-waivered physicians who are treating individuals with opioid addiction.

Training administrators and program directors on ASAM is important to ensure compliance.	DMAS, DBHDS, VDH, Magellan and the MCOs are designing a coordinated and comprehensive training program that will begin with in-person informational sessions on the ARTS benefit and ASAM levels of care in September 2016 and continue through the implementation process for the ARTS benefit program. DBHDS will also offer in-depth 2-day sessions for frontline clinicians and program directors on the ASAM criteria by Training for Change throughout the state.
Ensure compliance of the ASAM criteria through training, program review, and monitoring.	The DBHDS sessions on the ASAM criteria will provide the initial training providers need to ensure their programs are compliant with ASAM. The MCOs and Magellan will provide program review and monitoring to ensure compliance with ASAM criteria.
Allow pharmacist to assist in developing and conducting the training curriculum for Medication Assisted Treatment (MAT).	Virginia's MAT clinical and payment model was designed with input from a psychiatric pharmacist and includes pharmacists as integral members of the multidisciplinary team that will provide MAT.
Provide training opportunities for pharmacists including certified pain educator through The American Society of Pain Educators.	Training opportunities for pharmacists in pain management is beyond the scope of the ARTS benefit and waiver. However, pharmacists will be provided with online training opportunities in SBIRT and will be allowed to deliver SBIRT and obtain Medicaid reimbursement.
Support for training professionals. Suggestion to align DMAS training efforts with the Comprehensive Addiction and Recovery Act (CARA).	VDH is developing statewide MAT education and training for physicians, behavioral health providers, and clinic staff in partnership with SAMHSA and HRSA, which will be providing free CME and free access to online buprenorphine waiver training under CARA from Fall 2016 to Spring 2017. VDH and DMAS will align their training with CARA and will take advantage of any new federal

	resources available to expand provider training.
Train pharmacists in administration of naloxone.	The Virginia REVIVE! Program administered by DBHDS already trains pharmacists in the administration of naloxone: http://www.dbhds.virginia.gov/individuals-and-families/substance-abuse/revive

Iowa Department of Public Health
Promoting and Protecting the Health of Iowans

Gerd W. Clabaugh, MPA
Director

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

House File 2463 Report – December 2014
Substance-Related Disorder Reimbursement Provisions

Introduction

In House File 2463, the 2014 Iowa General Assembly directed the Iowa Department of Public Health (IDPH) to work with stakeholders to review reimbursement provisions for substance-related disorder providers as follows:

> *"The department of public health shall engage stakeholders to review reimbursement provisions applicable to substance-related disorder providers. The issues considered shall include but not be limited to the adequacy of the reimbursement provisions, whether it is appropriate to rebase reimbursement, equity of the reimbursement provisions as compared to the reimbursement methodologies used for providers of similar behavioral health services, and the effect of health coverage expansion through the Iowa health and wellness plan on such providers. The department shall report its findings and recommendations to the general assembly on or before December 15, 2014."*

IDPH discussed historical and current reimbursement provisions with specific stakeholders and convened stakeholder representative meetings on November 21 and December 12, 2014.

Stakeholder Representatives

Ron Berg, Executive Director	MECCA Services, Iowa City
Kermit Dahlen, Executive Director	Jackson Recovery Center, Sioux City
Marv Fangman, Executive Director	Clearview Recovery Inc., Prairie City
Jason Haglund, Treatment Services Director	Youth and Shelter Services, Ames
Jay Hansen, Executive Director	Prairie Ridge Addiction Treatment Services, Mason City
Liz Matney, Managed Care Director	Department of Human Services / Iowa Medicaid Enterprise, Des Moines
Maria Montanaro, Chief Executive Officer	Magellan of Iowa, West Des Moines
Dennis Petersen, Chief Operating Officer	Magellan of Iowa, West Des Moines
Deanna Triplett, Chief Executive Officer	Iowa Behavioral Health Association, Des Moines
Kathy Stone, Division Director	Iowa Department of Public Health / Division of Behavioral Health, Des Moines

Background

Providers of comprehensive substance-related disorder services have historically been one-third of what's been described as Iowa's "three-legged**" *collaborative, community-based safety-net health services infrastructure for low income Iowans***. In general, this three-legged arrangement has been comprised of the following:

(1) Community Health Centers/Federally Qualified Health Centers (CHC/FQHCs), providing primary medical care in this safety-net health services system;

(2) Community Mental Health Centers (CMHCs), providing most outpatient mental health services; and

(3) a core group of substance-related disorder providers, primarily those programs competitively procured as the IDPH-funded provider network, providing the majority of outpatient and residential substance abuse treatment.

This three-part safety-net infrastructure, comprised of ***one primary care provider type* – CHCs/FQHCs** – and ***two specialty behavioral health provider types* – CMHCs and substance-related disorder programs** – has generally operated differently and separately from the predominately private sector healthcare provider network of hospitals and private practices. ***Of the three safety-net provider types, only substance-related disorder providers do not receive reimbursement from Medicaid that is related to their costs.***

To understand the reimbursement methodologies used for providers of similar behavioral health services, the stakeholder representatives began their work by reviewing the reimbursement language in HF 2463 for CMHCs, which states:

> *"… For the fiscal year beginning July 1, 2014, community mental health centers may choose to be reimbursed for the services provided to recipients of medical assistance through either of the following options: (1) For 100 percent of the reasonable costs of the services. (2) In accordance with the alternative reimbursement rate methodology established by the medical assistance program's managed care contractor for mental health services and approved by the department of human services."*

The Iowa Plan for Behavioral Health is Iowa's managed care plan for mental health and substance-related disorder services funded by Medicaid under the authority of the Iowa Department of Human Services Iowa Medicaid Enterprise (DHS IME), and for substance-related disorder treatment funded by federal block grant and General Fund appropriation under the authority of the Iowa Department of Public Health Division of Behavioral Health (IDPH).

