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DMAS UPDATE ON GAP AND ARTS PROGRAM

Cindi B. Jones, Director, DMAS

House Appropriations Committee

October 16, 2017

Bridging the Mental Health Coverage GAP

GAP's Inception

The Governor's Access Plan

- 1 of a 10 point action plan toward *A Healthy Virginia*
- A targeted benefit package for uninsured, low income Virginians with a SMI diagnosis
- Provides basic medical and behavioral health care services through an integrated and coordinated delivery model

GAP Demonstration Goals

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

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Bridging the Mental Health Coverage GAP

Eligibility & Enrollment

Requirements
Ages 21 through 64
U.S. Citizen or lawfully residing immigrant
Not eligible for any existing entitlement program
Resident of VA
Income below 80%* of Federal Poverty Level (FPL) (*80% + 5% disregard) **Effective 10/1/2017**, Income below 100%* of FPL (*100% + 5% disregard)
Uninsured
Does not reside in long term care facility, mental health facility or penal institution
Screened and meet GAP SMI criteria

GAP application is a two step process:

- **Financial/non-financial determination with Cover Virginia**
- **GAP SMI determination with Magellan**

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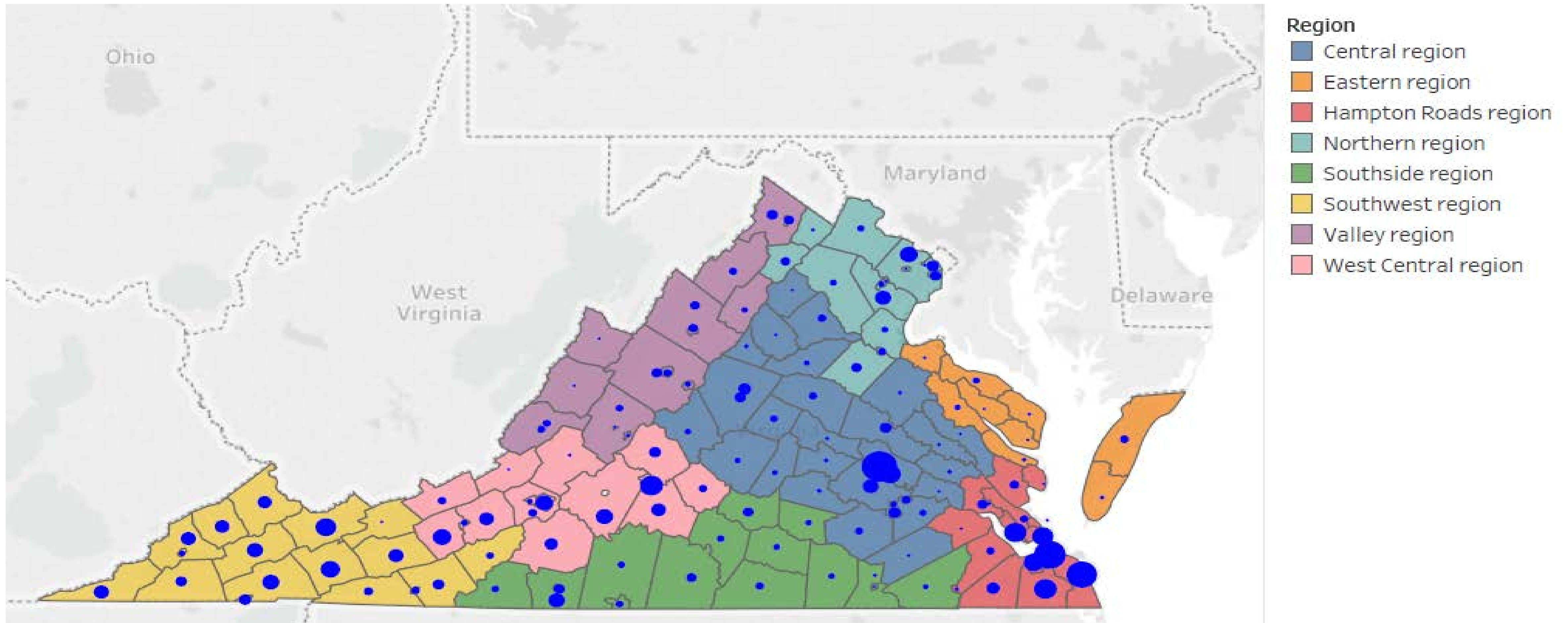
GAP Enrollment

