



# COMMONWEALTH of VIRGINIA

*Substance Abuse Services Council*

P. O. Box 1797

Richmond, Virginia 23218-1797

December 1, 2021

To: The Honorable Ralph Northam, Governor

and

Members, Virginia General Assembly

The 2004 Session of the General Assembly amended §2.2-2697.B. of the *Code of Virginia*, to direct the Substance Abuse Services Council (referred to as the Council in this report) to collect information about the impact and cost of substance use disorder treatment provided by public agencies in the Commonwealth. In accordance with that language, please find attached the *Substance Use Disorder Services Council Report on Treatment Programs for FY 2021*.

Sincerely,

A handwritten signature in black ink that reads "John J. Bell".

Senator John J. Bell, District 13, Senate of Virginia

xc: The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources  
The Honorable Brian J. Moran, Secretary of Public Safety and Homeland Security  
Alison Land, Commissioner, Department of Behavioral Health and Developmental Services  
Harold W. Clarke, Director, Department of Corrections  
Valerie Boykin., Director, Department of Juvenile Justice  
Karen Kimsey, Director, Department of Medical Assistance Services

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**SUBSTANCE USE DISORDER SERVICES COUNCIL  
REPORT ON TREATMENT PROGRAMS FOR FY  
2021  
(Code of Virginia § 2.2-2697)**

*to the Governor and  
the  
General Assembly*



***COMMONWEALTH OF VIRGINIA***

**December 1, 2021**

## Preface

Section 2.2-2697.B of the Code of Virginia directs the Council to report by December 1 to the Governor and the General Assembly information about the impact and cost of substance use disorder treatment provided by each agency in state government. The specific requirements of this section are below and have been revised to use non-stigmatizing language based on the Centers for Disease Control Health Equity Style Guide:

*§ 2.2-2697. Review of state agency substance use disorder treatment programs and recovery services.*

*B. Beginning in 2006, the Comprehensive Interagency State Plan shall include the following analysis for each agency-administered substance use disorder treatment program and recovery services:*

- (i). the amount of funding expended under the program for the prior fiscal year;*
- (ii). the number of individuals served by the program using that funding;*
- (iii). the extent to which program objectives have been accomplished as reflected by an evaluation of outcome measures;*
- (iv). identifying the most effective substance use disorder treatment and recovery services, based on a combination of per person costs and success in meeting program objectives;*
- (v). how effectiveness could be improved;*
- (vi). an estimate of the cost effectiveness of these programs; and*
- (vii). recommendations on the funding of programs based on these analyses.*

**SUBSTANCE USE DISORDER SERVICES COUNCIL  
REPORT ON TREATMENT PROGRAMS FOR FY  
2021**

**TABLE OF CONTENTS**

Introduction.....	2
Department of Behavioral Health and Developmental Services .....	4
Department of Juvenile Justice .....	9
Department of Corrections.....	12
Department of Medical Assistance Services.....	17

# SUBSTANCE USE DISORDER TREATMENT AND RECOVERY SERVICES COUNCIL REPORT ON TREATMENT PROGRAMS FOR FY 2021

## Introduction

This report summarizes information from the four executive branch agencies that provide substance use disorder treatment and recovery services: The Department of Behavioral Health and Developmental Services (DBHDS), the Department of Juvenile Justice (DJJ), the Department of Corrections (DOC) and the Department of Medical Assistance Services (DMAS). These agencies share the common goals of increasing the health and wellness of Virginia's individuals, families, and communities, increasing access to substance use disorder treatment and recovery services, and reducing the impact of those with a substance use disorder and involvement in the criminal justice system. All of the agencies included in this report are invested in providing evidenced-based treatment and recovery services to their populations within the specific constraints each has on its ability to provide these services. In this report, the following information is detailed concerning each of these four agencies' substance use disorder treatment programs:

1. Amount of funding spent for the program in FY 2021;
2. Unduplicated number of individuals who received services in FY 2021;
3. Extent to which program objectives have been accomplished as reflected by an evaluation of outcome measures;
4. Identifying the most effective substance use disorder treatment;
5. How effectiveness could be improved;
6. An estimate of the cost effectiveness of these programs; and
7. Funding recommendations based on these analyses.

As used in this document, treatment means those services directed toward individuals with identified substance use disorders and does not include prevention services. This report provides information for Fiscal Year 2021, which covers the period from July 1, 2020 through June 30, 2021.

### *Treatment Programs for FY 2021*

This report provides focused data on specific outcomes. Every opioid overdose death represents many affected individuals, and every individual who commits a crime associated with substance use disorder represents many others who are also involved.<sup>1</sup> Many of these individuals are struggling with functional impairment due to their substance use disorder and this is reflected in decreased workforce participation,<sup>2</sup> negative impact on the economy,<sup>3</sup> the potential for

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<sup>1</sup> Virginia Department of Health: Office of the Chief Medical Examiner. (2021). *Fatal Drug Overdose Quarterly Report*. Retrieved from <https://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology/>

<sup>2</sup> Over the last 15 years, LFP fell more in counties where more opioids were prescribed." Alan B. Krueger; BPEA Article; Brookings Institute; Thursday, September 7, 2017; "Where have all the workers gone? An inquiry into the decline of the U.S. labor force participation rate"; <https://www.brookings.edu/bpea-articles/where-have-all-the-workers-gone-an-inquiry-into-the-decline-of-the-u-s-labor-force-participation-rate/>

<sup>3</sup> Midgette, Gregory, Steven Davenport, Jonathan P. Caulkins, and Beau Kilmer, What America's Users Spend on

dissemination of blood borne diseases,<sup>4</sup> and recidivism.

While we are thankful for the inclusion of Methamphetamine treatment in the monies allocated for 2020, it should be noted that singling out specific substances such as opioids, methamphetamines, or other “unfunded” substances, fails to recognize substance use disorder as being non-substance specific. In turn, this leads to “chasing” one drug or another similar to squeezing a balloon – if it gets small on one end, it will get bigger on the other. This results in duplicated services, wasted money, and poor outcomes.

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Illegal Drugs, 2006–2016. Santa Monica, CA: RAND Corporation, 2019.

[https://www.rand.org/pubs/research\\_reports/RR3140.html](https://www.rand.org/pubs/research_reports/RR3140.html). Also available in print form.

<sup>4</sup> County-Level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections Among Persons Who Inject Drugs, United States; Buchanan et. al. MJAIDS Journal of Acquired Immune Deficiency Syndromes: [November 1, 2016 - Volume 73 - Issue 3 - p 323–331](#) doi: 10.1097/QAI.0000000000001098  
Epidemiology and Prevention

## Department of Behavioral Health and Developmental Services (DBHDS)

The publicly funded behavioral health and developmental services system provides services to individuals with mental illness, substance use disorders, developmental disabilities, as well as co-occurring disorders through state hospitals and training centers operated by DBHDS, as well as 40 community services boards (CSBs) and a network of collaborative private providers. CSBs were established by Virginia's 133 cities or counties pursuant to Chapters 5 or 6 of Title 37.2 of the Code of Virginia. CSBs provide services directly to their population and through contracts with previously mentioned private providers, which are vital partners in delivering services.

Summary information regarding these services is presented below.

### 1. Amount of Funding Spent for the Program in FY 2021.

Expenditures for substance use disorder treatment services totaled \$196,596,267. This amount includes state and federal funds, local funds, fees and funding from other sources. The table below provides details about the sources of these funds.