Dennis Petersen, representing Magellan of Iowa (Magellan), the state's managed care contractor for the Iowa Plan for Behavioral Health, outlined the ***history of CMHC Medicaid funding methodologies since 1995 under the Iowa Plan for Behavioral Health***:

a. Historically, CMHCs were paid on a *fee-for-service* basis for the mental health services they provided.
    - CMHCs sought rate increases from Magellan as the CMHCs determined necessary.
    - Magellan increased rates as Magellan determined appropriate and feasible.

b. CMHCs were also eligible to receive *Iowa Plan Medicaid Community Reinvestment funding* for priority projects to improve services to enrollees.
    - The majority of Iowa Plan Community Reinvestment projects have focused on mental health services and supports.

c. Over time, CMHCs determined that the fee-for-service rates were not adequate to cover their costs.

d. Around 2005, the General Assembly passed legislation that added a *100% cost-based reimbursement methodology* to CMHC fee-for-service payments, with defined cost parameters and processes.
    - CMHCs continued to submit claims to Magellan and were reimbursed on a fee-for-service basis for the mental health services they provided.
    - In addition, every year, each CMHC generated an annual cost report for the mental health services they provided and submitted that cost report to DHS IME.
        - The cost report reconciliation process was complex. It could take up to two years for CMHCs to receive their additional reimbursement.
        - CMHCs sometimes covered their costs in the interim by borrowing money from counties and repaying the counties after receiving their additional reimbursement from the cost report reconciliation.
    - Following implementation of the cost-based reimbursement methodology, the overall total cost of CMHC reimbursement rose approximately 15% a year for six years.

e. In 2011, Magellan, on behalf of DHS IME, launched an *Integrated Health Home pilot program* with five CMHCs in partnership with local FQHCs in four Iowa counties.
    - In July 2013, Magellan began an expanded program in accordance with the Affordable Care Act's Integrated Health Home provision Section 2703 focused on Medicaid enrollees with severe mental illness and concurrent chronic health conditions.

f. Certain CMHCs approached Magellan requesting an alternative to the cost-based reimbursement methodology and cost report reconciliation process.

g. With the approval of DHS IME, Magellan met with a CMHC group to understand the actual total dollars paid to CMHCs through both fee-for-service reimbursement and the cost-based methodology and to determine how to get those total dollars to the CMHCs in a more timely fashion,
    - DHS IME developed an *alternative reimbursement rate schedule* for CMHCs based on the actual total dollars paid for common services across all CMHCs.
        - The alternative rate schedule was intended to be cost neutral overall.
        - The alternative rates for specific services were not designed to be "reasonable" and may appear to be considerably higher than comparable standard fee-for-service reimbursement rates when viewed outside the perspective of overall cost neutrality.

h. In 2014, the General Assembly, through HF 2463, made it optional for each CMHC to choose its reimbursement methodology: (a) fee-for-service reimbursement plus cost-based reconciliation or (b) fee-for-service reimbursement at the alternative reimbursement rate level.
    - As of the time of this report, approximately 17 of 28 CMHCs have moved to the alternative reimbursement rates.

Mr. Petersen and provider representatives then reviewed the ***history of Medicaid reimbursement to substance-related disorder providers under the Iowa Plan for Behavioral Health since 1995:***

a. Substance-related disorder providers are paid on a *fee-for-service* basis for the substance-related disorder treatment they provide.
    - Substance-related disorder providers have sought rate increases from Magellan.
    - Magellan increased rates as Magellan determined appropriate and feasible.

b. Substance-related disorder providers were eligible to receive *Iowa Plan Medicaid Community Reinvestment funding* for a limited subset of projects focused on substance-related disorder services.

c. Historically, fee-for-service reimbursement rates for services provided by substance-related disorder providers have been lower than rates for similar services provided by CMHCs.

d. Around 2004, when Magellan moved to standardized coding and a standard rate sheet, the difference in reimbursement rates between CMHCs and substance-related disorder providers became clear.
    - Magellan then generally aligned rates for similar services, regardless of whether the services were provided in a CMHC or a substance-related disorder setting.
        - By 2005, the aligned rates were no longer comparable to the actual total reimbursement received by CMHCs through the combination of fee-for-service reimbursement and the cost-based reconciliation methodology.

e. In 2011, Magellan increased reimbursement rates for certain outpatient substance-related disorder services.

f. In 2011, Magellan launched its Integrated Health Home pilot program with five CMHCs and local FQHCs.
    - In July 2013, Magellan expanded the Integrated Health Home program for Medicaid enrollees with severe mental illness and concurrent chronic health conditions.
        - Certain CMHCs participating in the Integrated Health Home program are also licensed substance-related disorder providers.
        - Most of the Integrated Health Home providers are not licensed substance-related disorder programs.
            - Such providers may consider outpatient substance-related disorder services within the scope of practice for their staff who are professionally licensed at the independent level. They generally do not refer Integrated Health Home members with substance-related disorders to the substance-related disorder provider network for specialty care.

g. Substance-related disorder providers requested the opportunity to consider alternative reimbursement methodologies under the Iowa Plan for Behavioral Health, with the goal of assuring equitable fee-for service rates as well as overall reimbursement.
    - A concern for the providers was their understanding that under the fee-for-service plus cost-based reimbursement methodology as well as under the proposed alternative reimbursement methodology, CMHCs were being paid much higher rates for services similar to those provided by substance-related disorder providers.
        - Further, those CMHCs that were also substance-related disorder providers were being paid the higher rates for the same services provided by non-CMHC substance-related disorder providers.

h. In 2014, the General Assembly, through HF 2463, directed that there be a review and recommendations on reimbursement provisions for substance-related disorder providers.