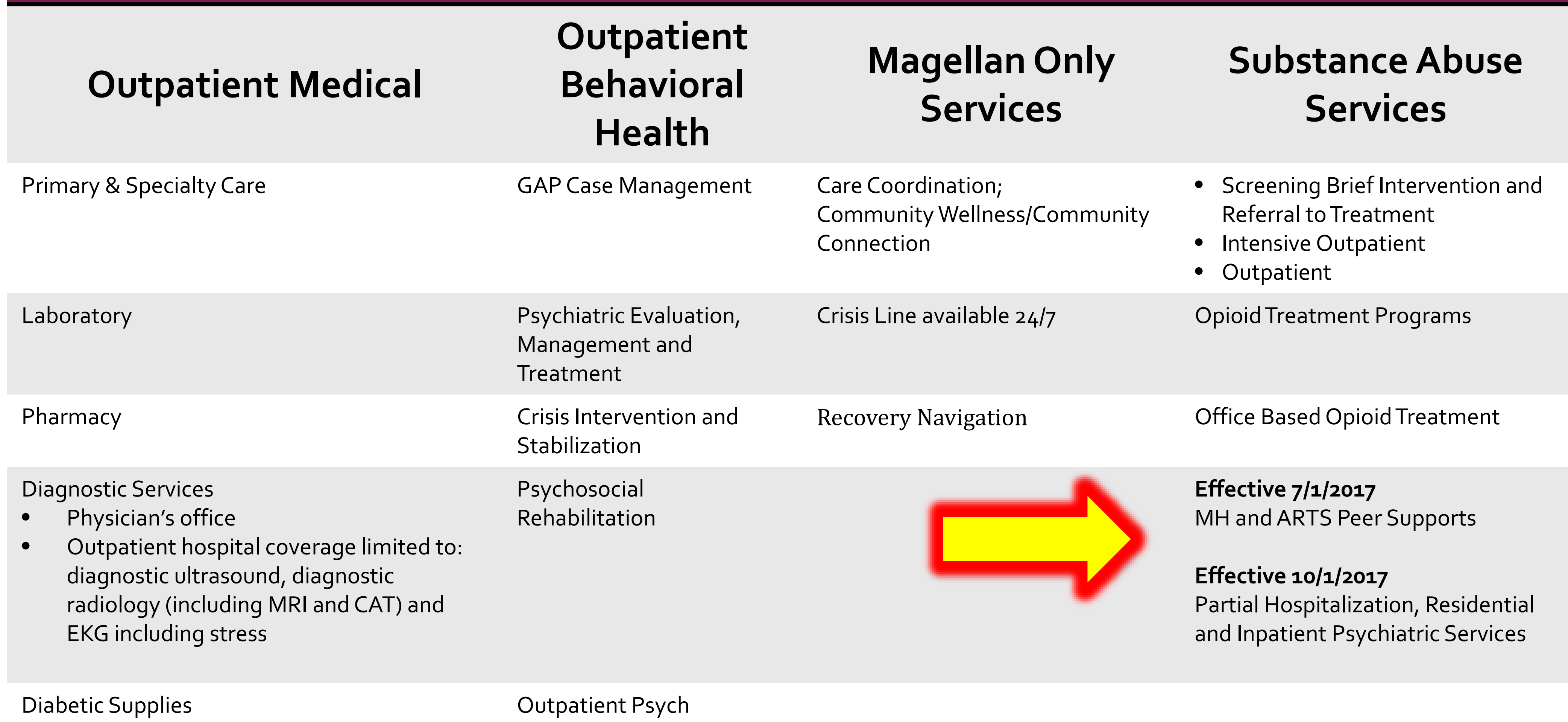
12,370 (266 localities represented)

16,662 Enrolled since 1/12/2015



Bridging the Mental Health Coverage GAP

GAP Benefits



Integrating care coordination, primary care, specialty care, pharmacy and behavioral health services			
Outpatient Medical	**Outpatient Behavioral Health**	**Magellan Only Services**	**Substance Abuse Services**
Primary & Specialty Care	GAP Case Management	Care Coordination; Community Wellness/Community Connection	• Screening Brief Intervention and Referral to Treatment • Intensive Outpatient • Outpatient
Laboratory	Psychiatric Evaluation, Management and Treatment	Crisis Line available 24/7	Opioid Treatment Programs
Pharmacy	Crisis Intervention and Stabilization	Recovery Navigation	Office Based Opioid Treatment
Diagnostic Services • Physician's office • Outpatient hospital coverage limited to: diagnostic ultrasound, diagnostic radiology (including MRI and CAT) and EKG including stress	Psychosocial Rehabilitation		**Effective 7/1/2017** MH and ARTS Peer Supports **Effective 10/1/2017** Partial Hospitalization, Residential and Inpatient Psychiatric Services
Diabetic Supplies	Outpatient Psych		

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FOLLOW-UP GAP QUESTIONS FROM SEPTEMBER 18TH

1. GAP continues to be a Medicaid fee-for-service benefit model. Why isn't it in the managed care environment?

To be in included in the managed care benefit model, the Managed Care Organizations (MCOs) need to be able to assume "full risk" for managing the benefits which requires them to be able to manage the full arena of Medicaid benefits. GAP is a limited medical benefit plan and thus the MCOs could not assume full risk.

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FOLLOW-UP GAP QUESTIONS FROM SEPTEMBER 18TH

2. What would it take to make it a full benefit plan?

The General Assembly would need to appropriate additional funding to allow the coverage of additional or all the benefits that Virginia Medicaid currently covers. The most frequently requested services that are not covered by GAP are inpatient (medical and psychiatric), emergency room services and transportation.

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FOLLOW-UP GAP QUESTIONS FROM SEPTEMBER 18TH

3. **Are there private, non-CSB providers serving GAP members?**

Yes. For both medical and behavioral health services.

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FOLLOW-UP GAP QUESTIONS FROM SEPTEMBER 18TH

4. Are there faith-based providers serving GAP members?

Magellan, DMAS' behavioral health service administrator, was able to provide us some information. They have over 600 providers (individuals, groups or organizations) that have self- identified as providing faith based services. Faiths that have been identified include Christian, Muslim, Latter Day Saints, Hindu, and Jewish. Most of the providers are private providers but there were some CSBs that noted they provide faith based services. Of those 600 providers, many of them have multiple sites/locations for providing faith based services.