<b>Expenditures for Substance Use Disorder Treatment Services by Source</b>	
State Funds	\$52,187,181
Local Funds	\$47,349,530*
Medicaid Fees	\$23,582,142
Other Fees	\$7,855,362*
Federal Funds	\$60,297,941
Other Funds	\$5,324,111*
<b>Total Funds</b>	<b>\$196,596,267</b>

\*Local Funds and Other Fees may have been utilized to support prevention activities.

### 2. Unduplicated Number of Individuals Who Received Services in FY 2021.

A total of 25,255 unduplicated individuals received substance use disorder treatment services supported by this funding in FY 2021.

### 3. Extent Program Objectives Have Been Accomplished as Reflected by an Evaluation of Outcome Measures.

Currently, DBHDS uses the following substance use disorder services quality measures for each CSB:

- **Intensity of Engagement in Substance Use Disorder Outpatient Services:** Intensity of engagement is measured by calculating a percentage. The denominator is the number of adults admitted to the substance use disorder services program area during the previous 12 months who received 45 minutes of outpatient treatment services after admission. The numerator is the number of these individuals who received at least an additional 1.5 hours of outpatient services within 30 days of admission. In FY21, almost two-thirds, 62 percent,

of all adults received at least 1.5 hours of additional outpatient services within 90 days of admission.

- **Retention in Community Substance Use Disorder Services:** Retention is measured by calculating a percentage at two points in time, three months and six months following admission. The denominator is the number of all individuals admitted to the substance use disorder services program area during the 12 months who received at least one valid substance use disorder or mental health service of any type in the month following admission. The numerator for retention at three months is the number of these individuals who received at least one valid mental health or substance use disorder service of any type every month for at least the following two months. The numerator for retention at six months is the number of these individuals who received at least one valid mental health or substance use disorder service of any type every month for at least the following five months. The 2021 three-month percentage for this measure was 67 percent retention (up from 61 percent last fiscal year). The six-month percentage for this measure was 42.5 percent retention (up from 32 percent last fiscal year). In calculating this measure, valid substance use disorder services do not include residential detoxification services or those services provided in jails or juvenile detention centers.

#### 4. Identifying the Most Effective Substance Use Disorder Treatment.

The sometimes chronic, relapsing nature of substance use disorder, often resulting in non-linear pathways to sustained recovery, makes identifying the most effective type of treatment difficult. Evidence-based treatment for substance use disorders consists of an array of modalities and interventions. Additionally, these modalities are presented and used through a lens of person centered treatment planning and therefore are tailored to the specific needs of each individual seeking treatment, coupled with their ASAM criteria (assessment of level of need) and partnered with their willingness to participate. Other factors, such as legal status, probation requirements, transportation difficulties, family expectations/responsibilities, and co-occurring behavioral health and medical issues further complicate measures of effectiveness across populations.

Additionally, the lack of a consistently available array of services across Virginia may cause additional stressors. The factors mentioned above can make it difficult to match individuals to the appropriate level of care. Virginia continues to work on system transformation through initiatives such as STEP VA and Project BRAVO in order to address and correct the inconsistency of available services and support individuals in care by ensuring appropriate reimbursement and coverage rates with ARTS and Medicaid expansion.

The deadly opioid overdose epidemic that began in the mid-2000s and resulted in 1,915 deaths in calendar year 2020<sup>5</sup> continues to drive home the need for comprehensive, expansive, and evidenced based treatment for all individuals and their families. Current information indicate a significant rise in opioid related overdoses across Virginia within the last year. While this data is still being collected and reviewed DBHDS continues to actively support our CSB partners in providing medication-assisted treatment (MAT), the evidence-based standard of care for opioid

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<sup>5</sup> Office of the Chief Medical Examiner Forensic Epidemiology All Opioids Table available at: <http://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology/>



use disorder through time-limited federal grant funding, as it is costly to provide.

Furthermore, Virginia, like the rest of the United States, is seeing a rise in Methamphetamine use.<sup>6</sup> This is to be expected, as substance use disorder *is not* substance specific. Failure to treat substance use disorder in its totality using Evidence Based practices will continue to result in the loss of life, misuse of resources due to being restricted to specific drug types, and community wide impact related to the continued spread of use and other complicating factors.

## **5. How Effectiveness Could be Improved.**

Successful healthcare outcomes are dependent on individuals receiving the appropriate level of care for their needs as well as a holistic approach to them as an individual. CSBs continue to experience level funding from federal and state sources. However, DBHDS is moving toward significant changes in funding structure as well as the implementation of an invoicing system for payment of services to allow for better use of funding across the state and better tracking at the state level. However, the funding streams used for services remain, in some cases, restrictive based on substance used and therefore create difficulties in the treatment system related to allocations for funds across all populations. It is important to note, these services require more time and skill to implement successfully and often require the services of medical and counseling staff trained in specific treatment models appropriate for the individual's needs and concerns, such as trauma-informed care or co-occurring disorders. This leads to the rise in costs for service.

Furthermore, individuals seeking and needing services frequently experience other life issues that present barriers to successful recovery such as lack of transportation, lack of childcare, unsafe housing, or serious health or mental health issues create dynamics that may be difficult for providers to address depending on their available service array. Successful treatment programs require personnel and resources to help individuals in care address these problems across many populations. Increased access to safe and equitable transportation assistance, opportunities to participate in supportive employment programs, and secure housing options are imperative to successful consumer engagement and sustainment in treatment options as well as helping to bolster a recovery-oriented approach to all services.

For providers to remain educated, supported, and clinical efficient ongoing dedicated funding related to continuing clinical training in support of the use of evidenced based practices across the Commonwealth is imperative to provide sustainable support of clinical expertise and goals within the existing workforce already heavily influenced by other factors in Virginia.

To support system change, DBHDS continues to move toward and support a data driven, outcomes based approach coupled with quality improvement initiatives at state and provider levels. DBHDS has developed a quality improvement process for CSBs that includes technical assistance in a comprehensive way based on areas of need. A data driven platform to improve program effectiveness can be developed through focusing on quality improvement and funding substance abuse services at a level adequate to make an expanded continuum of care and array of evidence-based practices available across the state.

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<sup>6</sup> 116<sup>th</sup> Congress second session S4491 To designate methamphetamine as an emerging threat, introduced by Ms. Feinstein and Mr. Grassley

Continued work to move toward ongoing training and support of evidence-based models of treatment for individuals with the disease of addiction will initially require more resources, but will eventually result in lowered costs. Like any other disease, incorrect diagnoses result in incorrect treatment resulting in poor outcomes. With this in mind, DBHDS is partnering with DMAS to provide ongoing ASAM training for providers to ensure the appropriate levels of care for the individual being served. With increased access to evidence based treatment for the disease of addiction, we expect to see better functioning workers and increased tax revenues, decreased crime, decreases associated medical costs (HIV, Hepatitis C, endocarditis resulting in valve replacement, Neonatal abstinence syndrome, trauma and accidents, etc.), improved life expectancy and a happier more productive population.