Findings

A. Adequacy of reimbursement provisions? → *No, current reimbursement provisions are not adequate.*

Historical and current reimbursement provisions have put substance-related disorder providers at a *competitive disadvantage* in hiring and retaining qualified staff when compared to CMHCs as providers of similar behavioral health services. Provider representatives gave multiple examples of how the low reimbursement they receive means they must hire staff at below market salary and benefit levels. These providers consistently hire entry level licensed professionals, train them for a year, and then lose these same professionals to CMHCs or to other providers or organizations that are able to offer higher salaries and benefits. One provider reported a 45% staff turnover rate in the past year.

In describing themselves as *specialty providers in the safety-net healthcare infrastructure*, the substance-related disorder provider representatives explained how they have expanded their capacity over the past several years to meet the complex needs of their patients, including integrating delivery of medical and mental health services into their program operations. Substance-related disorder providers often act as their patients' initial entry into the larger medical and mental health services system. In a survey conducted two years ago, 89% of the patients served by a specific core group of substance-related disorder providers, when asked where they would prefer to receive medical and mental health services, responded that they'd like to receive such services on-site in the substance-related disorder treatment setting in which they already felt welcomed and comfortable. While many substance-related disorder providers have added medical and mental health professionals to their staff, either directly or by contractual arrangement or co-location, they are hampered again by low salaries and benefits. This has most recently slowed efforts to address emerging trends like prescription abuse and to implement promising models like medication-assisted treatment. As one provider representative stated when asked about training and evidence-based practices, "You have to have revenue to conduct training [and] you can't have different care if you don't pay for it!"

The substance-related disorder providers have stated they *cannot survive on the current reimbursement rates*. Approximately 15% of Iowa Plan for Behavioral Health Medicaid enrollees participate in substance-related disorder services each year. A core group of the substance-related disorder providers has historically provided up to 80% of the substance abuse treatment received by Iowa Plan for Behavioral Health Medicaid enrollees. Losing this safety-net specialty provider network would decrease capacity for all substance-related disorder services statewide – for all patients and all payors.

B. Rebase reimbursement? → *Yes, rebasing reimbursement is needed.*

The current fee-for service reimbursement rates paid to substance-related disorder providers are not sufficient to support continued delivery of appropriate and effective substance-related disorder services. The current rates do not cover provider costs and do not allow financial flexibility in training for improved practices and vital quality initiatives.

Provider representatives have not requested cost-based reimbursement and do not believe a simple analysis of current substance-related disorder provider costs would accurately reflect their funding needs, primarily because their current costs, particularly for staff salaries and benefits, are not representative of current market levels across the state for similar staff and services.

C. Equity of reimbursement provisions compared to reimbursement methodologies for providers of similar behavioral health services? → *No, current reimbursement provisions are not equitable.*

Substance-related disorder providers are similar to CMHCs in the provision of behavioral health services to Iowa Plan for Behavioral Health Medicaid enrollees in terms of their accreditation processes and the types of staff they hire. The provider representatives specifically stipulated that the core group of substance-related disorder providers, primarily those that provide services that are prioritized by IDPH, provide comprehensive treatment services covering the full continuum of care from assessment through individual and group counseling to 24-hour residential treatment, making them different from private practice providers who generally offer outpatient counseling only. Substance-related disorder providers employ a mix of certified and licensed professionals to provide evidence-based practices and nationally-accepted models of care. Many of the core group of substance-related providers are accredited at the national level, e.g. under the CARF Integrated Behavioral Health Standards, in addition to IDPH licensure.

CMHCs, including those CMHCs that are also substance-related disorder providers, currently receive overall reimbursement that is much higher than that received by non-CMHC substance-related disorder providers for the same or similar services. The current reimbursement structure also pushes substance-related disorder providers to assign caseloads to their staff that exceed normal practice standards in an attempt to maximize revenue. The providers believe that the quality and effectiveness of substance-related disorder treatment suffer when high volume becomes the driving force.

D. Effect of health coverage expansion through the Iowa Health and Wellness Plan? → *Yes, health coverage expansion through the Iowa Health and Wellness Plan will affect providers but the full extent and implications are not yet known.*

In 2014, IDPH commissioned an initial analysis of the potential impact of implementation of the Iowa Health and Wellness Plan on the demand for substance-related disorder services. That analysis, conducted by the Milliman actuarial firm, suggests an increase in overall demand for services, with a *critical transition period for substance-related disorder providers between 2014 and 2017*.

The analysis considered but did not quantify the need or costs for what have been described as wraparound or gap-filling services such as transportation, that support the effectiveness of behavioral health services provided to the Medicaid population.

Recommendations

From the November 21, 2014 Stakeholder Meeting:

Establish a Plan to Address Findings:
In December 2014, provider representatives, DHS IME, IDPH and Magellan will meet to jointly establish a plan to improve Iowa Plan for Behavioral Health Medicaid reimbursement for substance-related disorder providers that addresses both adequacy and equity of reimbursement provisions.

From the December 12, 2014 Stakeholder Meeting:

1. **Iowa Plan for Behavioral Health Medicaid Reimbursement Rate Increases:**

    a. By January 30, 2015, Magellan will analyze fee-for-service reimbursement rates for substance-related disorder providers.

    b. By March 1, 2015, Magellan will implement an initial "stabilizing" increase in fee-for-service reimbursement rates for substance-related disorder providers.

    c. By July 1, 2015, Magellan will increase fee-for-service reimbursement rates for substance-related disorder providers based on analysis of costs; targeted priority services, enrollee groups, and providers; and available funding.