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FOLLOW-UP GAP QUESTIONS FROM SEPTEMBER 18TH

5. What can be shown to demonstrate that the GAP program is successful?

The 1115 demonstration waiver from the federal government requires an evaluation to be completed by an independent evaluator. DMAS is in the process of negotiating with VCU and has submitted a budget request to fund this formal evaluation. Prior to this more formal evaluation, DMAS utilized outside experts at VCU, George Mason, and the Commissioner of the DBHDS to help us identify data trends (behavioral health, drugs and medical care utilized). DMAS has a monthly report on these trends. Unfortunately, because DMAS has no way of obtaining record of claims or treatment for GAP members who were uninsured prior to GAP, we were not able to do a more comprehensive evaluation. Anecdotally, providers have told us that they are being paid for serving a previously non- reimbursed population is one indicator of success. We also have evidence that care coordination is working based on the member stories.

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FOLLOW-UP GAP QUESTIONS FROM SEPTEMBER 18TH

6. Is Vivitrol covered by GAP?

Vivitrol is covered without Prior Authorization as a physician-administered drug for Medicaid Fee-for-Service members and GAP members with opioid use disorder or alcohol use disorder under the ARTS benefit. With the implementation of ARTS, all the Medicaid health plans voluntarily agreed to cover Vivitrol without Prior Authorization for opioid use disorder and alcohol use disorder as part of the ARTS benefit.

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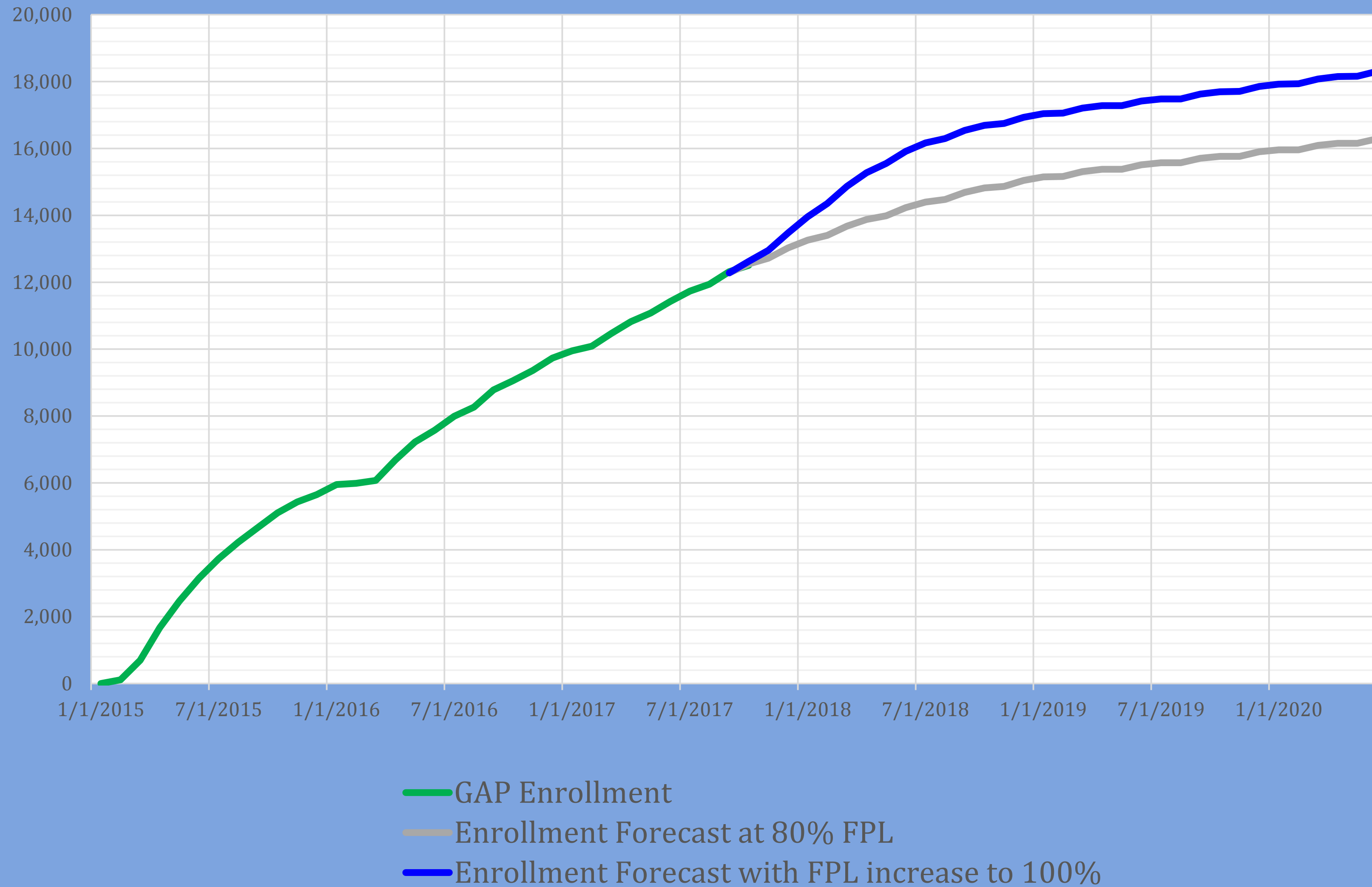
GAP Enrollment and Forecast



COST ESTIMATE QUESTIONS FOR GAP

Option 1: What would it cost to move existing GAP-eligible individuals to full Medicaid benefits and put them under Managed Care?