## **6. An Estimate of the Cost Effectiveness of These Programs.**

It remains difficult to assess and make recommendations on the cost effectiveness of programs as they vary across the state and as those struggling with addiction may have many different levels of functioning and many different needs for care and treatment. Access to a level of care that does not provide adequate intensity or duration cannot produce cost effective outcomes. However, with a person centered approach and a holistic view of individuals, the choice of the individual seeking services and the level of care that meets their current life circumstances must be evaluated.

## **7. Funding Recommendations.**

The Department of Medical Assistance Services (DMAS) continues to offer a waiver that supports a wide array of treatment services for individuals with substance use disorders, based on criteria developed by the American Society of Addiction Medicine. This array included improved access to medication-assisted treatment for individual with opioid use disorder. DBHDS continues to use the SAMHSA SOR funds to support, improve, and develop services that are more comprehensive across prevention, treatment, and recovery services state wide where needed. It is important to note that FY21's federal fiscal year is the second and possibly last year related to SOR funding and the systems and programs that SOR supports will need to be proactively planning for how to support services in case this funding is not renewed at the federal level. Medicaid expansion, which became effective January 1, 2019, continues to help support some needed infrastructure development, such as provider training to support implementation of evidence-based practices. However, a portion of Virginia's population has income greater than 138 percent of Federal Poverty Level (income eligibility threshold effective January 1, 2019), but cannot afford to purchase private insurance. This population combined with those who do not qualify for Medicaid Expansion remain in need of resources and services.

DBHDS also recently was awarded state funds in the amount of \$5 million to be spent to support substance use treatment. This funding, not restricted by substance, will allow for innovative support of the substance use disorder services system in a comprehensive way and help to address several holes in services such as transition aged youth (18 – 25) and intellectually disabled individuals who are struggling with substance use.

It is important to note that this period of time includes a significant impact on the state

related to COVID-19. DBHDS wants to highlight that throughout the course of the still ongoing pandemic, providers of services across the commonwealth a) pivoted quickly to telehealth as needed, b) allowed take home doses for MAT as needed, and c) worked diligently to engage individuals and continue that engagement in services through a number of innovative and progressive ways not previously included in treatment allowances prior to the pandemic. Substance use providers indicated more significant engagement by their populations due to telehealth. However, the overdose rate in Virginia is now at an all-time high and state and local government systems are engaged in way to pivot once again to better address this issue.

## **Department of Juvenile Justice (DJJ)**

The Department of Juvenile Justice (DJJ) provides and contracts with mental health / substance abuse treatment providers to conduct substance abuse treatment services to youth under community supervision and in direct care status who are assessed as needing substance abuse treatment. Youth in direct care status receive those services in a variety of settings including Bon Air Juvenile Correctional Center (JCC), Community Placement Programs at local detention facilities, and contracted residential treatment centers.

DJJ also manages Virginia Juvenile Community Crime Control Act (VJCCCA) funds, which are administered through a formula grant to all 133 cities and counties in the Commonwealth. Each locality or grouping of localities develop biennial plans for the use of VJCCCA funds that are consistent with the needs of their communities. Code changes that went into effect in July 2019 allow localities to incorporate prevention services into future biennial plans. The current biennial began on July 1, 2020. Of the 76 local VJCCCA plans, during FY 2021, 16 local plans included funds budgeted for programming or services in the category of substance abuse education.

As in previous annual reports, the information below focuses on the substance abuse treatment services provided by DJJ to direct care youth meeting the appropriate criteria at Bon Air Juvenile Correctional Center (JCC).

### **1. The Amount of Funding Expended for the Program in FY 2021.**

#### Bon Air JCC Programs:

Substance Abuse Services Expenditures: \$692,848

Total Residential Division Expenditures\*: \$36,152,884

\* Total division expenditures exclude closed facilities as well as the Virginia Public Safety Training Center (VPSTC) and all related costs to the VPSTC.

### **2. The Number of Individuals Served by the Program Using that Funding in FY 2021.**

In FY 2021, 145 (88.4%) of the 164 residents admitted to direct care were assigned a substance abuse treatment need. Youth can be assigned to Track I or Track II to reflect their individual needs. Track I is for juveniles meeting the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for Substance Use Disorder and in need of intensive services. Track II is for juveniles who have experimented with substances but do not meet the DSM criteria for Substance Use Disorder. Of the 164 youth admitted, 70.7% were assigned a Track I treatment need, and 17.7% were assigned a Track II treatment.

These youth may have received treatment at Bon Air JCC or at other direct care placements.

### **3. Extent to Which Program Objectives Have Been Accomplished as Reflected by an Evaluation of Outcome Measures.**

DJJ calculates 12-month rearrest rates for residents who had an assigned substance abuse treatment need. Rates are calculated based on a rearrest for any offense, excluding technical

violations. The substance abuse treatment need subgroup of direct care releases includes juveniles with any type of substance abuse treatment need. An assigned treatment need does not indicate treatment completion. The most recent rearrest rates available are for youth released during FY 2019.

Rearrest rates are slightly lower for all juveniles than for those with a substance abuse treatment need. In FY 2019, 55.3% of residents with a substance abuse treatment need were rearrested within 12 months of release, as compared to 54.4% of all residents. In FY 2018, 56.9% of residents with a substance abuse treatment need were rearrested within 12 months of release, as compared to 55.9% of all residents. Rearrest rates for residents with a substance abuse treatment need reflect rearrests for any offense, not specifically a drug offense.

While recidivism rates provide some insight to the effectiveness of programs, the rates presented here cannot be interpreted as a sound program evaluation due to a number of limitations. DJJ has begun to collect treatment completion data to determine if a juvenile actually completed treatment, but recidivism rates based on treatment completion are not yet available. Additionally, residents with assigned treatment needs may have risk characteristics different from those not assigned a treatment need; because juveniles are assigned treatment needs based on certain characteristics that distinguish them from the rest of the population, there is no control group for treatment need. Finally, data on whether reoffenses are substance-related are not available at this time.

As treatment program completion data matures, DJJ will analyze recidivism rates of program completers compared to non-completers. DJJ is also working with its partners in recidivism data collection (State Police, Virginia Criminal Sentencing Commission, Department of Corrections, and the State Compensation Board) to collect reoffense description data that will allow for analyses based on substance-related reoffenses.

#### **4. Identifying the Most Effective Substance Use Disorder Treatment.**

Per person costs cannot be determined because a large amount of the money allotted to substance abuse programming goes toward the salaries of staff who act as counselors and facilitators of the program. These staff also administer aggression management and sex offender treatment and perform other tasks within the behavioral services unit (BSU). Staff members perform different sets of duties based on their individual backgrounds and current abilities. Staff do not devote a clear-cut percentage of their time to each duty, but rather adjust these percentages as needed; therefore, there is no way to calculate how much of a staff member's pay goes directly toward substance abuse programming, and per person cost cannot be determined.

#### **5. How Effectiveness Could be Improved.**

DJJ is continuing to implement evidence-based programming, including Cannabis Youth Treatment (CYT) and individualized treatment plans for residents with co-occurring disorders. Reentry systems and collaboration with community resources and families should continue to be strengthened to ensure smooth transition of residents to the community. On the horizon for 2022, DJJ residential services is exploring grant options to import prevention and cessation programs related to vaping, e-cigarettes, and tobacco use.

**6. An Estimate of the Cost Effectiveness of These Programs.**

Due to an inability to calculate per person costs, estimates are not available to address this issue.