2. **Alternative Reimbursement Methodologies:**

    a. In January 2015, DHS IME and IDPH will convene substance-related disorder providers to identify options for their participation in existing alternative funding methodologies, such as the Chronic Condition Health Home and Integrated Health Home models, or in new models or demonstration projects.

    b. In March 2015, pending approval by DHS IME and by the Centers for Medicare and Medicaid Services (CMS), Magellan will release an Iowa Plan for Behavioral Health Medicaid Community Reinvestment funding opportunity announcement for implementation of evidence-based practices that includes $1.5M (25% of the total funding opportunity) for substance-related disorder providers.

    c. By March 2015, provider representatives will work with IDPH, Magellan, and others to understand potential reimbursement methodology options available outside of the Iowa Plan for Behavioral Health, such as expanded FQHC linkage to increase medical care capacity and professional loan repayment.

3. Analysis of Iowa Plan for Behavioral Health Substance-Related Disorder Provider Costs and Reimbursement Adequacy:

a. By February 2015, providers, with DHS IME, IDPH, and Magellan support, will conduct a cost-based rate study to quantify:

(1) The current total costs for substance-related disorder providers, acknowledging that current and historical costs are artificially low;

(2) The projected total costs for substance-related disorder providers if current costs are rebased at appropriate market levels, e.g. at salary and benefit levels that are consistent with CMHC and other community norms for like professionals;

(3) The disparity between current/projected total substance-related disorder provider costs and current reimbursement rates;

(4) The projected cost of the loss of the substance-related disorder specialty health services safety-net provider network that currently provides the bulk of Iowa Plan for Behavioral Health Medicaid-funded substance abuse treatment and related priority services; and

(5) The funding needed to support an effective statewide substance-related disorder provider network in State Fiscal Year 2016 and subsequent years.

b. By July 2015, IDPH will update the substance abuse treatment section of its Milliman ACA Impact Study Report to reflect the analysis contained in the provider cost-based rate study referenced above and data available on 2014 actual service utilization and related expenditures. IDPH will also include, as feasible, related DHS IME data and information as well as data from associated IDPH federal grant programs and the annual treatment outcomes study.

Both reports will be made available to the General Assembly.

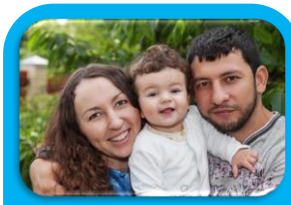
Questions about this report may be directed to Kathy Stone/IDPH at
kathy.stone@IDPH.iowa.gov or at 515/281-8021.

UPDATE ON ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS) TO OPIOID AND HEROIN STAKEHOLDERS GROUP

Karen Kimsey, MSW
Deputy Director, Complex Care
Virginia Department of Medical Assistance Services
June 21, 2017

www.dmas.virginia.gov

Virginians Covered by Medicaid and CHIP



1 in 8 Virginians rely on Medicaid

Medicaid is the primary payer for **behavioral health** services

Medicaid covers **1 in 3** births in Virginia

50% of Medicaid beneficiaries are children

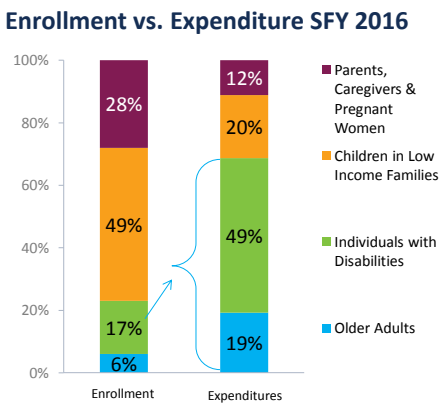
2 in 3 nursing facility residents are supported by Medicaid

62% of long-term services and supports spending is in the community

Medicaid plays a critical role in the lives of over 1 million Virginians

1 DMAS

Virginia Medicaid: Enrollment and Expenditures



1.3 M Enrolled

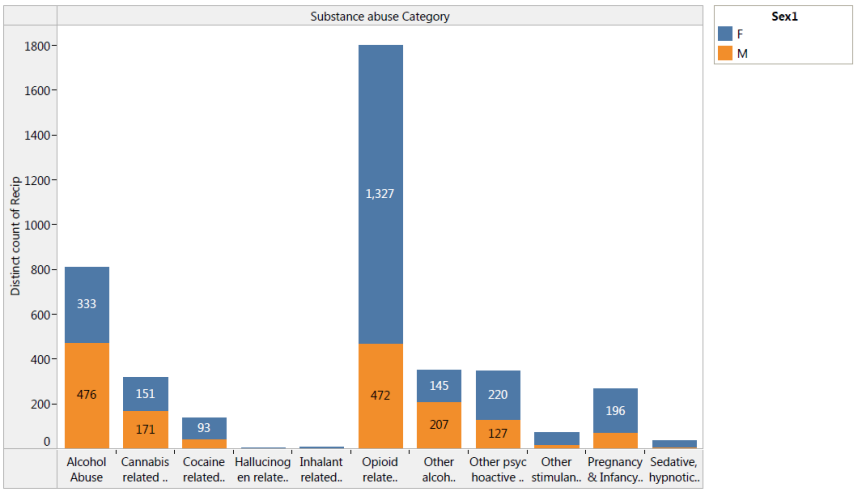
$8.41 B Spent

23% of the Medicaid population → **Drives** → **68%** of total expenditures

Expenditures are disproportionate to population where services for older adults and individuals drive a significant portion of Medicaid costs

2

Medicaid Members with Substance Use Disorder Diagnosis



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Source: Department of Medical Assistance Services – claims/encounter data (CY2017).
Circles # of Medicaid recipients whose claims/encounter data included an addiction related diagnosis.