Moving GAP to Managed Care			
	Total Funds	**General Funds**	**Non-General Funds**
SFY19	$48,477,772	$24,238,886	$24,238,886
SFY20	$70,842,089	$35,421,044	$35,421,044

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COST ESTIMATE QUESTIONS FOR GAP

Option 2a: What would it cost to expand the existing GAP program to serve individuals with Substance Use Disorders?

Adding SUD as Diagnosis			
	Total Funds	**General Funds**	**Non-General Funds**
SFY19	$5,154,584	$2,577,292	$2,577,292
SFY20	$16,057,309	$8,028,654	$8,028,654

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COST ESTIMATE QUESTIONS FOR GAP

Option 2b: What would it cost to expand the existing GAP program to serve individuals with Substance Use Disorders and provide full Medicaid benefits under Managed Care?

Adding SUD as Diagnosis while Moving All to Full Benefit Managed Care			
	Total Funds	General Funds	Non-General Funds
SFY19	$57,358,229	$28,679,115	$28,679,115
SFY20	$99,467,840	$49,733,920	$49,733,920

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COST ESTIMATE QUESTIONS FOR GAP

Option 2 Administrative costs to be added to both a and b options

Administrative cost of adding SUD			
	Total Funds	**General Funds**	**Non-General Funds**
SFY19	$549,752	$183,374	$366,378
SFY20	$620,937	$169,072	$451,865

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COST ESTIMATE QUESTIONS FOR GAP

Option 3a: What would it cost to expand the existing GAP program to serve individuals with an expanded definition of Mental Illness?

Adding additional MI as Diagnosis			
	Total Funds	**General Funds**	**Non-General Funds**
SFY19	$2,458,692	$1,229,346	$1,229,346
SFY20	$7,659,739	$3,829,870	$3,829,870

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COST ESTIMATE QUESTIONS FOR GAP

Option 3b: What would it cost to expand the existing GAP program to serve individuals with an expanded definition of Mental Illness and provide full Medicaid benefits under Managed Care?

Adding additional MI as Diagnosis while Moving All to Full Benefit Managed Care			
	Total Funds	**General Funds**	**Non-General Funds**
SFY19	$52,713,674	$26,356,837	$26,356,837
SFY20	$84,497,307	$42,248,653	$42,248,653

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COST ESTIMATE QUESTIONS FOR GAP

Option 3 Administrative costs to be added to both a and b options

Administrative cost of adding additional MI DX			
	Total Funds	General Funds	Non General Funds
SFY19	$366,501	$122,250	$244,252
SFY20	$413,958	$112,715	$301,243

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COST ESTIMATE QUESTIONS FOR GAP

Current GAP Diagnoses

- Schizophrenia spectrum disorders and other psychotic disorder with the exception of substance/medication induced psychotic disorders
- Major depressive disorder
- Bipolar and related disorders with the exception of cyclothymic disorder
- Post-Traumatic Stress Disorder
- Other disorders including OCD, Panic Disorder, Agoraphobia, Anorexia nervosa, Bulimia nervosa

Additional Mental Illness Diagnoses That Could Be Covered

- Generalized Anxiety Disorder
- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder
- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
- Avoidant Personality Disorder
- Dependent Personality Disorder
- Obsessive-Compulsive Personality Disorder

For more information, please contact:

BridgetheGAP@dmas.virginia.gov

http://www.dmas.virginia.gov/Content_pgs/gap.aspx

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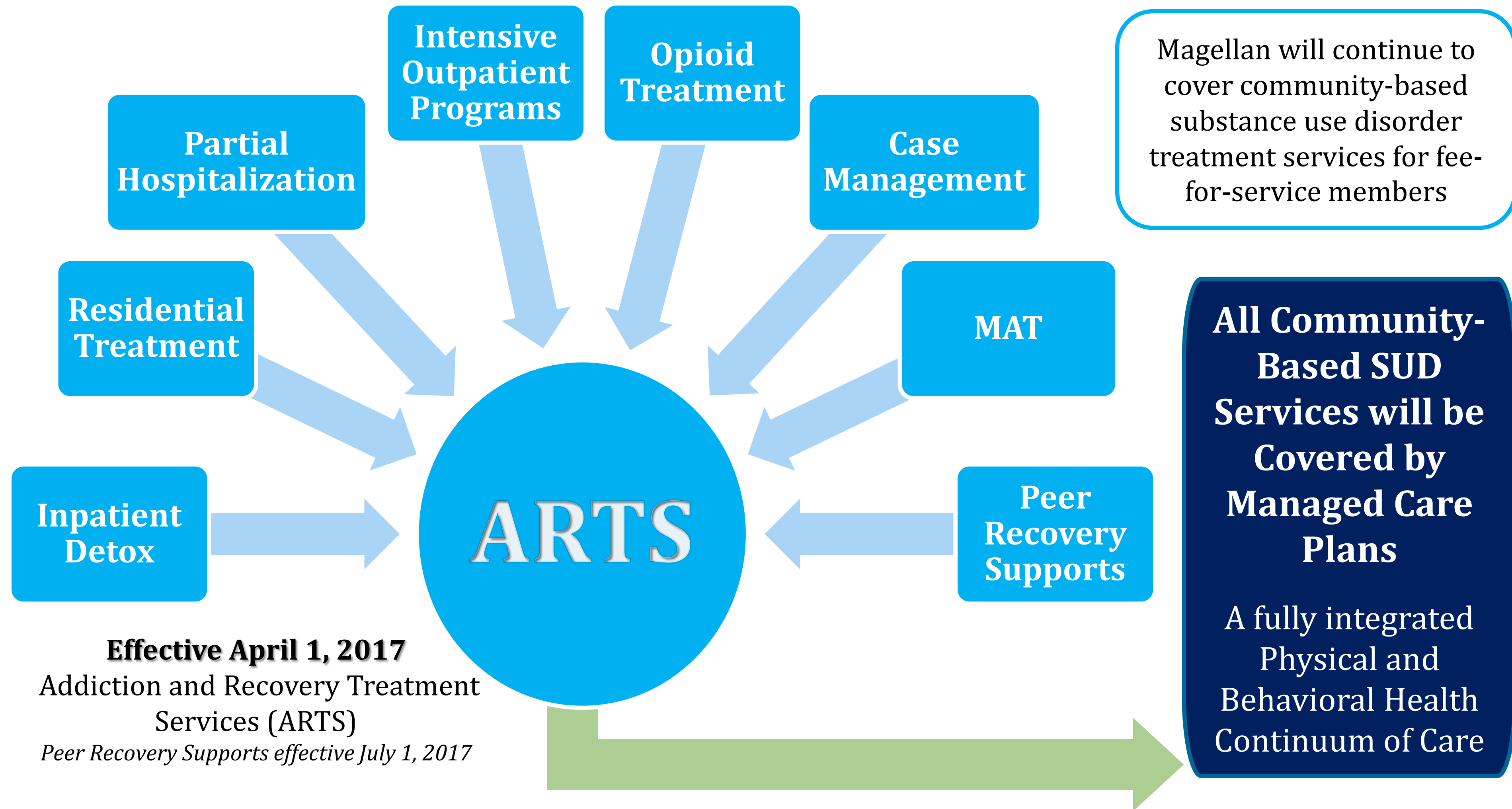
ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)