**7. Recommendations on the Funding of Programs.**

Program funding for youth in direct care with substance abuse treatment needs should continue. Addressing these needs is an important aspect of youth's overall treatment and preparation for reentry to their home communities.

## Virginia Department of Corrections (VADOC)

### 1. Amount of Funding Spent for the Programs in FY 2021.

Treatment services expenditures totaled \$8,620,238 for FY 2021. The table below displays how these funds were expended across VADOC programs.

*\*\*The COVID-19 pandemic has impacted the delivery of programs in congregate settings; virtual services and a hybrid approach to treatment has been a necessary modification.\*\**

Community Corrections Substance Abuse		\$1,846,039
Spectrum Health		\$5,032,812
Appalachian CCAP	\$505,512	
Brunswick CCAP	\$588,060	
Cold Springs CCAP	\$588,060	
Indian Creek/Greenville Work Center	\$2,161,104	
State Farm Work Center	\$665,892	
VCCW	\$524,184	
Facilities (previously RSAT funded)		\$909,600
RSAT Grant (federal and state match)		\$75,017
State Opioid Response Grant (federal funded)		\$527,773
MAT Navigators		\$228,998
<b>Total</b>		<b>\$8,620,238</b>

### 2. Unduplicated Number of Individuals Who Received Services in FY 2021.

As of June 30, 2021, there were 66,337 probationers/parolees under active supervision in the community. This data includes participants in the Community Corrections Alternative Programs (CCAPs) and those on Shadowtrack Supervision. The VADOC utilizes the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) assessment tool for risk assessment and service planning. Information collected from this process indicates that approximately 65.6 percent of those under active supervision have some history of substance use disorder according to COMPAS, indicated as probable or highly probable on the Substance Abuse subscale. Treatment services are provided mainly by community services boards (CSB) and private vendors. Probationers/parolees also have access to community support groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) groups.

The CCAPs continue to be enhanced, offering intensive and moderate substance use services at four locations. Medication Assisted Treatment (MAT) services expanded at CCAPs in March 2021 to include Buprenorphine, an additional FDA-approved medication for the treatment of opioid use disorder. This expansion is made possible through State Opioid Response (SOR) funding. During this reporting year, the VADOC has launched a Peer Recovery Specialist (PRS) initiative, providing substance abuse specific PRS support groups to those on supervision who are opioid dependent, stimulant dependent or have a history of overdose. During FY 2021, the PRS program actively provided groups in a total of 24 probation and parole districts and CCAPs. This initiative is largely funded through SOR grant funds. The VADOC also operates an Intensive Opioid Recovery Program pilot at the District 22 Chesapeake Probation and Parole Office through

SOR funding. The program uses evidence based cognitive behavioral treatment to provide substance use disorder treatment to those on probation with opioid dependency. In FY 2021, the program admitted 54 new probationers to the program, for a total of 97 unduplicated individuals served in the program.

In institutions, as of June 30, 2021, there were 815 inmates (per a CORIS Report) participating in Cognitive Therapeutic Communities (CTC) programs at Indian Creek Correctional Center and the Virginia Correctional Center for Women. The CTC Programs are designed for those inmates needing the most intensive level of substance use disorder services. The female CTC Program utilizes a gender responsive substance use disorder curriculum, Helping Women Recover, along with the additional curriculum of Criminal Conduct and Substance Abuse. Throughout the VADOC, Cognitive Behavioral Interventions for Substance Abuse (CBI-SA) is offered as an evidence based cognitive behavioral approach to treatment. This curriculum has six specific components to the program. To address the growing number of inmates with moderate to low treatment needs and limited time remaining in prison sentence, Recovery Route was implemented as a program option. Approximately 43 inmates completed sections within CBI-SA program or Recovery Route in a correctional institution during FY 2021. The major decline in program completion is largely due to the COVID-19 pandemic.

To meet the substance use disorder needs at the level one facilities, a modified substance use disorder program was implemented during FY2021, allowing for 51 inmates to complete treatment workbooks. An additional 55 inmates completed substance use disorder specific workbooks throughout major facilities as an alternative to in-person programming. The Intensive Substance Use Disorder Program has been relocated and modified to support those inmates in active addiction. This program officially relaunched in July 2021 and data will be provided in the council report next year. The number of inmates participating in volunteer or inmate led support groups such as NA and AA varies.

In addition, grant funding has continued to allow for a residential substance use program at a VADOC field unit. The VADOC continues to implement the Medication Assisted Treatment Reentry Initiative (MATRI) program at nine pilot locations including all six CCAPs and three additional institutions. A total of 31 inmates/probationers released in FY2021 have received their first naltrexone injection. At the end of FY2021, eighteen individuals were actively participating in the MATRI program post-release, and three individuals graduated from the program. An individual graduates when they receive their first naltrexone injection inside the MATRI pilot site and continue to receive twelve months of consecutive treatment including medication and outpatient substance use disorder treatment post release. The naloxone take home program allows inmates/probationers at the nine MATRI pilot sites the option to take a two dose kit of naloxone home once released. In FY 2021, 467 kits were provided to releasing inmates and probationers. The implementation of these additional initiatives are still in their infancy. During the COVID-19 pandemic, treatment services have been impacted due to limited inmate transfers and modification of services.



### **3. Extent Program Objectives Have Been Accomplished.**

In September 2005, the VADOC submitted the Report on Substance Abuse Treatment Programs that contained research information on the effectiveness of therapeutic communities and contractual residential substance abuse treatment programs. The findings from these studies suggest that VADOC's substance abuse treatment programs, when properly funded and implemented, are able to reduce recidivism for the substance abusing inmate population. Due to a lack of evaluation resources, more up-to-date formal studies are not available. However, a one-year recommitment status check is performed annually for the CTC participants. The check completed for the calendar year 2012 cohort indicated a promising recommitment rate of eight percent. Since this status check is not a formal outcome evaluation, caution should be exercised in the interpretation of the data. In recent years, the VADOC has been working to improve the validity regarding data input within the offender management system. These efforts will result in updated research findings within the coming year. During the FY 2021, the VADOC held working dialogues to review the CTC Programs in comparison to research. Recommendations are forthcoming with program modifications.

Assessment results for the inmate population have established the need for substance abuse treatment programs and services. The VADOC has implemented evidence-based substance abuse treatment programs including CTC for inmates assessed with higher treatment needs, CBI-SA Program for those with moderate treatment needs and Recovery Route for those with low to moderate treatment needs and limited time left in sentence. The VADOC has established a fidelity review process that can be used by Community Corrections to assess and monitor the quality of contracted programs and services, although the reviews are restricted by limited staff resources. In addition, the scope of services for Community Corrections vendor contracts to provide treatment services for individuals with substance use disorders have been restructured to require specific evidence-based programs that will allow VADOC to monitor probationer/parolee progress and program fidelity more effectively. During FY 2021, a Memorandum of Agreement boilerplate for the CSB has been developed. Finalization of the document and dissemination of will be provided in FYI 2022. The implementation of the Virginia Corrections Information System (CORIS) has improved the collection of data that can be used in future outcome and cost effectiveness studies. The VADOC will continue to make every effort within its resources to provide substance use disorder services to inmates in need of them.

### **4. Identifying the Most Effective Substance Abuse Treatment.**

Although VADOC specific information is not available at this time, a report from the Washington State Institute for Public Policy indicated that drug treatment in prison as well as the community has a positive monetary benefit. In order for evidence-based treatment programs to be cost effective and achieve positive outcomes, they must be implemented as designed, a concept referred to as fidelity. The VADOC has placed an emphasis on implementation fidelity and created program fidelity reviews for this purpose; this is an important first step that is necessary prior to performing any cost effectiveness studies.

### **5. How Effectiveness Could be Improved.**

The VADOC continues to face a number of challenges related to substance abuse services:

- Limited staff to address the impact of substance use disorder on those under the care of the VADOC, specifically targeting initiatives and grants to direct services;
- Limited staff to conduct fidelity reviews of the substance abuse treatment contract, memorandum of agreement with the CSBs, and residential substance use disorder contract in community corrections;
- Limited staff to oversee expansion of the peer recovery specialist initiative;
- Limited staff resources for programming, assessment, and data collection activities;
- Limited recovery housing options;
- No state funded resources for substance use disorder treatment at level 1 (low security) or high security correctional centers;
- Limited availability of evidence-based treatment services in specific geographic areas within community corrections for probationers/parolees with substance abuse problems;
- Limited special resources for inmates with co-occurring mental illnesses;
- Lack of inpatient residential treatment services in community corrections;
- Lack of medication assisted treatment providers in community corrections; and
- Unavailability of optimal programming space in prisons.

Fully funding the VADOC's substance use disorder treatment services based on the challenges listed above would increase the number of inmates/probationers who may receive treatment and enhance the quality of the programs, thereby producing better outcomes and likely reducing recidivism.

## **6. An Estimate of the Cost Effectiveness of These Programs.**

In general, successful outcomes of substance abuse treatment programs include a reduction in drug and alcohol use which can produce a decrease in criminal activities, and result in improved public safety. The cost avoidance and benefits to society that are achieved from inmates not returning or not coming into prison offset treatment costs. Effective treatment benefits local communities as former inmates can become productive citizens by being employed, paying taxes, and supporting families. In addition, when former inmates can interrupt the generational cycle of crime by becoming effective parents and role models, the community is also enhanced. Finally, it is critical to recognize the ever increasing rate of overdose and the need for continued substance use disorder services to prevent overdoses and deaths.

## **7. Funding Recommendations.**

- Funding for one (1) substance use disorder statewide manager to oversee substance use disorder initiatives, grants, manage contracts, serve on committees and workgroups, enhance collaboration with Department of Medical Assistance Services (DMAS), Department of Behavioral Health and Developmental Services (DBHDS) and other state/local entities, and expand staff training to increase certified VADOC staff.
- Funding for three (3), designated regional positions to support substance use disorder services in probation and parole districts. Duties include fidelity reviews of contractors

associated with the outpatient substance use disorder contract and residential substance use disorder contract, collaboration with recovery residence programs, facilitate substance use disorder staff training and provide probationer/parolee substance use disorder services.

- Funding for three (3) regional wage positions to support the peer recovery specialist initiative offered in probation and parole districts to enhance the program expansion.
- Funding for two (2) positions to provide substance use specific program for high treatment needs inmates at a VADOC work center.
- Funding for resources to provide dual diagnosis assessments, treatment and post release continuum of care including recovery housing.
- Funding for transitional recovery housing to provide a seamless transition of services for persons reentering the community after completing prison intensive treatment programs and residential recovery for probationers/parolees needing recovery support services.

## Department of Medical Assistance Services

The Department of Medical Assistance Services (DMAS) implemented the Addiction and Recovery Treatment Services (ARTS) benefit in April 2017. ARTS expanded coverage of many addiction treatment and recovery services for members enrolled in Medicaid and Children's Health Insurance Program (referred to as Medicaid in this report), including Medications for Opioid Use Disorder (MOUD) treatment, outpatient treatment, short-term residential treatment, inpatient withdrawal management services and Peer Recovery Support Services. The Centers for Medicare and Medicaid Services (CMS) approved Virginia's application for a Section 1115 Demonstration Waiver for substance use disorders (SUD) to allow federal Medicaid payment for addiction treatment services provided in short-term residential facilities in December 2016. CMS recently approved a five-year extension of the waiver in July 2020 giving DMAS funding authority through December 31, 2024.

Coverage of SUD services through ARTS is based on the American Society of Addiction Medicine (ASAM) National Practice Guidelines, which comprise a continuum of care from Early Intervention/Screening, Brief Intervention, and Referral to Treatment (ASMA Level 0.5) to medically managed intensive inpatient services (ASAM Level 4). ARTS also emphasizes evidence-based treatment for opioid use disorder (OUD), which combines pharmacotherapy and counseling. Care coordination services provided by Preferred Office-Based Treatment Services (OBOT) and Opioid Treatment Programs facilitate integration of addiction treatment services with physical health and social service needs. "Preferred OBOT" means addiction treatment services for members with OUD provided by buprenorphine-waivered practitioners working in collaboration with licensed behavioral health practitioners providing co-located psychosocial treatment in public and private practice settings.

For the purposes of this report to the Council, DMAS is reporting outcomes based on SUD treatment services utilization, access and quality of care among Medicaid members through calendar year 2019 based on the ARTS three year evaluation including the first year of Medicaid expansion. DMAS is reporting funding by SFY 2021.

### 1. Amount of funding spent for the program in SFY 2021.

<b>SFY 2021 ARTS Expenditures</b>					
<b>PROGRAM</b>	<b>General Funds</b>	<b>Special Funds*</b>	<b>Federal Funds</b>	<b>Managed Care</b>	<b>TOTAL</b>
<b>Base Medicaid</b>	\$476,993	\$0	\$612,032	\$90,547,218	<b>\$91,636,243</b>
<b>Medicaid Expansion</b>	\$0	\$542,527	\$4,882,745	\$176,529,871	<b>\$181,955,143</b>
<b>FAMIS</b>	\$3,521	\$0	\$9,337	\$177,836	<b>\$190,694</b>
<b>MCHIP</b>	\$961	\$0	\$2,253	\$172,905	<b>\$176,119</b>
<b>Totals</b>	<b>\$481,474</b>	<b>\$542,527</b>	<b>\$5,506,368</b>	<b>\$267,427,829</b>	<b>\$273,958,198</b>

*\*The Provider Coverage Assessment Fund pursuant to § 3-5.15 of the Virginia Acts of Assembly Appropriations Act*

## **2. Unduplicated number of individuals who received services in CY2019.**

Virginia Commonwealth University (VCU) reported about 94,000 members had a SUD diagnosis, including about 42,000 members enrolled through Medicaid expansion in 2019. Around 46,500 members used ARTS in 2019 which is a 79 percent increase from 2018. Among base Medicaid members (non-expansion), 47.4 percent of members with SUD and 65.9 percent of members with OUD received some type of treatment in 2019. Among members enrolled in Medicaid expansion, 53.4 percent received treatment for a diagnosed SUD, while 72.8 percent received treatment for a diagnosed OUD.

According to the 2018 to 2019 National Survey on Drug Use and Health (NSDUH), a major source of national estimates of SUD and OUD prevalence among civilian, non-institutionalized persons aged 12 years and older, ten percent of Virginia Medicaid members reported past year illicit drug or alcohol dependence or abuse. Notably, this prevalence among Virginia Medicaid members represented in the NSDUH is higher when compared to the population of the Commonwealth as a whole (6.8 percent), national Medicaid estimates (9.5 percent) and the overall US population (7.4 percent). Additionally, three percent of Virginia Medicaid members reported past year opioid dependence or abuse. Similarly, past year opioid dependence or abuse among Virginia Medicaid members is higher when compared to the population of the Commonwealth as a whole (0.7 percent), national Medicaid estimates (1.7 percent) and the overall US population (0.7 percent).

## **3. Extent to which program objectives have been accomplished as reflected by an evaluation of outcome measures.**

CMS requires an independent evaluation for Section 1115 Demonstration Waivers, which includes the ARTS benefit. DMAS contracted with VCU School of Medicine to conduct an independent evaluation of the ARTS program. Faculty and staff from the Department of Health Behavior and Policy have led the evaluation, which has focused primarily on how the ARTS benefit affected: (1) the number and type of health care practitioners providing ARTS services; (2) members' access to and utilization of ARTS services; (3) outcomes and quality of care, including hospital emergency department and inpatient visits; and, (4) the performance of new models of care delivery, especially Preferred OBOT programs.

### (1) The number and type of health care practitioners providing ARTS services:

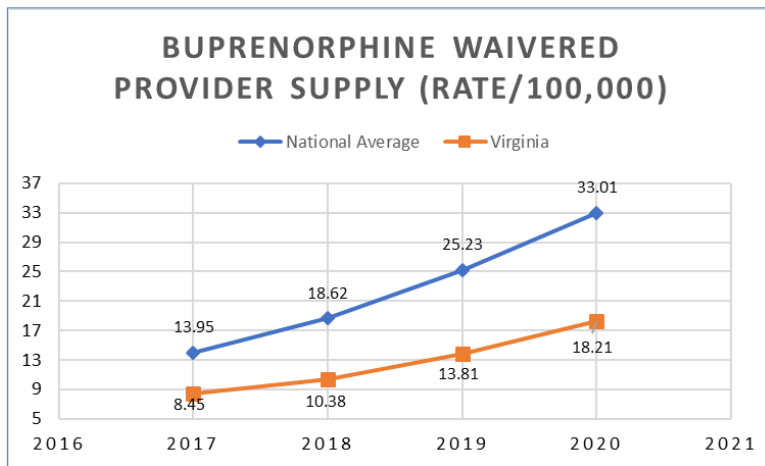
Three years after ARTS implementation, the number of providers providing ARTS services to Medicaid members have increased dramatically. As of September 2019, around 450 new ARTS provider sites have been added while the number of outpatient practitioners billing Medicaid for ARTS services have quadrupled. Some of the sites that have grown the most include residential treatment facilities, inpatient detoxification facilities, Intensive Outpatient Programs, and Opioid Treatment Services.<sup>7</sup> The number of Preferred OBOT providers increased from 38 sites at the beginning of the ARTS benefit to 176 sites as of September 2021.

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<sup>7</sup> Virginia Commonwealth University, Department of Health Behavior and Policy. An Evaluation Report Prepared for the Virginia Department of Medical Assistance Services. ARTS Access and Utilization During the Second Year (April 2018 – March 2019). February 2020. Available at <https://www.dmas.virginia.gov/files/links/5218/ARTS%202%20year%20report.Feb2020%20FINAL.pdf>

The supply of buprenorphine waived providers has also seen an increase from 500 in 2016 to 1,133 in 2019.<sup>8</sup> Many of these waived providers are nurse practitioners and physician assistants. Geographic coverage for providers in the Commonwealth also increased between 2016 and 2019, from 71 counties that had at least one buprenorphine practitioner in 2016 (53 percent) to 91 counties with at least one practitioner in 2019 (68 percent of counties). In addition to an increased number of waived providers, the Commonwealth has seen an increase in available treatment capacity in regards to waiver patient limits with the total prescribing capacity increased by 173 percent, from 27,950 patients in 2016 to 76,165 patients in 2019.<sup>9</sup>

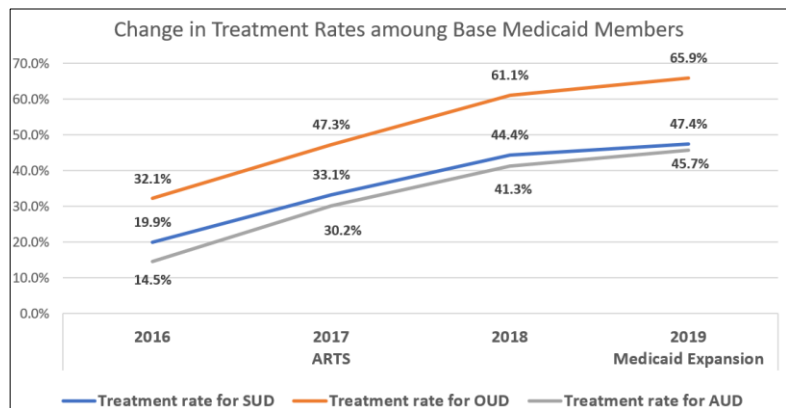
Even though the number of buprenorphine waived practitioners throughout the Commonwealth have increased, as of 2019 only 40 percent of the available waived practitioners treated at least one Medicaid member. Another access concern is that 42 counties or independent cities in the Commonwealth had no waived practitioners as of 2019. Overall supply of waived practitioners in the Commonwealth is relatively low compared to most other states in the South Atlantic region: 12.71 waived practitioners per 100,000 people in the Commonwealth, which is less than half of the number in West Virginia (32.8 waived practitioners per 100,000 people) and Maryland (35.2 waived practitioners per 100,000 people).



Another access concern is that 42 counties or independent cities in the Commonwealth had no waived practitioners as of 2019. Overall supply of waived practitioners in the Commonwealth is relatively low compared to most other states in the South Atlantic region: 12.71 waived practitioners per 100,000 people in the Commonwealth, which is less than half of the number in West Virginia (32.8 waived practitioners per 100,000 people) and Maryland (35.2 waived practitioners per 100,000 people).

(2) Members’ access to and utilization of ARTS services

VCU’s analysis shows large increases in treatment rates for SUD in the first two years following implementation of ARTS. Despite the increase in members with SUD in 2019 due to Medicaid expansion, treatment rates continued to increase between 2018 and 2019. Among members with any diagnosed SUD who did not enroll through Medicaid expansion, treatment rates increased from 44.4 percent in 2018 to 47.4 percent in 2019. Since the year before ARTS (2016), SUD treatment rates have increased 138 percent as of 2019. Treatment rates for OUD and alcohol use disorder (AUD) also increased between 2018 and 2019.



Overall, OUD treatment rates have increased by more than 100 percent since 2016, while AUD treatment rates have increased 215 percent.

<sup>8</sup> Saunders, Britton, Cunningham et al., Medicaid participation among Buprenorphine waived prescribers (in review)

<sup>9</sup> VCU DBHP. (2020). The Addiction and Recovery Treatment Services (ARTS) Program at Three Years: What Have We Learned?

### (3) Outcomes and quality of care, including hospital emergency department (ED) and inpatient visits

ED visits for SUD and OUD increased in 2019, after having decreased following implementation of ARTS in 2017. SUD-related ED visits increased from 60.1 visits per 100 persons with SUD in 2018 to 73.5 visits, a 22 percent increase. OUD-related ED visits increased from 25.9 visits per 100 persons with OUD in 2018 to 33.3 visits, a 28.6 percent increase. Despite the increase between 2018 and 2019, there was still a 4.3 percent overall decrease in OUD-related ED visits between 2016 and 2019. Part of the increase reflects a more general increase in ED visits among Medicaid members, but it may also be related to an increase in drug overdoses in Virginia between 2018 and 2019.

More Medicaid members are getting treatment following an ED visit or stay at a SUD residential treatment center. Among Virginia Medicaid members who had an ED visit with a principal diagnosis of a SUD, receipt of some type of ARTS addiction treatment services has increased since ARTS implementation. Use of pharmacotherapy within 30 days of an ED visit increased from 5.6 percent in 2017 after ARTS implementation, to 12.2 percent by 2019. Use of outpatient, residential treatment and medically managed inpatient treatment has also increased. Nevertheless, 41.1 percent of members with a SUD-related ED visit still had no treatment services within 30 days of the visit in 2019.

### (4) The performance of new models of care delivery, especially Preferred OBOT programs

In 2019, 9,558 members received services through Preferred OBOT or Opioid Treatment Programs (OTP). This is more than 2.6 times the number of members using Preferred OBOT and OTP services in 2018, and 15 times the number in 2017. To reduce barriers to MOUD, several additional guidance were issued in 2020 and 2021 including urine drug screen best practices, increasing access to Preferred OBOTs through allowance of Mobile Clinics and most recently, coverage of buprenorphine prescriptions by out-of-network prescribers targeting ED prescribers and prescribers within a correctional setting to increase access to MOUD for those transitioning from an institutional stay.

As part of the independent evaluation, VCU conducted a member survey to assess patient experience using an adapted version of Consumer Assessment of Health Plans Survey (CAHPS) which is utilized by CMS to improve healthcare in the United States<sup>10</sup>. VCU compared patient experiences based on members' use of Preferred OBOT, OTP, and other outpatient treatment providers, identified based on Medicaid claims data at the time of survey sampling. Among individuals who participated in the survey and reported needing SUD treatment or counseling, 67.5 percent reported that they were usually or always able to see someone as soon as they wanted. Timeliness of care did not vary by treatment setting.

Most survey respondents reported strong communication with and trust in their providers, including 83.6 percent who reported that the provider usually or always explained things in a way that they could understand; 84.5 percent reported that the provider usually or always showed respect for what they had to say; and 90.1 percent reported that they usually or always felt safe with the people they went to for counseling or treatment. The level of communication and trust was high across all three

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<sup>10</sup> <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS>

provider types, although members using OTP services had somewhat lower levels on two of the three measures compared to OBOT and other outpatient providers. Of significance, surveyed members generally report positive experiences with their treatment providers in terms of trust, communication, and level of involvement with their treatment. Having positive experiences with treatment providers is important, as this supports individuals' outcomes and retention in care<sup>11</sup>.

#### **4. Identifying the most effective substance use disorder treatment.**

Treatment of OUD in the ARTS program was based on ASAM's National Practice Guidelines. Along with guidelines for MOUD treatment, ASAM recommends a number of practices in combination with MOUD treatment, such as regular toxicology testing, assessment of and referral for psychosocial needs, testing for HIV and hepatitis C, and prescribing of naloxone. ASAM also recommends against the prescribing of opioid pain medications or benzodiazepine medications during MOUD treatment. Although ASAM does not specify a minimum length of MOUD treatment, six months of continuous treatment has frequently been used as a minimum threshold, although many clinicians recommend even longer treatment periods.

MOUD: Among all outpatient episodes of treatment for OUD, 71.5% involved the use of some type of MOUD, including buprenorphine (48.4%), methadone (23.8%) or naltrexone (1.4%). MOUD treatment was more frequently used at Preferred OBOT and OTP providers (80.8% and 89.1%, respectively) compared to other outpatient treatment providers (56.2%). As expected, Methadone was much more frequently used at OTP providers compared to Buprenorphine, while Buprenorphine treatment (vs naltrexone) was used at Preferred OBOT and other outpatient providers.

Among those who received MOUD treatment, the median length of treatment was 4 months, based on the consecutive number of months during the episode in which there were any claims for any type of MOUD treatment. Length of MOUD treatment varied considerably, lasting only 2 months or less for 25% of episodes, and 9 months or longer for another 25 percent of episodes. Length of MOUD treatment was somewhat longer for those receiving MOUD treatment at OTP providers (median of 4 months) compared to those receiving treatment at Preferred OBOT (median of 3 months).

Co-Prescribing Naloxone: Naloxone was prescribed during 17.3% of episodes, with higher prescribing rates during Preferred OBOT episodes (30.5%) compared to OTP (6.4%) and other outpatient episodes (16.5%).

Behavioral Health: Counseling or psychotherapy for the treatment of OUD was used for 61.5% of episodes. Counseling/psychotherapy was used more often at OTP providers (78.8%), compared to 67.2% of episodes at Preferred OBOT providers, and 48.3% for other outpatient providers. Among episodes involving counseling or psychotherapy, the median number of visits was 6, or about 2 visits per month based on the median length of treatment. The number of visits was somewhat lower at Preferred OBOT providers compared to OTP and other outpatient providers.

Urine Drug Screening (UDS) as Therapeutic Tool: DMAS updated the provider manual for Opioid

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<sup>11</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4732308/>



Treatment Services in July 2021 to provide guidance to providers on the use of UDS as relapse to opioid use is a common occurrence among individuals with OUD. In this policy, DMAS encourages providers to use UDS as a therapeutic tool and not to discharge patients based on relapse and/or positive drug test results. Upon discovering relapse, providers should re-assess a patient's condition, their adherence, their dose of pharmacotherapy and behavioral treatment, and consider intensification of care. In analyzing claims for UDS among Medicaid members, at least one claim for UDS occurred for 80.9% of episodes, with episodes at Preferred OBOTs having a higher percentage of any UDS claim (88.7%) compared to OTP (74.9%) and episodes at other outpatient providers (80.2%). Among episodes with a UDS claim, the median number of UDS claims was 6, averaging about 2 per month. The number of UDS claims (for episodes with any) was somewhat lower at other outpatient providers compare to Preferred OBOT and OTP.

## **5. How effectiveness could be improved.**

### Medicaid Expansion

Access to SUD treatment services through the Medicaid program was further expanded on January 1, 2019, when Virginia implemented the Affordable Care Act's expansion of Medicaid eligibility for adults aged 19-64 to include those with family incomes of up to 138 percent of the federal poverty level. As of September 1, 2021, over 580,000 Virginians had enrolled in Medicaid through the expanded eligibility criteria, which resulted in around 52,750 individuals receiving an ARTS service, who otherwise would have not had access to this benefit. Medicaid expansion has permitted thousands of Virginians access to treatment.

### SUPPORT Act Section 1003

In September 2019, Virginia Medicaid was award a \$4.8 million grant from the Centers for Medicare and Medicaid Services (CMS) Section 1003 Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act Grant. The grant's goal is to increase addiction and recovery treatment provider capacity throughout Virginia that supports DMASs' core values including person-centered, strengths-based and recovery-oriented care. The Grant focusses on expanding access to treatment for two priority populations, Medicaid members who are pregnant and parenting and members who are involved in the legal/carceral system. The Grant time period is September 2019 through September 2022.