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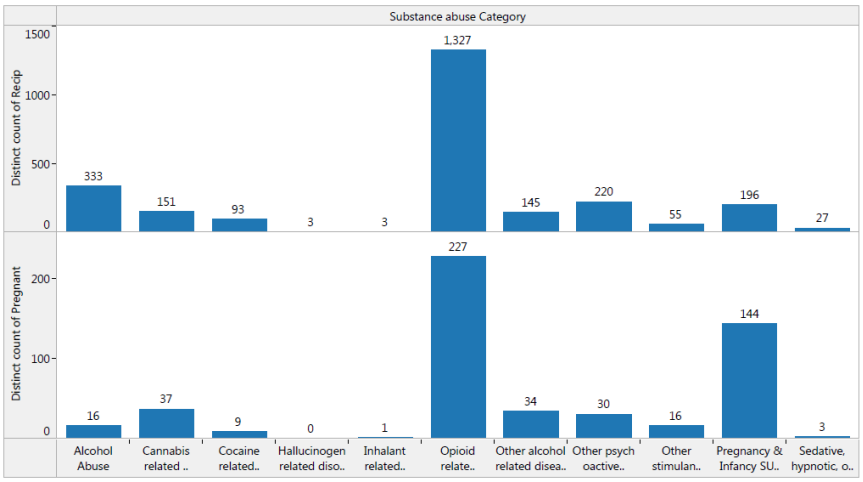
Medicaid Members who are Pregnant by Substance Use Disorder Diagnosis



Source: Department of Medical Assistance Services – claims/encounter data (CY2017).
Top row are all female recipients whose claims/encounter data included an addiction related diagnosis.
Bottom row identifies recipients who are pregnant.

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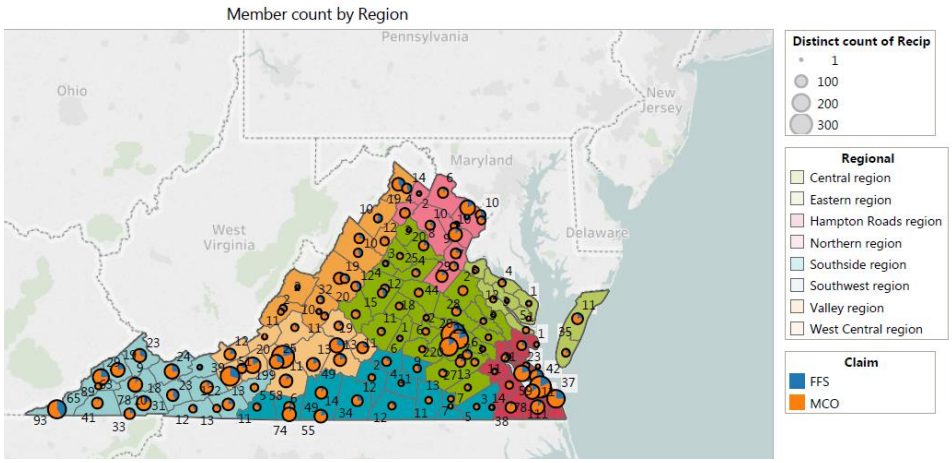
Communities Impacted by Addiction



Source: Department of Medical Assistance Services – claims/encounter data (CY2017).

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Addiction and Recovery Treatment Services (ARTS) Benefit

Changes to DMAS's Substance Use Disorder (SUD) Services for Medicaid and FAMIS Members

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 rates 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

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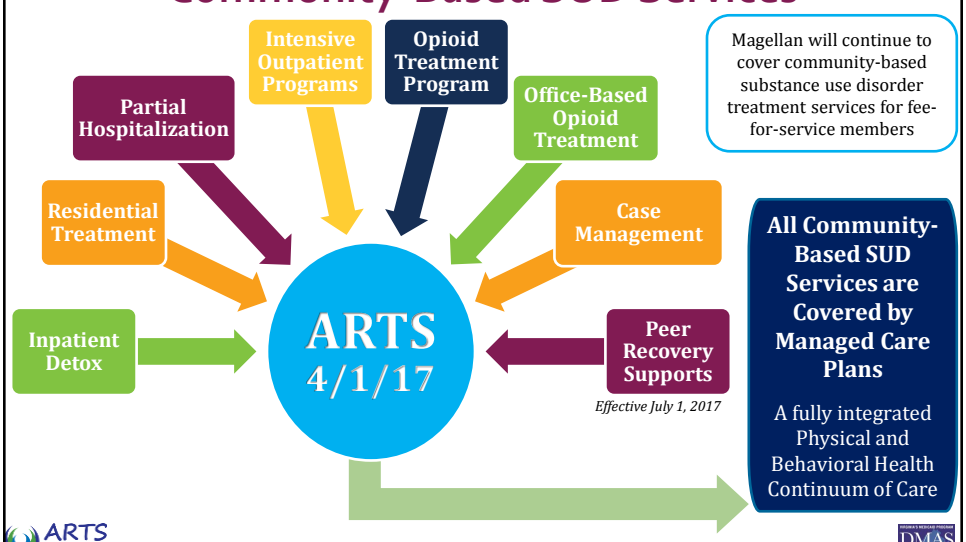
Transforming the Delivery System for Community-Based SUD Services