How Did We Get Here? A Brief Recap

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. Provide Provider Education, Training, and Recruitment Activities

Reforming the Current Delivery System for Community-Based Services



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Medicaid and FAMIS Coverage for Individuals with SUD

SUD Service	Children < 21	Adults*	Pregnant Women
Traditional Services			
Inpatient Detox	Covered	Added	Added
Outpatient Therapy	Covered	Covered	Covered
Medication Assisted Treatment (MAT)	Rate Increase	Rate Increase	Rate Increase
Community-Based Services			
Residential**	Rate Increase	Added	Rate Increase
Partial Hospitalization	Rate Increase	Rate Increase	Rate Increase
Intensive Outpatient	Rate Increase	Rate Increase	Rate Increase
Case Management / Care Coordination	Rate Increase	Rate Increase	Rate Increase
Peer Supports	Not Covered	Added	Added

*Dual eligible individuals have coverage for inpatient and residential treatment services through Medicare.

**DMAS seeking to waive the CMS IMD ruling which limits coverage for RTC to facilities with 16 beds or fewer.

Note: **FAMIS** coverage does not include residential treatment. **GAP** does not cover Inpatient Services in Acute Care Setting.

Services Highlighted in Yellow were added by the 2016 Appropriations Act

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Coverage of Pharmacotherapy for Opioid Use Disorder and Alcohol Use Disorder

Medication	Prior Authorization Required
Buprenorphine/Naloxone and Buprenorphine (for pregnant women only)	**Induction (7 days) – no** Maintenance - yes
Methadone	No (for opioid use disorder)
Naltrexone Long-Acting Injection (Vivitrol)	No
Naltrexone (oral)	No
Naloxone	No
Disulfiram	No
Acamprosate	No

Note: Prior Authorizations are not required for buprenorphine/naloxone or buprenorphine provided by Preferred Office-Based Opioid Treatment (OBOT) Providers or Opioid Treatment Programs (OTPs) credentialed by health plans.

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Increases in Addiction Providers Due to ARTS

Over **350 new addiction treatment** provider organizations in Medicaid.
Over a **two fold increase** in workforce capacity!

Addiction Provider Type	# of Providers before ARTS	# of Providers after ARTS	% Increase in Providers
Inpatient Detox (ASAM 4.0)	Unknown	103	NEW
Residential Treatment (ASAM 3.1, 3.3, 3.5, 3.7)	4	78	↑ 1850%
Partial Hospitalization Program (ASAM 2.5)	0	13	NEW
Intensive Outpatient Program (ASAM 2.1)	49	72	↑ 47%
Opioid Treatment Program	6	29	↑ 383%
Office-Based Opioid Treatment Provider	0	55	NEW

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Key Findings
First Quarter of ARTS Implementation

- **Treatment rates** among Medicaid members with substance use disorders (SUD) **increased by 50%**
- The **number of practitioners providing outpatient psychotherapy or counseling** to Medicaid members **more than doubled**:
  - Treating Opioid Use Disorder (OUD) - **300 to 691 practitioners**
  - Treating SUD - **667 to 1,603 practitioners**

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

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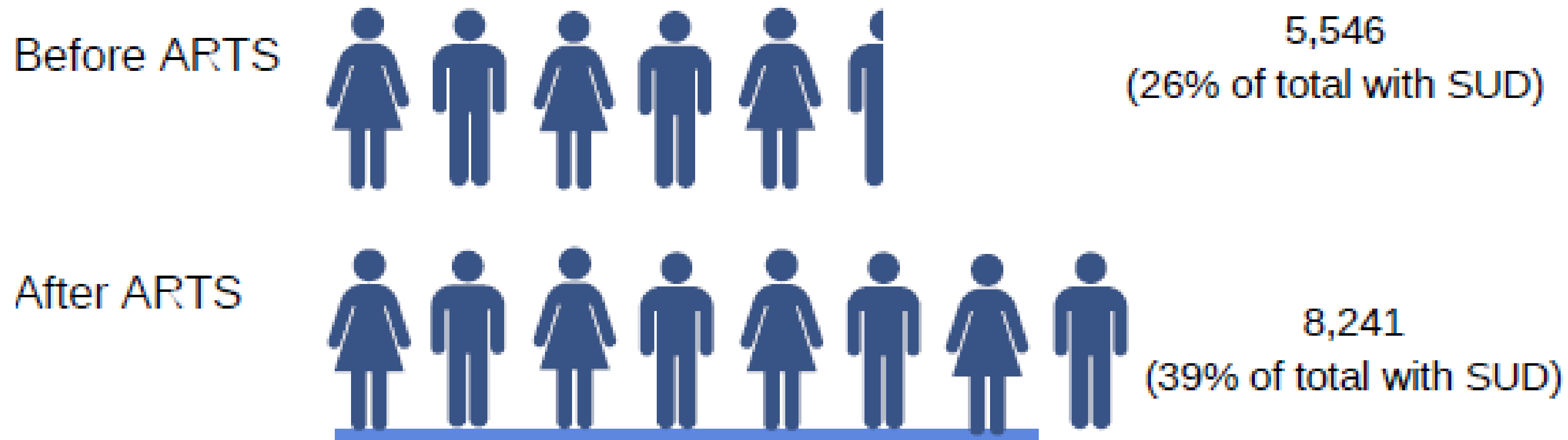
ARTS Narrows the Treatment GAP



Prevalence of members with SUD is likely higher than the estimates in this report because they include only those who have been diagnosed or treated for SUD.

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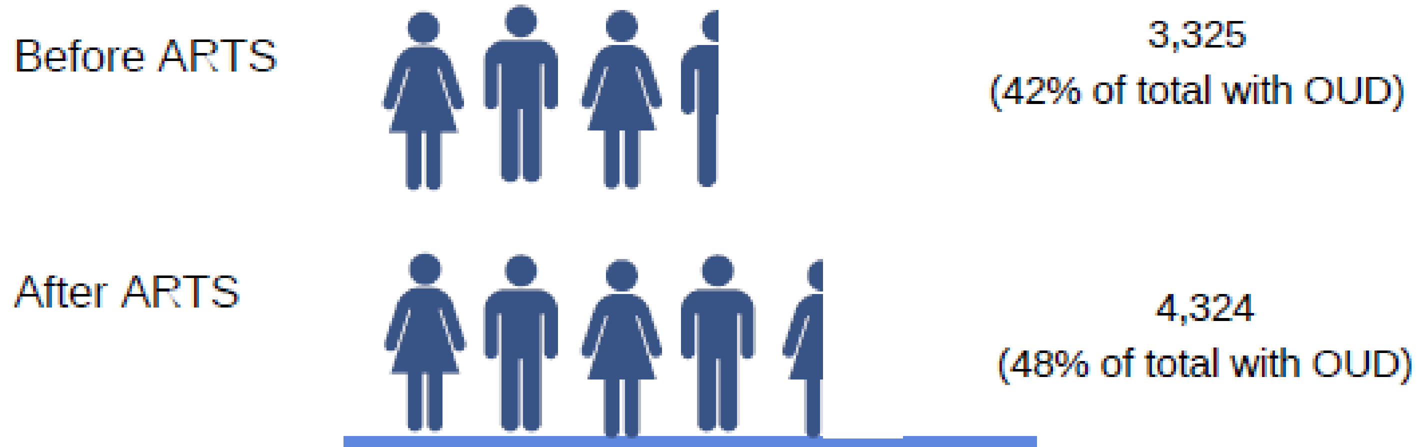
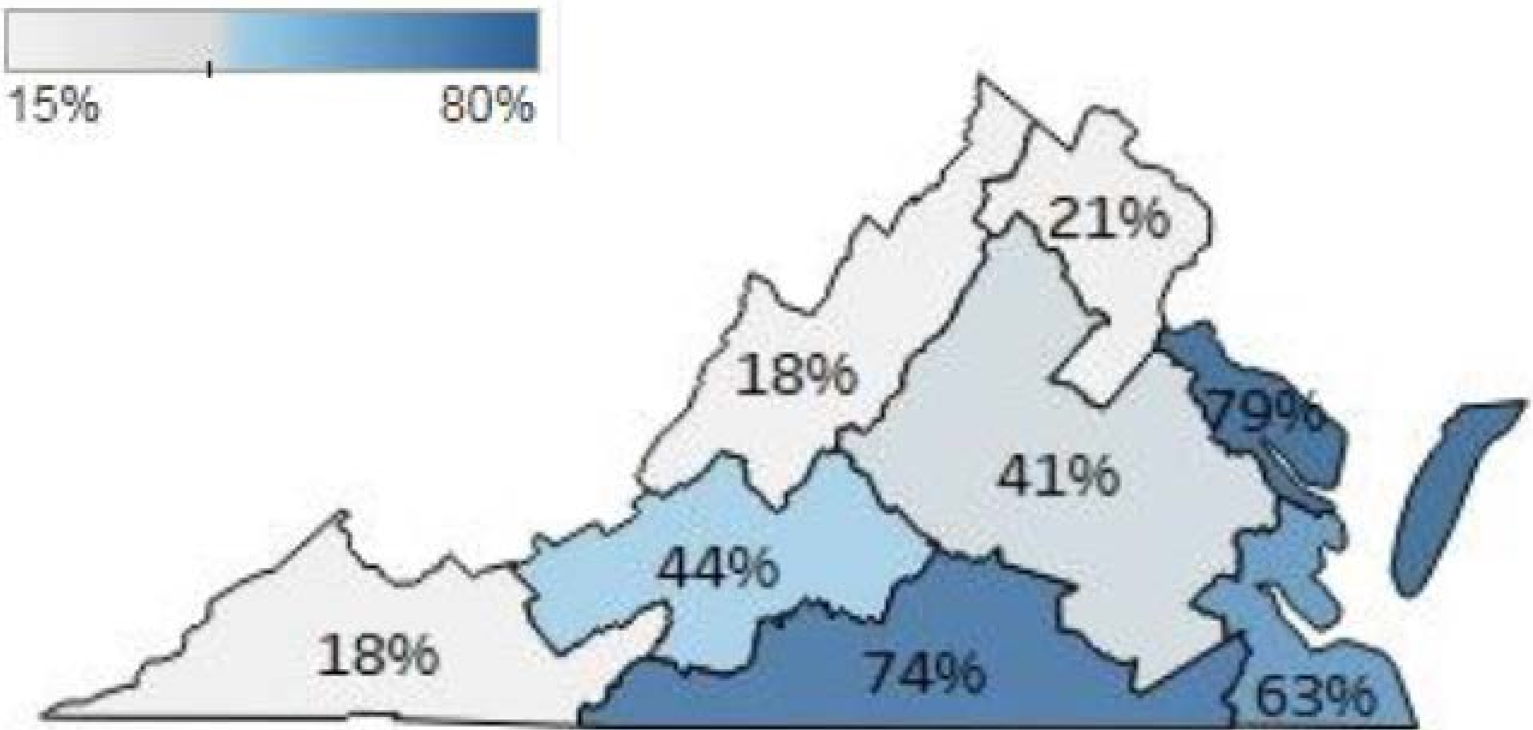
ARTS Narrows the Treatment GAP



Pharmacotherapy for Opioid Use Disorder Increasing



ARTS **significantly increased** the number of Medicaid members receiving **pharmacotherapy for OUD** in all regions in Virginia.

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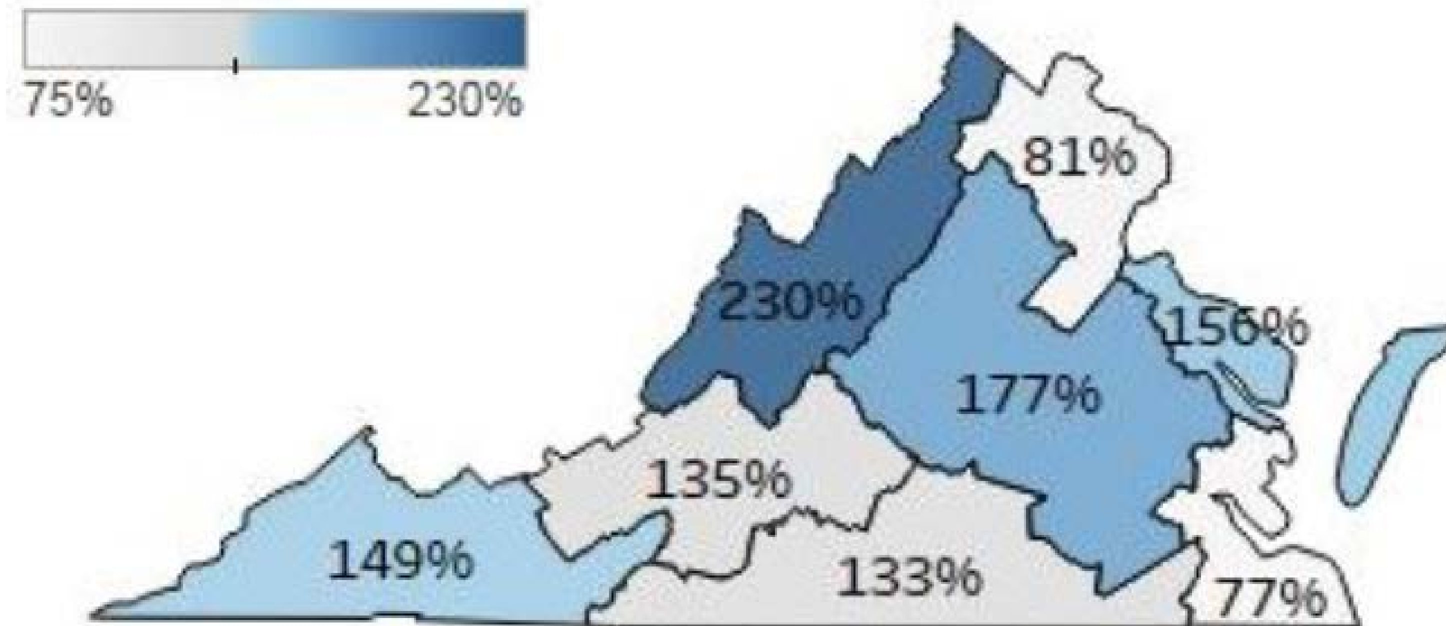
Number of Outpatient Providers Treating OUD More than Doubled



During the first three months, **ARTS has reduced the treatment gap** for SUD by **increasing the number of practitioners** providing services for SUD **across all regions** in Virginia!