Activities of the grant include:

- 1) Completing a needs assessment to determine current SUD treatment needs and provider treatment capacity in the Commonwealth,
- 2) Completing a 'Brightspot' assessment to assess community strengths in SUD treatment, and
- 3) Additional activities such as clinician trainings and pilot programs focusing on expanding SUD treatment access.

One of the major accomplishments of the Grant for this reporting period include an extensive web-based clinical training on various topics related to substance use disorder treatment. As of August 2021 DMAS hosted over 140 webinars, covering 33 webinar topics reaching over 8,500 participants at no cost. DMAS provided approximately 55 hours of in-house technical assistance to over 20 providers throughout the state covering topics such as peer recovery specialist integration, screening and assessments, stigma reduction, and streamlining intake. Ongoing

training and technical assistance is needed to expand provider knowledge and experience for evidence-based treatment and recovery services.

Obtaining feedback from individuals with lived experience can help improve effectiveness of treatment services. The Grant team is worked with VCU to conduct Medicaid Member Surveys. There were just over 100 surveys completed to learn more from the individual's experience in SUD treatment and recovery. This feedback will be used to determine necessary changes to policies to help increase access to treatment and recovery services.

#### Access to Peer Recovery Support Services

Utilization of Peer Recovery Support Services within the ARTS benefit has been low since implementation in 2017. An analysis of claims paid by DMAS in 2021 shows a total of just over 1,500 members receiving a Medicaid covered Peer Recovery Support Services, which is only about 1.5 percent of Medicaid members with a SUD diagnosis. While this is still an increase from only 174 members in 2018, expanding Peer Recovery Support Services provider capacity and increasing member access is an area of opportunity for DMAS. Common barriers to increasing Peer Recovery Support Services treatment capacity, gathered from stakeholder feedback from a General Assembly Workgroup, include: Medicaid documentation requirements; low reimbursement rates; no separate requirements distinguishing for PRSS in emergency departments; limitations to caseloads; and limiting telephonic service delivery. These are captured in this report: [Recommendations for Changing Medicaid Regulations for Peer Recovery Support Services](#). Other themes shared from stakeholders that appear to hinder expanding access to Peer Recovery Support Services include recovery service infrastructure design, prejudice from non-peer staff, service integration ambiguity, medical necessity criteria and recovery ideology. Additional Peer Recovery Support Services workforce barriers include limited access among agencies to provide the 500 experiential hours, barrier crime disenfranchisement, low wages available to hire peer recovery specialists and limited sustainability of the workforce. As of July 2021, there are only 301 peer recovery specialists who have pursued their registration with the Virginia Board of Counseling, out of 2,300 who have received the appropriate training and are eligible to register (the registration component is required to meet the Medicaid policies to receive reimbursement).

#### Reduction of Drug Overdoses

Strategies to impact fatal and non-fatal overdoses include increasing the number of SUD and MOUD treatment providers, increasing access to MOUD in EDs and bridging access to out-patient care, increasing access to Medicaid enrollment and supporting re-entry transition of care for members are experiencing incarceration, increasing access to harm reduction services, increasing access to peer recovery support services, and adding treatment options for polysubstance use. The Governor and General Assembly also approved Appropriations in the 2021 session to expand the Preferred OBOT model to allow for other primary SUD diagnoses. DMAS is currently working on policy updates to expand this model.

#### Access to Housing and Housing-related Supports

Addressing the housing needs of individuals with SUD is an opportunity for Virginia to improve

the effectiveness of resources available currently through partnerships and coordination. This can be addressed by working within the existing delivery systems in place to support individuals in this population. Significant federal and state funding has been provided to the Commonwealth's Continuum of Care (CoC). The CoCs are designed to promote community-wide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness.

In 2020, DMAS began working closely with the Department of Housing & Community Development (DHCD), Department of Veteran's Services (DVS) and DBHDS to ensure providers that are working with individuals experiencing homelessness are coordinating with Medicaid Managed Care Organizations (MCOs) to leverage all available support services and housing resources. This partnership will directly benefit individuals with SUD who are served through the CoCs. In May 2021, providers of SUD services received training on how to access housing resources and HUD-funded support services through the CoCs.

To further the efforts to enhance coordination between providers and the CoCs, DMAS facilitated a meeting between the MCOs and COCs around coordination of behavioral health services. This led to outreach from the CoCs to assist with care coordination for Medicaid members in the population.

Next, DMAS and DHCD are analyzing data from the Homeless Data Integration Project (HDIP) to better target training and resources to communities reporting larger portions of individuals experiencing homelessness or at risk of homelessness who have a SUD. The initial data reviewed so far indicates that over 30% of individuals entering the homeless system had a SUD and/or serious mental illness and this increased to 60% for individuals exiting a justice facility in to homelessness.

The CoC's coordinated entry process does not screen people out for assistance because of perceived barriers to housing or services, including, but not limited to, lack of employment or income, drug or alcohol use, or having a criminal record. DMAS, DHCD, and the CoCs are exploring opportunities to better serve individuals with SUD. For example, incorporating disability-related questions into a community's coordinated entry system can assist in identifying potential SSI/SSDI Outreach, Access, and Recovery (SOAR) applicants.

Virginia also received approval to implement a supportive housing program through the Medicaid 1115 waiver High Needs Supports program. This program will provide much needed housing support services to help individuals, including those living with a SUD, find and maintain community-based housing while receiving services including treatment and recovery services. The funding source will allow Virginia to expand the available housing options for individuals with a substance use disorders.

In the interim, a project launched in July 2021 called the Housing & Health Institute (HHI) will identify American Recovery Act and other available funding for housing supports. DMAS will

continue to work with state agency partners and the CoCs to prioritize individuals with a SUD to access federal and state-funded rental assistance, which is critical for obtaining and maintaining housing stability.

## **6. An estimate of the cost effectiveness of these programs.**

Health Research and Education Trust performed an analysis of the benefit-cost of SUD treatment. The finding of this research showed a greater than 7:1 ratio of benefits to costs<sup>12</sup>. Treatment rates for SUD and OUD continued to increase in 2019. While MOUD treatment rates among Medicaid members have been increasing in other states, the increase in Virginia far outpaces that of other states, providing further evidence of the impact of the ARTS benefit. Thus, while MOUD treatment rates for Virginia in 2016 were well below that of many other states, Virginia is now roughly equivalent with other states in terms of MOUD treatment.

DMAS is also monitoring expenditures for ARTS services and measuring quality of care through 36 quality measures reported quarterly to CMS. As part of upcoming program evaluations, VCU, an independent evaluator for the ARTS program, will be including cost analyses into overall program evaluation design.

## **7. Funding recommendations based on these analyses.**

- Workforce training for evidence-based practices for SUD treatment and recovery.
- Expand Peer Recovery Support Services including Medicaid reimbursement.
- Expand ED Bridge Clinic programs.
- Expand eligibility of state rental assistance funding for individuals with SUD to support their treatment and recovery.
- Coordinate with DHCD and the regionally-based Continuum of Care to prioritize individuals with substance use disorders to identify potential SOAR applicants.
- Fund technical assistance to the Commonwealth's Continuum of Care in Virginia, which includes Community Services Boards, to ensure provider capacity.

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<sup>12</sup> <https://onlinelibrary.wiley.com/doi/full/10.1111/j.1475-6773.2005.00466.x>