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ASAM LOC Placement	Setting
4 Medically Managed Intensive Inpatient	• Acute Care General Hospital - Inpatient Detox in Medical Beds
3.7 Medically Monitored Intensive Inpatient Services (Adult) Medically Monitored High-Intensity Inpatient Services (Adolescent)	• Inpatient Psychiatric Unit • Freestanding Psychiatric Hospital • Community-Based Facility
3.5 Clinically Managed High-Intensity Residential Services (Adults) / Medium Intensity (Adolescent) **3.3** Clinically Managed Population-Specific High-Intensity Residential Services (Adults)	• Community-Based Facility Licensed for SA Residential Treatment Services • Specialty Unit in a Health Care Facility
3.1 Clinically Managed Low-Intensity Residential Services	• Mental Health and Substance Abuse Group Home • Supervised Living Services for Adults
2.5 Partial Hospitalization Services **2.1** Intensive Outpatient Services	• Licensed Program at a Health Care Facility or Community Provider
1 Outpatient Services	• Outpatient Services
0.5 Early Intervention	• Emergency Departments, Primary Care Clinics, FQHCs, CSBs, Health Departments, Pharmacies, etc.
Opioid Treatment Program (OTP)	• Public and Private Methadone Clinics
Office-Based Opioid Treatment (OBOT)	• CSBs, FQHCs, Outpatient Clinics, Physician's Offices

ARTS Provider Education, and Training

Partnership of DMAS, Department of Behavioral Health and Developmental Services, and Virginia Department of Health

- Over **800** providers attended 12 DMAS "ARTS 101" in-person sessions across the Commonwealth in the Fall, and an additional 140 providers attended ARTS webinars.
- Over **750** physicians, NPs, PAs, behavioral health clinicians, and practice administrators attended VDH Addiction Disease Management trainings
- Over **500** providers attended DBHDS trainings on ASAM patient placement criteria
- Over **800** providers attended 10 "ARTS provider manual trainings"

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"Gold Card" Office-Based Opioid Treatment

Settings and Care Model

- CSBs, FQHCs, outpatient clinics psychiatry practices, primary care clinics
- Provide Medication Assisted Treatment (MAT) - use of medications in combination with counseling and behavioral therapies that results in successful recovery rates of 40-60% for opioid use disorder compared to 5-20% with abstinence-only models
- Supports integrated behavioral health - buprenorphine waivered practitioner with on site credentialed addiction treatment professional (e.g., licensed clinical psychologist, LCSW, LPC, licensed psychiatric NP, etc.) providing counseling to patients receiving MAT

Payment Incentives

- Buprenorphine-waivered practitioner in the OBOT can bill all Medicaid health plans for **substance use care coordination code** ($243 PMPM) for members with moderate to severe opioid use disorder receiving MAT
- Can bill **higher rates for individual and group opioid counseling**
- Can bill for Certified Peer Recovery Support specialists

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Preliminary Increases in Addiction Providers Due to ARTS

Addiction Provider Type	# of Providers before ARTS	# of Providers after ARTS	% Increase in Providers
Inpatient Detox (ASAM 4.0)	Unknown	83	NEW
Residential Treatment (ASAM 3.1, 3.3, 3.5, 3.7)	4	79	↑ 1525%
Partial Hospitalization Program (ASAM 2.5)	0	14	NEW
Intensive Outpatient Program (ASAM 2.1)	49	88	↑ 16%
Opioid Treatment Program	6	35	↑ 467%
Office-Based Opioid Treatment Provider	0	36	NEW

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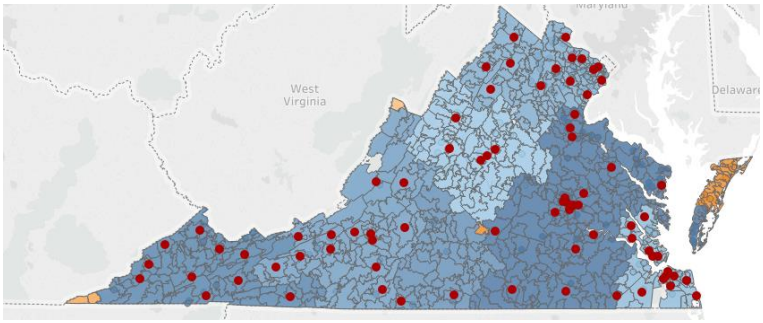
NEW ARTS Medicaid Provider Network Adequacy
ASAM 4 Inpatient Detox



Source: Department of Medical Assistance Services - ARTS provider network data (May 15, 2017). Circles are locations of Medicaid providers used in the network adequacy calculation. For a zip code to be deemed accessible, there must be at least two providers within 60 miles driving distance as calculated as the distance between the centroids of the zip code of the member and the zip code of the provider.

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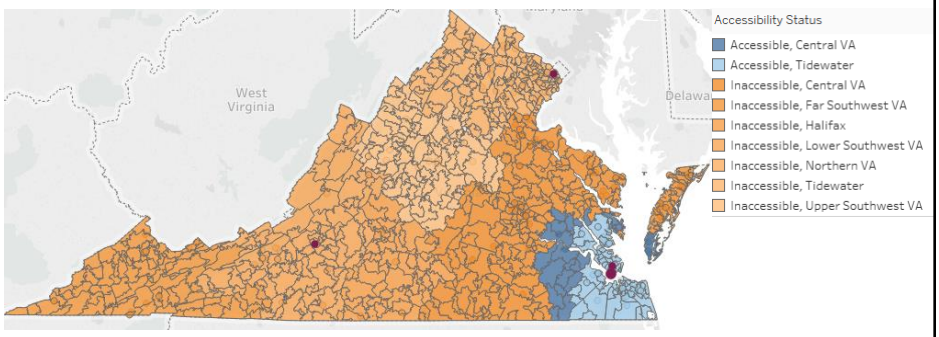
Before ARTS Medicaid Provider Network Adequacy
Residential Treatment



Source: Department of Medical Assistance Services - Provider Network data (March 20, 2017).
Circles # of Medicaid providers included in network adequacy access calculation.
Accessible is considered to be at least two providers within 60 miles of driving distance.
Driving distance is calculated by Google services based on the centroid of each zip code.