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Implementation of CDC Opioid Prescribing Guideline in Medicaid Fee-for-Service and all MCOs

- Uniform, Stream-lined Prior Authorization Forms for
  - All Short acting opioids > 7 days or 90 MME and long-acting opioids
  - Requires PMP check and urine drug screen
- Increase access to Naloxone
  - Naloxone injection and Naloxone nasal spray (Narcan®) available **without PA** and no quantity limits
- Include **non-opioid pain relievers** on all MCO formularies **without PA**
  - Lidocaine patches
  - Capsaisin topical gel
  - SNRIs including duloxetine
  - Gabapentin and pregabalin (Lyrica®)
  - NSAIDs including oral and topicals (diclofenac gel)
  - Baclofen
  - Tricyclic antidepressants (TCAs)
  - Buprenorphine patches and buccal film for pain (requires PA)

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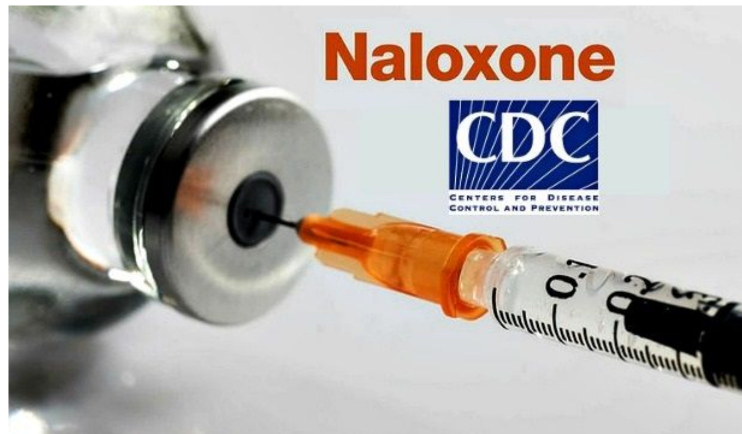
Opioid Overdose Fatality Prevention

Increase Access to Naloxone

- FFS and Managed Care Plans Expand Naloxone Coverage
- Prior Authorization **not** required for
  - Naloxone injection
  - Naloxone (Narcan®) nasal spray



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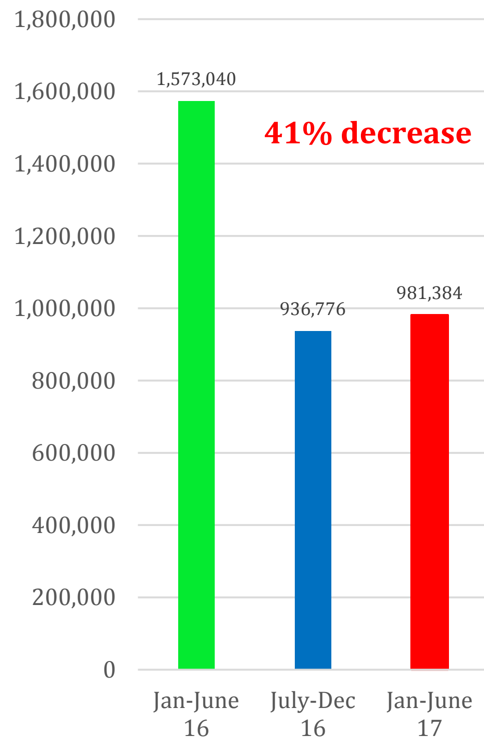
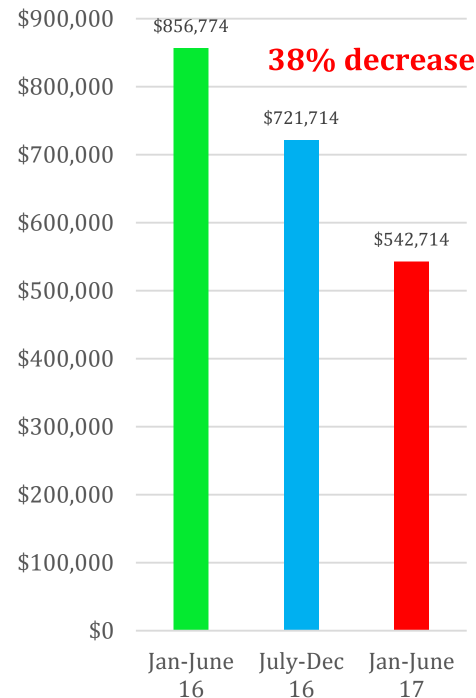
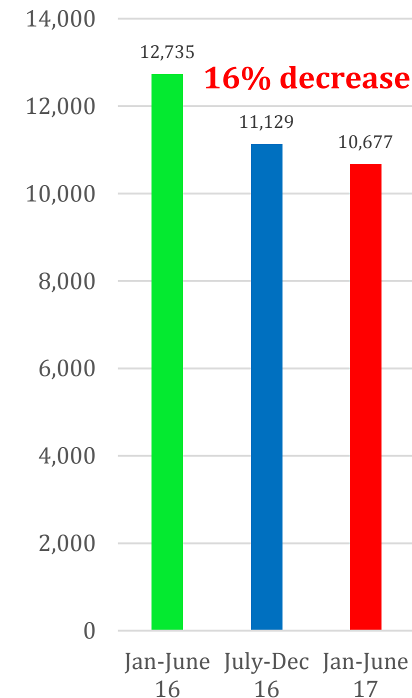
Decrease in Opioid Rx and Costs After CDC Opioid Prescribing Guideline Implemented 7/1/16

Medicaid Fee-for-Service Opioid Utilization







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