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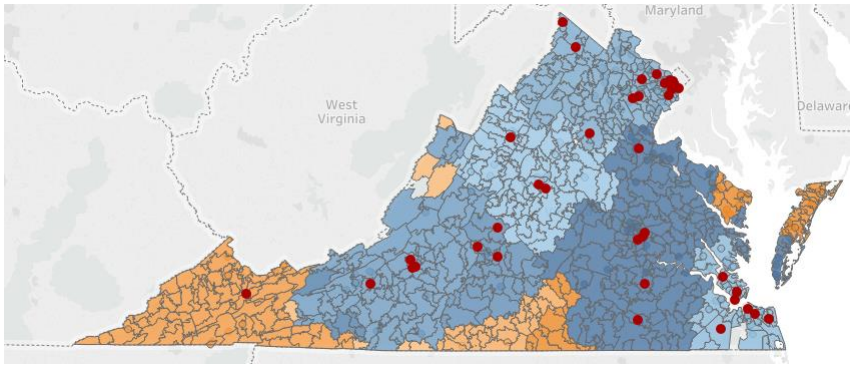
After ARTS Medicaid Provider Network Adequacy

ASAM 3.1/3.3/3.5/3.7 Residential Treatment



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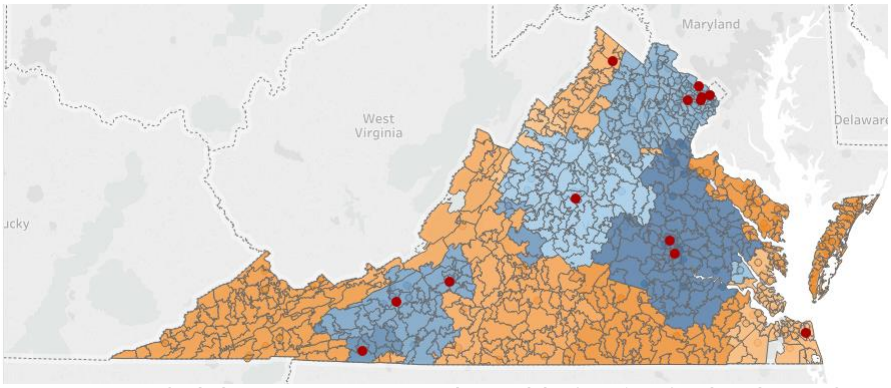
NEW ARTS Medicaid Provider Network Adequacy

ASAM 2.5 Partial Hospitalization



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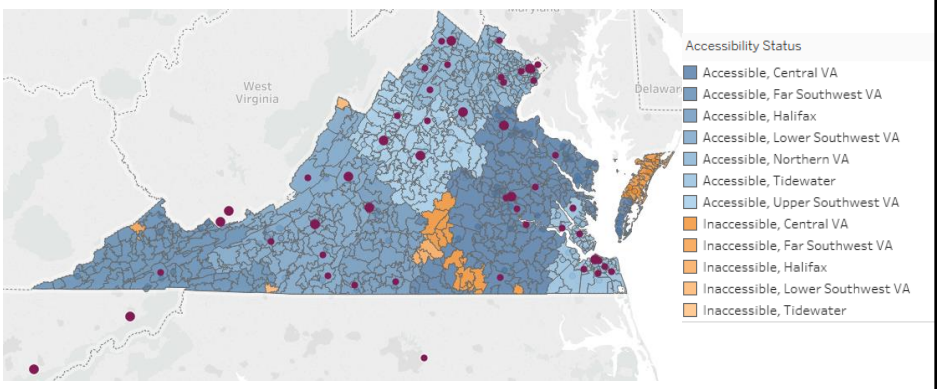
Before ARTS Medicaid Provider Network Adequacy
Intensive Outpatient Programs



Source: Department of Medical Assistance Services - Provider Network data (March 20, 2017).
Circles # of Medicaid providers included in network adequacy access calculation.
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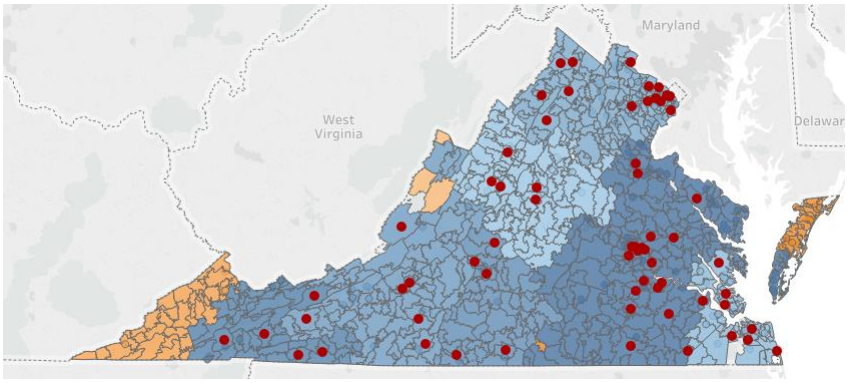
After ARTS Medicaid Provider Network Adequacy
ASAM 2.1 Intensive Outpatient



Source: Department of Medical Assistance Services - ARTS provider network data (May 15, 2017). Circles are locations of Medicaid providers used in the network adequacy calculation. For a zip code to be deemed accessible, there must be at least two providers within 60 miles driving distance as calculated as the distance between the centroids of the zip code of the member and the zip code of the provider.

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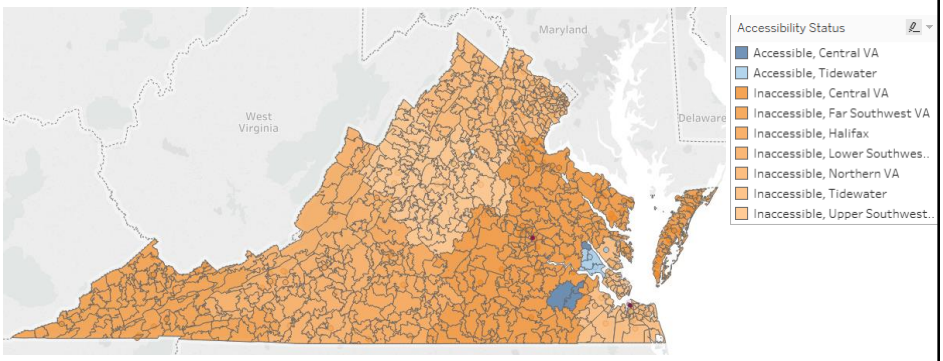
Before ARTS Medicaid Provider Network Adequacy
Opioid Treatment Program



Source: Department of Medical Assistance Services - Provider Network data (March 20, 2017).
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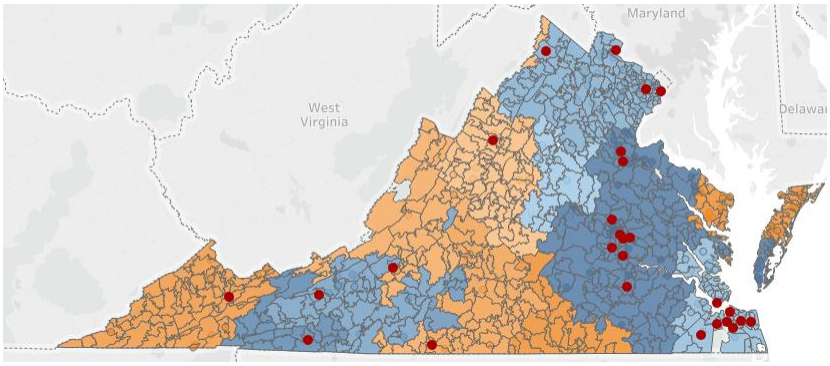
After ARTS Medicaid Provider Network Adequacy
Opioid Treatment Programs



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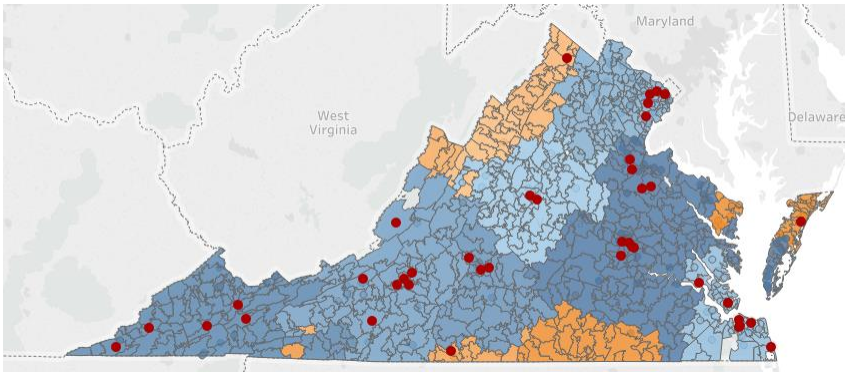
NEW Medicaid Provider Network Adequacy Office Based Opioid Treatment



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Peer Support Services

Effective July 1, 2017

- A Peer Recovery Specialist (PRS) is a self-identified individual with lived experience with mental health or substance use disorders, or co-occurring mental health and substance use disorders who is trained to offer support and assistance in helping others in the recovery and community-integration process.
- Available to individuals who have mental health conditions and/or substance use disorders

Supported by The Centers for Medicare & Medicaid Services (CMS) as "…an important component in the State's delivery of effective treatment."

Supported by the Governor's Task Force on Prescription Drug and Heroin Addiction

Established in response to a legislative mandate

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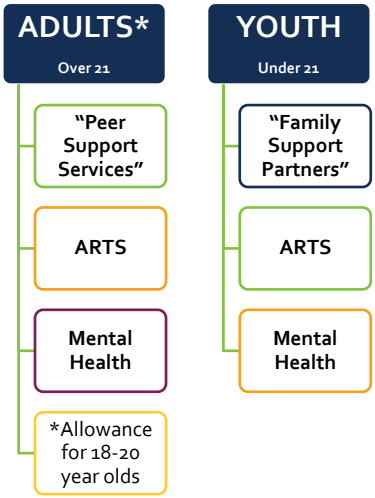
Peer Support: Targeted Populations



*Individuals 18-20 years old who meet the eligibility criteria for Peer Support Services in ARTS or MH, who would benefit from receiving peer supports directly, and who choose to receive Peer Support Services directly instead of through their family are permitted to receive Peer Support Services by an appropriate Peer Recovery Specialist.

Governor's Access Plan for the Seriously Mentally Ill and ARTS

- A targeted benefit package for uninsured, low income Virginians who have a serious mental illness (SMI).
- The GAP provides basic medical and targeted behavioral health care services through an integrated and coordinated delivery model to qualifying individuals with SMI.
- Currently covers ARTS Outpatient, Intensive Outpatient and Medication Assisted Treatment.
- ARTS coverage expanding to include Partial Hospitalization and Residential Treatment Services 10/1/17!

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QUESTIONS

For more information, please contact:
SUD@dmas.virginia.gov

http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx