COMMONWEALTH of VIRGINIA

Virginia Addiction & Recovery Council

P. O. Box 1797
Richmond, Virginia 23218-1797

December 1, 2024

To: Governor Glenn A. Youngkin
The Honorable Winsome Earle-Sears, Lieutenant Governor of Virginia
The Honorable Don Scott, Speaker, Virginia House of Delegates

From: The Honorable John J. Bell, Chair, Virginia Addiction & Recovery Council

RE: § 2.2-2697.B. of the *Code of Virginia,* Virginia Addiction & Recovery Council Comprehensive Interagency State Plan Report

§2.2-2697.B. of the *Code of Virginia* directs the Virginia Addiction & Recovery Council (VARC), formerly named the Substance Abuse Services Council (hereby referred to as "the Council") 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 Virginia Addiction & Recovery Council's Report on Treatment Programs for FY 2024. Staff are available should you wish to discuss this request.

Cc: The Honorable Janet V. Kelly, Secretary of Health and Human Resources
The Honorable Terrance C. Cole, Secretary of Public Safety and Homeland Security
Nelson Smith, Commissioner, Department of Behavioral Health and Developmental Services
Chadwick S. Dotson, Director, Department of Corrections
Amy Floriano, Director, Department of Juvenile Justice
Cheryl Roberts, Director, Department of Medical Assistance Services

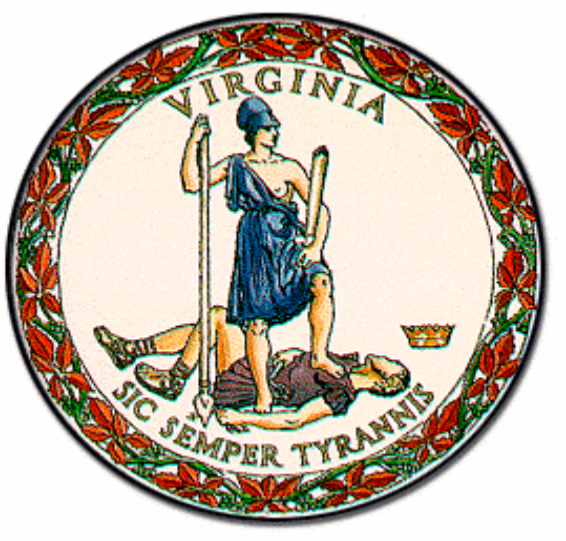
Enc.

VIRGINIA ADDICTION & RECOVERY COUNCIL'S REPORT ON TREATMENT PROGRAMS FOR FY 2024
(Code of Virginia § 2.2-2697)

to the Governor

and the

General Assembly



COMMONWEALTH OF VIRGINIA

December 1, 2024

Preface

§ 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 and Prevention 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 to increase efficiency
(vi). an estimate of the cost effectiveness of these programs; and
(vii). recommendations on the funding of programs based on these analyses.

Virginia Addiction & Recovery Council Report on Treatment Programs for FY 2024

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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 improving 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. In this report, the following information includes each of these four agencies' substance use disorder treatment programs:

1. Amount of funding spent for the program in FY 2024;
2. Unduplicated number of individuals who received services in FY 2024;
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 to increase efficiency;
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 FY 2024, which covers the period from July 1, 2023, through June 30, 2024.

Treatment Programs for FY 2024

This report provides focused data on specific outcomes. Every fatal drug overdose represents many affected individuals, and every individual who commits a crime associated with substance use disorder represents many others who are impacted.[1] Many of these individuals are struggling with functional impairment due to their substance use disorder and this is reflected in decreased workforce participation,[2] negative impact on the economy,[3] the potential for dissemination of blood borne diseases,[4] and recidivism.

The inclusion of methamphetamine treatment in monies allocated for 2020 allowed for much

[1] Virginia Department of Health: Office of the Chief Medical Examiner. (2024). *Fatal Drug Overdose Quarterly Report*. Retrieved from https://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology/

[2] 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/

[3] Midgette, Gregory, Steven Davenport, Jonathan P. Caulkins, and Beau Kilmer, What America's Users Spend on Illegal Drugs, 2006–2016. Santa Monica, CA: RAND Corporation, 2019. https://www.rand.org/pubs/research_reports/RR3140.html. Also available in print form.

[4] 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

needed expansion of services. It should be noted that earmarking funds to ameliorate the impact specific drugs have on health outcomes may fail to acknowledge that substance use, or substance use disorder (SUD) is not limited to a specific drug. SUD is a non-substance specific recognized and diagnosable disorder. Lack of flexibility to utilize funding when addressing misuse of ALL drugs may indirectly result in increased use. We observe that while fatal overdoses due to opioids and methamphetamines decreased from 2022 to 2023, overdose rates increased for cocaine.[5] A reactive or drug specific approach to substance use funding may result in duplicated services, and poorer outcomes.

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. These services are operated by DBHDS, the 40 community services boards (CSBs), and a network of collaborative private providers. CSBs are locally-operated public health agencies that provide services directly to their population and through contracts with private providers.

Summary information regarding these services is presented below.

1. Amount of Funding Spent for the Program in FY 2024.

Expenditures for substance use disorder treatment services totaled $231,529.194. This amount includes state and federal funds, local funds, fees, and funding from other sources. Table 1, below, provides details about the sources of these funds.

Table 1.

Expenditures for Substance Use Disorder Treatment Services by Source	
State Funds	$69,376,454
Local Funds	$57,543,969*
Medicaid Fees	$22,944,927
Other Fees	$6,373,032*
Federal Funds	$64,876,210
Other Funds	$10,414,603*
Total Funds	**$231,529,194**

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

2. Unduplicated Number of Individuals Who Received Services in FY 2024.

A total of 23,600 unduplicated individuals received substance use disorder treatment services supported by this funding in FY 2024.

[5] Virginia Department of Health: Office of the Chief Medical Examiner. (2024). *Fatal Drug Overdose Quarterly Report*. Retrieved from https://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology/

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

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

- **Initiation of Substance Use Disorder Services**: Initiation of services is measured by calculating a percentage. The denominator is the number of all individuals admitted to the substance use disorder services program area with a new substance use diagnosis during the fiscal year. The numerator is all individuals in the fiscal year who then received a first substance use service within 14 days of that new diagnosis. The state average for FY 2024 was 71.8 percent of all individuals being successfully initiated within 14 days of new substance use diagnosis. This far exceeds the latest national average for this measure of 37 percent indicated on the website for the National Committee for Quality Assurance.

- **Engagement in Substance Use Disorder Services**: Engagement is focused on the number of individuals with a new substance use disorder diagnoses who then received a first substance use service within 14 days of that diagnosis and received an additional services 30 days thereafter. The statewide average in FY 2024 was 60.2 percent of individuals meeting the requirement for engagement. Similar to the initiation measure, this state average far surpasses the latest national average for the engagement measure of 14 percent listed on the website for the National Committee for Quality Assurance.

4. Identifying the Most Effective Substance Use Disorder Treatment.

The chronic, relapsing nature of substance use disorder, often results in non-linear pathways to sustained recovery and makes identifying the most effective type of treatment difficult. Evidence-based treatment for substance use disorders consist of an array of modalities and interventions provided to individuals in need. These modalities are tailored to the specific needs of each individual seeking treatment, and include their ASAM criteria (assessment of level of need) and willingness to participate. Other factors, such as legal status, probation requirements, transportation hurdles, family expectations/responsibilities, and co-occurring behavioral health and medical issues further complicate measures of effectiveness across populations.

The lack of a consistently available and accessible services across Virginia may impose additional stress to individuals seeking care and create difficulties when matching individuals to the appropriate level of care. Virginia continues to work on system transformation through initiatives such as STEP-VA to address the inconsistency of available services and ensure reimbursement and coverage rates through Medicaid.

In addition, like many other states, Virginia has a significant shortage of providers for substance use disorder services. In Virginia, workforce challenges include lingering labor market impacts of COVID-19, low wages for medical professional, increasing regulations and certifications, and a significant lack of younger individuals entering the field. These issues can

lead to longer wait times to access services, , increased engagement issues, and higher caseloads.

The deadly opioid overdose epidemic that began in the mid-2000s and resulted in 2,229 deaths in calendar year 2021[6] continues to illustrate the importance of comprehensive, expansive, and evidenced-based treatment for all individuals and their families. Opioid overdoses declined slightly in 2022 and 2023 successively.[7] While encouraging, it remains critical to continue ALL mitigation efforts to ensure this trend continues. To this end DBHDS, continues to actively support local CSBs in providing medication-assisted treatment (MAT), the evidence-based standard of care for opioid use disorder through federal grant funding, as it is costly to provide.

Virginia is also seeing a rise in Methamphetamine use.[8] Additionally, fatal overdoses due to cocaine continued to increase in 2022 and 2023.[9]

5. How To Increase Efficiency

In some cases, the funding streams used for services are restricted based on substance usage, creating difficulties when allocating funds, across all populations. It is important to note substance use disorder services require trained medical and counseling staff in specific treatment models appropriate for individuals' 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 stable employment, lack of childcare, unsafe housing, or serious physical or mental health issues. Increased access to safe transportation assistance that work across urban and rural areas, opportunities to participate in supportive employment programs, increased access to psychiatric care, and secure housing options are imperative to successful engagement and sustainment in treatment options. Successful treatment programs require personnel and resources to help individuals in care address these problems.

Ongoing funding for clinical training is imperative for providers to remain educated, supported, and clinically efficient. DBHDS is partnering with DMAS to provide ongoing ASAM training for providers to ensure the appropriate levels of care for each individual. . 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 result in lowered costs.

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.

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[6] Office of the Chief Medical Examiner Forensic Epidemiology All Opioids Table available at: http://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology/

[7] Office of the Chief Medical Examiner Forensic Epidemiology All Opioids Table available at: http://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology/

[8] 116th Congress second session S4491 To designate methamphetamine as an emerging threat, introduced by Ms. Feinstein and Mr. Grassley

[9] Office of the Chief Medical Examiner Forensic Epidemiology All Opioids Table available at: http://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology/

DBHDS has developed a quality improvement process for CSBs that include 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 Commonwealth.

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 statewide and as those struggling with addition often involve complex challenges that affect care and treatment. However, the ability to access an appropriate level of care is a measure that impacts successful treatment and outcomes. It is recommended that cost effective evaluations focused on the use of evidence-based treatment and holistic outcomes lead to long-term effectiveness.
With the implementation of telehealth as a part of the COVID-19 response, treatment services are available to individuals that were previously not served. Treatment providers have indicated an increase in retention and engagement from individuals receiving care through telehealth. While privacy concerns remain a priority, telehealth offers a valuable opportunity to expand treatment for more individuals who need substance use disorder services.

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 (ASAM). This array included improved access to medication-assisted treatment for individuals with opioid use disorder. DBHDS continues to use the SAMHSA State Opioid Response (SOR) funds to support, improve, and develop services that are more comprehensive across prevention, treatment, and recovery services statewide where needed. In the long term, the systems and programs that SOR supports will need to proactively plan how to support services in case this funding is not renewed at the federal level.

DBHDS also was awarded an increase of $5 million to its baseline funding 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 gaps in services such as transition aged youth (18 – 25) and individuals with intellectual disabilities who are struggling with substance use. This funding has also been accessed to support Naloxone access in the Commonwealth.

Department of Juvenile Justice (DJJ)

The Department of Juvenile Justice (DJJ) provides and contracts with mental health / substance use treatment providers to provide substance use treatment services to youth under community supervision and in direct care status who are assessed as needing substance use treatment. Youth in the community receive mental health and substance use services through a variety of agencies, referral sources, and funding entities. Those include services made available through local

Community Services Boards, services arranged by local Family Assessment & Planning Teams and services contracted and funded by DJJ through the Regional Service Coordination (RSC) model. In addition to youth in the community, youth in direct care status receive mental health and substance use services in a variety of settings including Bon Air Juvenile Correctional Center (JCC), local juvenile detention centers (JDCs) including direct care intake placements, Community Placement Programs, and individual bed placements, and residential programs including residential treatment centers and therapeutic group homes. Residential programs and services for youth in direct care intake placements and individual bed placements are secured through the RSC model.

DJJ 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 biennium began on July 1, 2024 and concludes on June 30, 2026. Some but not all localities, included substance use services on their FY2023-FY2024 biennial plans. Of the 76 local VJCCCA plans, during the first year of the biennium (FY2023), 30 local plans included funds budgeted for programming or services in the category of substance abuse assessments/ evaluations, substance use education and /or treatment.

In FY2024, DJJ contracted with two service coordination agencies, AMIkids (AMI) and Evidence-Based Associates (EBA), to serve as RSCs and assist DJJ with continuing to build a statewide continuum of services for youth and families. For consistency and efficiency of the model, EBA will be the sole RSC for the entire Commonwealth in FY2025. The RSCs support DJJ's continuum of services by managing centralized referrals, service coordination, quality assurance, billing, and reporting. They are responsible for assessing existing programming, developing new service capacity, and selecting and subcontracting with Direct Service Providers (DSPs). They also are responsible for monitoring the quality of the DSPs and fidelity to evidence-based practices and programs, completing ongoing service gap analyses, and filling those service gaps.

The RSC model has increased DJJ's access to evidence-based models including but not limited to Functional Family Therapy (FFT), Multi-systemic Therapy (MST), Adolescent Community Reinforcement Approach (ACRA), Substance Abuse Intensive Outpatient Program (SAIOP), Seven Challenges, and Trauma Focused Cognitive Behavioral Therapy (TF-CBT).

1. The Amount of Funding Expended for the Program.

Bon Air JCC Programs in FY 2024:

Substance Use Services Expenditures: $950,321.33
Total Residential Division Expenditures*: $67,686,200.00

* Total division expenditures exclude closed facilities as well as the Virginia Public Safety Training Center (VPSTC) and all related costs. Substance use services expenditures at Bon Air

JCC are estimated based on a percentage of treatment provider salaries. Substance-related expenditures at non-JCC direct care placements cannot be separated from overall expenditures; therefore, the total residential division expenditures are included to provide additional context.

VJCCCA Substance-Related Programs in FY 2024: $602,881
- Substance Use Evaluations/Assessments Expenditures: $2804
- Substance Use Services under the category of Specialized Program Services Expenditures: $36,350 (includes assessments/evaluations, education and treatment)
- Substance Use Education Expenditures: $27,013
- Substance Use Education/Treatment Expenditures: $416,737
- Substance Use Prevention Expenditures: $119,977

Regional Service Coordinator (RSC) Programs in FY 2023:**
- Substance Use Evaluation Expenditures: $36,693
- Substance Use Treatment Expenditures: $308,915
- Total RSC Substance-Related Expenditures: $348,608

** FY 2023 is the most recent year with available RSC service expenditure information. RSC expenditure data includes all RSC services billed during the FY. Data are not comparable to previous reports due to updated methodology.

2. The Number of Individuals Served by the Program Using that Funding in FY 2024.

In FY 2024, 186 (91.2 percent) of the 204 residents admitted to direct care were assigned a substance use treatment need. Youth can be assigned to Track I or Track II to reflect their individual needs. Track I is for youth 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 youth who have experimented with substances but do not meet the DSM criteria for substance use disorder. Of 204 youth admitted, 84.3 percent were assigned a Track I treatment need, and 6.9 percent were assigned a Track II treatment. These youth may have received treatment at Bon Air JCC, direct care JDC placements, or in a residential program.

In FY 2024, 762 youth (does not include prevention data; number not available) received VJCCCA funding for substance use services to include assessments/evaluations, education, and treatment.

Additionally, several youth in contact with DJJ receive various services across the state through the RSC model, including youth on probation, on parole, and in direct care. As noted above, FY 2024 data is not available for RSC programs. Following referrals during FY 2023, 181 youth received substance use evaluations and 163 youth began one or more substance abuse treatment services through the RSCs. Most youth receiving substance use treatment through the RSCs received individual therapy for substance use (60.1 percent) and/or relapse prevention services (24.5 percent). Some youth receiving RSC services for substance use issues participated in the Seven Challenges® services (19.2 percent), substance use family therapy (3.7 percent), substance use intensive outpatient program (3.1 percent), and/or group therapy for substance use (0.6 percent). In addition to services specifically labeled substance use treatment, youth participating in individual therapy, FFT, and MST had an identified need in the area of substance use, which

may have been addressed by those services; however, those services are not included in the expenditures or counts above.

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 use treatment need. Rates are calculated based on a rearrest for any offense, excluding technical violations. An assigned treatment need does not indicate treatment completion. The most recent rearrest rates available are for youth released during FY 2022. It is important to note that rearrest rates do not measure whether a youth used substances (or not) after discharge and is therefore not a direct outcome measure of treatment program success. Substance use treatment within DJJ primarily focuses on preventing and/or minimizing future substance use. Notwithstanding, while substance use treatment is not inherently focused on reducing reoffending behaviors, it directly addresses criminogenic risk factors related to decision-making, impulse control, emotion regulation, prosocial skills, etc. Additional limitations are described below.

In FY 2022, 52.2 percent of former residents with a substance use treatment need were rearrested within 12 months of release, as compared to 50.3 percent of all residents. Rearrest rates for residents with a substance use treatment need reflect rearrests for any offense, not specifically a drug offense.

Additionally, youth with higher substance use treatment needs (Track I) had similar rearrest rates to those in Track II. Of youth released in FY 2022, 52.4 percent of Track II youth were rearrested in the 12 months following their release, as compared to 52.2 percent of Track I youth.

Treatment completion may be related to lower recidivism rates among youth with treatment needs. For example, 49.1 percent of youth released in FY 2022 with completed substance use treatment were rearrested in the following 12 months, as compared to 66.7 percent of youth with incomplete substance use treatment.

In FY 2023, 128 youth receiving substance use treatment through DJJ's RSC model had their services closed. Of those, 43 (33.6 percent) met all overarching and/or service goals while 59 (46.1 percent) met some overarching and/or service goals. Recidivism rates for youth receiving RSC substance use treatments are not currently available.

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. Residents with assigned treatment needs may have risk characteristics different from those not assigned a treatment need or those assigned a different level; 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. Additionally, data on whether re-offenses were substance-related are not available at this time. As mentioned above, rearrest rates do not reflect the focus of substance use treatment, which is to prevent and/or minimize future substance use rather than reoffending behaviors. Lastly, FY 2021 rearrest rates especially should not be used to evaluate program efficacy. Due to the COVID-19 pandemic, FY 2021 saw many changes across the juvenile justice system, impacting actual and tracked criminal and delinquent

behaviors. Recidivism rates decreased system-wide for most groups in contact with DJJ in FY 2021 (see the Recidivism section of the FY 2023 DJJ Data Resource Guide for more information). FY 2021 groups are much smaller than previous years; therefore, FY 2021 rearrest rates compared to those of previous years are more strongly influenced by the reoffence of only a few youth. While most rearrest rates increased in FY 2022 these rates remained slightly lower or comparable to the pre-pandemic rates (i.e., FY 2018 and FY 2019).

4. Identifying the Most Effective Substance Use Disorder Treatment.

Committed youth are assessed for treatment services at the Juvenile Correctional Center (JCC) or the Juvenile Detention Center (JDC) by the Central Admission and Placement (CAP) Unit for the most appropriate level of substance use treatment. The process includes medical, psychological, behavioral, educational, and career readiness evaluations. Depending on the youth's individual needs, youth may be assigned to one or more treatment programs to include aggression management, substance use and/or sex offender treatment.

Male youth in direct care who are assessed as having a substance use disorder as identified in the current version of the DSM are referred for Track 1 substance use treatment, which is addressed through the CBT-MET Cannabis Youth Treatment Program. CBT and MET, otherwise known as Cognitive Behavioral Therapy, and Motivational Enhancement Treatment, are well known throughout the research literature as evidence-based treatment models for adolescents.

Male youth who do not meet the DSM criteria for a substance use disorder but have a history of experimentation with marijuana and/or alcohol, are referred to Track 2 services, which are provided through an individualized treatment plan that may draw from various resource materials.

Female youth who are assessed as having a substance use disorder as indicated in the current version of the DSM are referred to Track 1 services and receive VOICES, a gender specific journaling-based program that focuses on a variety of topics. VOICES is designed using the foundational evidence-based practice of interactive journaling and is listed as a Legacy Program in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices.

Additionally, all direct care youth are assigned to a therapist, and those youth with a co-occurring disorder can receive mental health treatment to address individual needs as applicable to their assessed risk, needs and responsivity.

For justice-involved youth in the community, Probation or Parole Officers coordinate a variety of services to achieve a balanced evidence-based approach to public safety, accountability and competency development. For those youth in need of substance use treatment, community-based services are provided by public or private sector DSPs and may differ according to region and the availability of services.

5. How Effectiveness Could be Improved.

DJJ continues to implement CBT-MET Cannabis Youth Treatment, as well as individualized treatment for direct care youth with co-occurring disorders. Additionally, DJJ residential services

implemented prevention programming, which focused on the dangers of fentanyl, vaping, e-cigarettes, and tobacco use via a Virginia Foundation for Healthy Youth (VFHY) grant. DJJ will continue to explore relevant prevention programming that targets public health risks.

DJJ also utilizes RSCs that facilitate a series of continuum services to youth and families across the state. This service model has increased DJJ's access to evidence-based models and pre-release services for direct care youth returning to the community on parole. These re-entry and community-based services should continue their collaboration to ensure smooth transition of residents to the community, residential diversion and public safety.

Effectiveness could be improved by using additional evidence-based and evidence-informed models of substance use treatment.

The Standardized Program Evaluation Protocol, (SPEP™) will allow DJJ to evaluate programs and services for their effectiveness, including substance use programming.

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 use treatment needs should continue. Addressing these needs is an important aspect of youth's overall treatment and preparation for reentry to their home communities.

Funding for community-based treatment, including for substance use treatment, should continue. Addressing these needs in the community is critical so that youth's usage does not worsen and lead to a need for in-patient treatment.

Virginia Department of Corrections (VADOC)

1. Amount of Funding Spent for the Programs in FY 2024.

Treatment services expenditures totaled $10,767,188 for FY 2024. Table 2, below, displays how these funds were expended across VADOC programs.

Table 2.

FY2024 Expenditures:		
Community Corrections Substance Abuse		$1,657,694
Spectrum Health		$6,439,985
Appalachian CCAP	$475,951	
Brunswick CCAP	$564,583	
Cold Springs CCAP	$575,830	
Chesterfield CCAP	$564,583	
Indian Creek Correctional Center	$2,512,269	

State Farm Work Center	$584,412	
Virginia Correctional Center for Women	$521,253	
Nottoway Work Center	$191,031	
Green Rock Correctional Center	$269,568	
Fluvanna Correctional Center (partial year due to contract modification)	$38,496	
Greensville Correctional Center (partial year due to contract modification)	$89,764	
Pocahontas Correctional Center	$52,244	
Facilities (previously RSAT funded)		$1,082,534
State Opioid Response Grant (federal funded)		$527,345
Recovery Navigators		$244,459
Roving Substance Use Disorder Cognitive Counselors		$463,289
Statewide SUD Manager and Statewide Coordinator		$165,449
Opioid Abatement Authority Funding (MAT Social Workers)		$118,750
DOC Funded MAT Social Worker		$67,683
Total		**$10,767,188**

2. Unduplicated Number of Individuals Who Received Services in FY2024.

As of June 28, 2024, there were 61,502 probationers/parolees under active supervision in the community. This data includes participants in, the Community Corrections Alternative Programs (CCAPs), those on Shadowtrack Supervision, absconders, and those supervised on out of state supervision. The VADOC utilizes the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) assessment tool for risk assessment and service planning. Data collected from this screening tool indicates that approximately 70 percent of those under active supervision who have history of substance use disorder (SUD) as indicated by scores of "Probable" or "Highly Probable" on the COMPAS substance abuse subscale.

SUD treatment services in the community are provided mainly by community services boards (CSB) and vendor partnerships. During FY 2024, 40 probation and parole districts received SUD treatment services through contracted providers while seven probation and parole districts utilized memorandum of agreements (MOA) with their local CSB. Six probation and parole districts used both private contractors and MOAs. Additionally, probationers/parolees also had access to community support/mutual self-help groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Celebrate Recovery groups facilitated by community volunteers.

The Community Corrections Alternative Programs (CCAPs) continued to offer intensive and moderate SUD services at four locations. CCAPs were designed to offer Circuit Court judges an alternative to incarceration that provides intensive, residential treatment in a controlled setting. The goal of the program is to provide a structured environment where participants acquire and practice the skills necessary to sustain positive behavioral changes and long-term recovery. In FY 2024, 401 individuals graduated from the CCAPs.

Throughout FY 2024, the VADOC continued to ensure that medications for opioid use disorder (MOUD) are accessible through consultation between the prescriber and patient. Both continuation

of care and induction were offered. The VADOC can continue treatments initiated from a regional jail, adult detention center, or community provider with a MOUD product prescription. In FY 2024, the VADOC continued to offer Buprenorphine, Sublocade, Suboxone, Vivitrol, Naltrexone, and Methadone options.

In FY 2024, the VADOC continued to provide two-dose Naloxone rescue kits to participants upon release from incarceration. The Naloxone Distribution Initiative was made available at VADOC locations where a primary SUD program was housed. Additionally, Narcan education was provided to all inmates as part of the Reentry Release Packet. This packet contained a wealth of information, including SUD treatment resources, Narcan distribution sites, and instructions on how to administer Narcan. A total of 1,117 rescue kits were distributed during FY 2024. As efforts to expand Narcan availability continue, the VADOC is exploring ways to provide additional kits to its population.

The State Opioid Response (SOR) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), of which VADOC receives as a sub-recipient through DBHDS, continued funding for a large portion of VADOC's Peer Recovery Specialist (PRS) initiatives. During this reporting year, the VADOC continued to expand recovery services provided by state trained PRSs servicing both institutions and community. The VADOC continued two full time PRS positions and one part time position which supports probation and parole. These PRSs worked directly with probationers who have opioid use disorder, stimulant use disorder, or a history of overdose. They continued engaging the difficult to reach probationer population at times of crisis and supported the probation and parole staff in assisting the supervisee.

An average of 24 recovery groups statewide were facilitated by a mix of PRS vendors and VADOC PRS employees on a weekly basis during FY 2024, serving those under probation and parole supervision. This was comprised of approximately 210 participants from 17 probation and parole districts or Community Corrections Alternative Programs. The VADOC is now facilitating the Virginia DBHDS PRS training in correctional centers statewide. In FY 2024, the VADOC trained 53 inmates in seven different correctional centers to offer SUD peer recovery services. This program continued to provide inmate employment positions that offer recovery support to fellow inmates. Inmate PRSs offered coaching and support which augmented current residential SUD programs. VADOC has developed a process to offer supervision hours for inmate PRSs to facilitate certification. This practice will continue to enhance recovery access and create healing environments for those incarcerated individuals with SUDs. In addition, professional development has been offered to our growing PRS certified inmates which has included Peer Activated Resilience and PRS Ethics training.

In FY 2024, the VADOC served as a mentor site for the Comprehensive Opioid Stimulant and Substance Use Program's Peer Recovery Support Services Mentoring Initiative (PRSSMI). Virginia continues to advise leaders from Colorado DOC and Wyoming DOC regarding peer support services. Future site visits are scheduled to teach how the VADOC leverages the uniqueness of peer status in program design. This will include discussion of sound evidence-supported practices and policies, systematic recruitment, screening, and hiring of peer workers, and training in core competencies (basic) and specialized skills (advanced) for peer staff.

In FY 2024, through SOR grant funding, VADOC continued to operate an Intensive Opioid Recovery (IOR) Program pilot at the District #31 Chesapeake Probation and Parole Office. The

program used evidence-based cognitive behavioral treatment to provide SUD treatment to probationers with Opioid Use Disorder (OUD). The IOR program serves individuals with either a history of and/or current opioid abuse and evaluate them for treatment services, including MAT and counseling services. This program allowed individuals living in Chesapeake and in surrounding jurisdictions (Virginia Beach, Norfolk, and Portsmouth) to remain in the program and on supervision. Program participants also worked closely with a PRS for additional recovery support. The IOR program allowed individuals on probation to receive specialized SUD supervision from probation officers who also have advanced training and education in SUDs and addiction. During FY 2024, 69 supervisees participated in the IORP program. At the end of the fiscal year, over one-half (55 percent) were still enrolled in the program, one-third (33 percent) were removed, and eight have completed the program.

In VADOC Correctional Centers, as of June 30, 2024, there were 662 inmates participating in Cognitive Therapeutic Communities (CTC) programs at Indian Creek Correctional Center and the Virginia Correctional Center for Women. The CTC Programs were designed for those inmates needing the most intensive level of SUD services. The female CTC Program utilizes a gender responsive SUD curriculum, Helping Women Recover, along with the additional curriculum of Criminal Conduct and Substance Abuse. A Women's Way Through the 12 Steps is available on a voluntary basis. In FY 2024 there were 769 competitions across all 3 phases of these CTC programs.

The Nottoway Work Center continued to meet level one SUD needs during FY2024. The 50-bed program is a modified CTC program that consists of assessments, individualized treatment plans, cognitive behavioral interventions for substance abuse supplemented with Spectrum Health curriculum, process groups and aftercare planning. For FY2024, the program had 10 completions.

The Voluntary Substance Use Disorder Treatment Program (VSUDTP) is located at Green Rock Correctional Center and Indian Creek Correctional Center for male inmates and at Virginia Correctional Center for Women for female inmates. In FY2024, the VSUDTP continued to provide intensive SUD programs, implementing a modified CTC model. It provided treatment objectives, as appropriate, for a range of primary treatment services for alcohol and other drug use. This was for inmates who self-admit to using substances while incarcerated and volunteered for this program. The program utilizes SUD assessments, individualized treatment plans, evidenced based programs including Spectrum Health Systems Psychoeducational curriculum. The program includes drug education, relapse prevention/management, and peer led groups. FY2024 had 151 inmates successfully complete VSUDTP at the three facilities.

In November 2023, the Department launched the Residential Illicit Drug Use Program or RIDUP at Greensville Correctional Center. This was as a response to risks associated with overdose. This program has provided an environment where illicit substances are highly unlikely to enter the unit, removing the temptation and creating safety for participants. RIDUP offers peer support and cognitive restructuring skills that reduce illicit substance use and overdoses within the inmate population. For FY2024, there were 52 total participants and 24 completions.

In response to the ongoing danger posed by fentanyl in carceral settings, December 2023 marked the Virginia Department of Corrections launch of the Fentanyl Response Program or FRP, at Pocahontas Correctional Center, followed by a high security Fentanyl Response Program at Wallens Ridge State Prison in March 2024. FRP is a four-month residential treatment program to

support inmates who have had one or more positive drugs screens for fentanyl. This proactive approach to reducing overdoes and treating SUD has provided treatment programing and peer support to participants. Inmates who complete the program can move forward in sobriety and safety. For FY2024, there were 156 total participants at Pocahontas with 53 completions. Wallen's Ridge had 39 participants pending program completion.

The VADOC opened an Aftercare Center in April of 2024 at Green Rock Correctional Center. This residential treatment community offered additional support for inmates who completed RIDUP or who completed FRP and were assessed as needing continuing care recovery support. The program provides 4-6 months of evidenced based SUD support including PRS support. Since the April 2024 launch, 33 participants have been enrolled.

Throughout the Department, Cognitive Behavioral Interventions for Substance Abuse (CBI-SA) is offered as an evidence based cognitive behavioral approach to treatment. Approximately 435 inmates completed CBI-SA in 2024. Moving into FY2025, the VADOC has adopted the revised and updated Cognitive-Behavioral Interventions-Substance Use Adult (CBI-SUA) curriculum by the University of Cincinnati. This curriculum was designed for people involved with the criminal justice system who are at moderate to high need of substance abuse services. The curriculum includes 47 sessions. All five current roving SUD cognitive counselors have been trained in facilitating this new curriculum. Ten inmates completed CBI-SUA in FY2024.

To address the growing number of inmates with moderate to low treatment needs and limited time remaining in their prison sentence, Recovery Route was utilized as a program option. There were 519 Recovery Route completions in 2024. From FY 2023 to FY 2024, there was an increase of 431 combined CBI-SA and Recovery Route completions. The VADOC employed six mobile SUD cognitive counselors. They provided SUD programming at institutions with higher ratios of inmates who scored probable or highly probable of having an SUD as assessed by the COMPAS substance abuse scales. Interactive Journals supplement SUD programs in the VADOC. The Medication Assisted Treatment (MAT) workbook from the Change Companies, saw 23 completions in FY2024. MAT journals are for individuals who are actively participating in VADOC's MAT programs.

VADOC has deployed seven MAT Social Workers to coordinate care during incarceration and enhance a warm handoff from incarceration to the community for inmates engaged in Medication Assisted Treatment. Six of these positions were funded through the Opioid Abatement Authority grant funding. For incarcerated individuals with SUD, the MAT Social Workers were responsible for leading collaboration between Health Services, Treatment, and Operations. The position also facilitated linkages to the community for a continuum of care post release.

Throughout the reporting period, Medicaid enrollments have been prioritized for inmates releasing from incarceration, as well as those on probation and parole. This effort ensured greater access to SUD services post release. VADOC developed a comprehensive training for staff to increase enrollment efforts. From July 1, 2023 to June 30, 2024, there were 6,454 inmates released from VADOC facilities. Twelve of these inmates were ineligible to apply for community Medicaid due to non-citizenship. The remaining 6,442 inmates were classified as the following: 5,144 inmates released had Medicaid (80 percent), 647 inmates had Medicaid in the past (10 percent), 190 inmates had submitted applications for Medicaid (3 percent), 55 inmates refused Medicaid enrollment (1 percent), and 406 inmates have no record of being offered Medicaid (6 percent). VADOC will

continue the provision of streamlining Medicaid enrollment efforts as it plays a vital role with reentry and ensures continuum of care for inmates and probationers in our custody.

In FY 2024, VADOC developed a marketing campaign to educate staff, inmates, and probationers on the deadly impacts of fentanyl. It included the *One Pill Can Kill* video featuring four Virginia families who lost a loved one due to fentanyl poisoning. The video was shared with employees, inmates, probationers, and Virginians. This video recently earned a National Capital Emmy Award. Funding for this video was made possible from State Opioid Response Grant. In addition, six unique posters were developed targeted to the inmate/probationer population designed to bring awareness to the risk of overdose associated with fentanyl. The posters were released to all correctional centers and probation districts. The VADOC's awareness efforts were further supported by mass information blasts through email, social media, written notification, and inmate tablet system regarding dangers of illicit drug use with an emphasis on fentanyl.

3. Extent Program Objectives Have Been Accomplished.

Assessment results for the inmate population have established the need for SUD treatment programs and services, with approximately 66.7 percent of inmates scoring probable or highly probable on the substance abuse scales of the COMPAS, and 70 percent of probationers/parolees with probable SUDs. According to the most recent SAMHSA National Survey on Drug Use, this is compared with approximately 17.5 percent of the general population, age 12 or older having a SUD. To combat this rising tide of substance abuse, the VADOC has implemented new evidence-based residential SUD treatment programs including Fentanyl Response Programs, RIDUP and Aftercare. In addition, the agency launched inmate PRS services in correctional centers. As mentioned, the Department has prioritized Medicaid enrollment to ensure treatment access. All existing SUD programs and services continue to be maximized. The VADOC has implemented a fidelity review process to assess and monitor the quality of vendor SUD treatment services in Community Corrections. The VADOC continues to utilize CORIS for data reporting/collection. The VADOC will continue to assess programs for fidelity and effectiveness and respond with SUD programing appropriate to the changing landscape.

4. Identifying the Most Effective Substance Use Disorder Treatment.

The VADOC continues to utilize evidenced based programs for treatment of SUDs, as well as regular fidelity reviews of these programs. To maintain fidelity and effectiveness of SUD programs, the programs must be implemented as designed. The VADOC continues to emphasize fidelity, or quality control, to all SUD programs. These fidelity efforts are supported by traveling managers and ongoing program and curriculum development and auditing to ensure the highest quality of inmate support.

5. How Effectiveness Could be Improved.

The VADOC continues to face several challenges related to SUD treatment services:

- Limited specialized staff to address the impact of SUD on those under the care of the VADOC
- Limited screening, assessment, and treatment resources for inmates with co-occurring

mental illness and SUD

- Reliance on grants for key sectors of VADOC's SUD treatment offerings including six of seven MAT Social Workers, three full-time PRSs serving those on supervision, and all three SUD trained staff in the Chesapeake IOR.
- Continued reliance on pilot programs due to lack of SUD specialized trained staff and resources necessary to implement programs on a broader scale Limited staff to oversee expansion of the PRS initiative and reliance on SOR grant funding for the PRS initiative
- Limited recovery housing options spread geographically throughout the Commonwealth, and limited funding for the housing options that do exist
- Challenges securing programming space in VADOC correctional centers

Based on the challenges listed above, fully funding the VADOC's SUD treatment services would increase the number of inmates and probationers who may receive treatment and services. Furthermore, it would enhance the quality of the programs, thereby producing better outcomes and likely reducing recidivism and risk of overdose. Based on research cited below, the benefits of providing SUD programs for the incarcerated population can decrease overall healthcare costs once the individual is released. This includes costs for inpatient and long-term hospitalizations and emergency room visits. Additionally, inmates who successfully complete treatment and remain in active recovery are less likely to commit additional crimes which leads to reduced recidivism. This is a significant cost savings to the Virginia criminal justice system.

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

Although specific information is not available for the VADOC currently, reports from other states show promise of the cost benefit of SUD programs while an individual is incarcerated. For example, 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 FY2017, Kentucky estimated that for every dollar spent on substance use treatment in correctional facilities, there was a return of over $4 in offset costs. According to a report by the National Governors Association: Expanding Access to Medications for Opioid Use Disorder in Corrections and Community Settings, "for MOUD treatment more broadly, states have found that treatment reduces overall health costs, due to avoided emergency department utilization and inpatient stays."

Additional successful outcomes of SUD treatment and programs for incarcerated individuals and those involved with the justice system include a reduction in illicit substance use which leads to a reduction in recidivism, increase in public safety, and improved health outcomes. Treatment of opioid use disorder with medications and cognitive programming can lead to reduced fatal and nonfatal overdoses and decrease in infectious disease. Furthermore, by remaining in SUD treatment once released from incarceration, an individual is more likely to become and remain employed, both predictors of retention in treatment and decrease in future criminal involvement.

7. Funding Recommendations

- Funding for the existing two full-time and one wage PRS positions and the two existing full-time and one wage positions to support the Intensive Opioid Recovery Program due to SOR Grant funding term limits

- Funding for three designated regional positions to offer oversight to SUD programs, both in institutions and community corrections, enhancing the agency's SUD infrastructure
- SUD Social Workers at all correctional centers to coordinate care and ensure a warm handoff for post release services
- SUD Specialists to support the probation and parole districts
- PRS positions to expand PRS services in correctional centers
- Funding for resources to provide co-occurring SUD and mental illness assessments, treatment, and post release continuum of care including recovery housing.
- Funding for transitional recovery housing to provide aftercare and stability post release from an incarceration SUD program

Department of Medical Assistance Services (DMAS)

Please note: 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 for Calendar Year (CY) 2022****, which overlaps with state FY 2023 by six months. This is the most recent data that is available for DMAS to report.*

The Department of Medical Assistance Services (DMAS) implemented the Addiction and Recovery Treatment Services (ARTS) benefit in April 2017. ARTS expanded coverage of many substance use disorder (SUD) 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 SUD to allow federal Medicaid payment for addiction treatment services provided in short-term residential facilities in December 2016. CMS approved a five-year extension of the waiver in July 2020 giving DMAS funding authority through December 31, 2024. DMAS applied to CMS to renew the 1115 Demonstration for five (5) additional years. This application is pending CMS review.

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 (ASAM Level 0.5) to medically-managed intensive inpatient services (ASAM Level 4). ASAM has released the fourth edition of the ASAM Guidelines, and DMAS is currently reviewing the new Guidelines to incorporate the changes made in the fourth edition into ARTS. This will entail a full review of the benefit, as well as coordination with other state agencies. As such, DMAS expects this process to take more than 12 months to complete.

ARTS also emphasizes evidence-based treatment for opioid use disorder (OUD), which combines pharmacotherapy and counseling. Care coordination services provided by Preferred Office-Based Addiction Treatment providers (OBATs) and Opioid Treatment Programs facilitate integration of addiction treatment services with physical health and social service needs. "Preferred OBATs" refer to addiction treatment services provided by practitioners working in collaboration with licensed behavioral health practitioners providing co-located psychosocial treatment in public and private

practice settings. The Preferred OBAT model was initially limited to individuals with a primary OUD diagnosis. Per requirements of Item 313 Section ZZZ of the 2020 Appropriations Act, DMAS expanded the model effective March 1, 2022, to allow for other primary SUDs.

CMS requires an independent evaluation for Section 1115 Demonstration Waivers, which includes the ARTS benefit. DMAS contracted with Virginia Commonwealth University (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 OBAT programs.

1. Amount of funding spent for the program in CY 2022.

In CY 2022, spending on ARTS services totaled $284,560,000. Expenditures by level of service are detailed below.

Table 3. ARTS Expenditures, CY 2022

Service	CY 2022
ASAM 1	$34,728,000
OBAT/OTP	$36,454,000
Care Coordination	$24,508,000
ASAM 2	$37,474,000
ASAM 3	$48,235,000
ASAM 4	$563,000
Pharmacotherapy	$96,924,000
Case Management	$5,080,000
Peer Recovery Support Services	$593,000

2. Unduplicated number of individuals who received services in CY 2022.

ARTS services were provided to 60,846 Medicaid members in CY 2022. Table 4 details the growth in Medicaid members receiving ARTS services since the inception of ARTS in 2017:

Table 4. Medicaid members served by ARTS since inception of benefit

	Apr 2017-Dec 2017	2018	2019	2020	2021	2022	% change 2018-2022
Used any ARTS service	10,523	15,780	37,577	46,048	54,067	60,846	74.1%
Type of Service							
ASAM 1	8,991	13,215	31,273	39,129	46,300	51,901	74.5%
OBAT/OTP	1,805	4,012	11,447	15,007	17,014	17,941	77.6%
Care Coordination[1]	795	2,515	7,921	11,085	13,436	14,807	83.0%
ASAM 2	584	1,285	4,018	4,825	5,964	7,507	82.9%
ASAM 3	556	1,261	3,876	4,377	5,686	7,028	82.1%
ASAM 4	6	5	47	100	152	78	93.6%
Pharmacotherapy	8,382	12,516	24,300	30,959	37,608	43,234	71.1%
Case Management	641	930	2,842	3,975	4,241	4,445	79.1%
Peer Recovery Support Services	33	275	886	1,247	1,652	1,768	84.4%

[1]Refers to care coordination services through OBAT/OTP providers.

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

The number and type of health care practitioners providing ARTS services:
Five years after ARTS implementation, the number of providers in the Medicaid network providing ARTS services to Medicaid members continues to increase. As of December 2022, there are more than 6,000 Medicaid-enrolled ARTS providers, which represents continued growth since the inception of ARTS. The greatest growth in provider types has been in ASAM levels 2 (intensive outpatient/partial hospitalization) and 3 (residential). The number of Preferred OBAT providers increased from 38 sites at the beginning of the ARTS benefit to 201 sites as of December 2022.

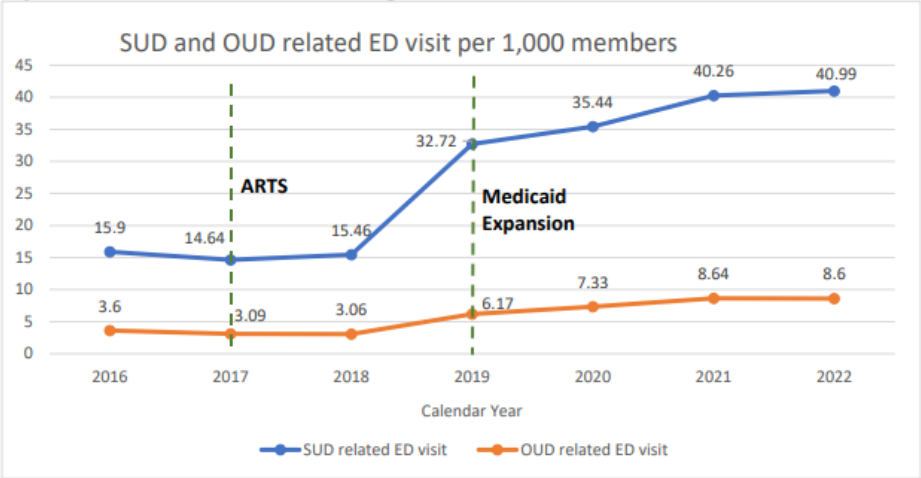
Table 5. ARTS Providers by Calendar Year, 2020-22

Service	2020	2021	2022
ASAM 1	5,058	5,703	6,088
OBAT/OTP	245	225	202
Care Coordination	166	160	142
ASAM 2	231	254	270
ASAM 3	52	72	75
ASAM 4	15	13	8

The rates of medication for Opioid Use Disorder (MOUD) treatment rates have also increased every year, from 43 percent in 2016 to 78 percent by 2022. Buprenorphine has consistently been the most frequently used MOUD treatment since the inception of ARTS, but treatment rates are also increasing for methadone and naltrexone. While less than 5 percent of members with MOUD received methadone and naltrexone treatment in 2016, this increased to 25.5 percent for methadone and 11.2 percent for naltrexone by 2022.

Outcomes and quality of care, including hospital emergency department (ED) and inpatient visits:
SUD- and OUD-related ED visits held nearly steady from CY 2021 to 2022, a departure from the

trend of steadily increasing visits from 2018 to 2021.



DMAS continues to work with its evaluators to better understand the drivers of ED utilization and identify strategies to increase community-based treatment options that may be able to provide more effective and efficient services for members with SUD and OUD.

The performance of new models of care delivery, especially Preferred OBAT programs:
In CY2022, 43,234 members received MOUD services from Medicaid providers, a 15 percent increase since 2020. Increases were seen in all modalities of MOUD, including buprenorphine, methadone, and naltrexone.

Table 6. Number of Medicaid members with MOUD utilization

	Calendar Year						
	2016	2017	2018	2019	2020	2021	2022
Members with MOUD use or OUD dx	14,505	18,190	22,661	37,233	44,424	50,979	55,481
Type of MOUD use							
Any MOUD	6,244	9,070	12,516	24,300	30,959	37,608	43,234
Buprenorphine	4,968	6,093	7,240	13,281	17,175	21,702	26,025
Methadone	709	2,402	4,719	9,878	12,506	13,740	14,175
Naltrexone	645	932	1,472	3,173	4,037	5,191	6,206

DMAS has also been working with community providers and pharmacists to address issues of buprenorphine access from pharmacies. Members and providers have reported being unable to obtain buprenorphine from pharmacies despite presenting legitimate prescriptions for this important medication. DMAS has been part of a cross-disciplinary effort convened by the Substance Abuse Mental Health Services Administration (SAMHSA) that called together Mid-Atlantic states to help determine the scope and cause of the problem and collaborate to identify opportunities to address them. Additionally, DMAS has worked directly with providers, pharmacies, and pharmacists to review buprenorphine access issues, including referrals to the DMAS Office of the Chief Medical

Officer as well as Managed Care Organizations to monitor reported events to ensure that all policies are being followed.

4. Identifying the most effective substance use disorder treatment.

Treatment of OUD in the ARTS benefit is based on ASAM's National Practice Guidelines including a special focus on same day access for MOUD treatment. MOUD includes the use of buprenorphine, methadone, and naltrexone as part of evidence-based treatment for OUD. This method is considered best practice for treating OUD and has been found to be the most effective treatment in preventing OUD-related overdoses. To further increase access to buprenorphine treatment beginning in March 2019, DMAS removed prior authorization requirements for Suboxone films for in-network prescribers. In Fall 2021, DMAS also added the generic buprenorphine/naloxone tablet to the formulary. More detail about the utilization of MOUD services is included above.

An important goal of the ARTS demonstration is to improve transitions across different levels of care, and coordinating addiction treatment services with other physical, mental health, and social needs. This is to be accomplished by a number of strategies, including, but not limited to the use of licensed care coordinators by managed care organizations for addiction treatment services. To help determine the effectiveness or care coordinators, VCU performed a survey of MCO care coordinators in 2022-23.

Care coordinators play a vital role in linking Medicaid members with necessary services to ensure that the needs of the Medicaid members are met. This survey focused on the background, trainingand professional experiences of care coordinators; care coordinators normal work activities with Medicaid members; care coordinators work with members who have a SUD and specific activities commonly performed to assist members with SUD; the type of data and information used by these coordinators to support their duties and responsibilities; major barriers faced by care coordinators, and care coordinators feelings about their job.

Key findings included:

- Care coordinators have a wealth of experience; over 70 percent had more than five years of experience as care coordinators and almost 80 percent had three or more years of experience working with Medicaid members.
- Care coordinators report a median caseload of 143 members (Interquartile Range or IQR:88-208); two-thirds of care coordinators report that their caseload has increased "a lot" or "somewhat" in the past year.
- Size of case load, administrative burden and paperwork and finding resources for social services were the three challenges most cited by case workers as major barriers to successfully performing their role.
- Over 92 percent of care coordinators generally feel their work is "moderately", "a lot" or "extremely" meaningful, while over 43 percent report feeling burned out from work once a week or more.

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 July 2023, 737,658 Virginians had enrolled in Medicaid through the expanded eligibility criteria, which resulted in around 84,835 receiving an ARTS service, who otherwise would have not had access to this benefit. Medicaid expansion has permitted thousands of Virginians access to treatment.

Continuing Efforts of the SUPPORT Act Grant

In September 2019, Virginia Medicaid was awarded a $4.9 million dollars 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 project's goal was to increase addiction and recovery treatment provider capacity throughout Virginia that supports DMAS's core values including person-centered, strengths-based and recovery-oriented care. The grant focused 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 project, which ended in 2022, had three key activities:

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.

Key successes of the grant included:

- Landscape reviews of Medicaid policies for SUD, including a review specifically focused on members with legal or carceral experience and the specific challenges that they face as they transition out of and back into community settings;
- Bright-spotting communities who have been successful in addressing SUD and OUD in their communities (see below for more details);
- A "first of its kind" survey of members who have accessed ARTS services to help understand ARTS successes and opportunities for growth;
- Providing over 230 training and technical assistance sessions and webinars that were attended by more than 12,300 individuals throughout the state, that included provider-specific technical assistance and training programs provided for the Virginia Department of Social Services;
- Working with state agencies to promote the utilization of peer recovery services, including developing a symposium designed to help expand capacity for this important service;
- Awarding grants to providers to support expansion of telehealth, peer recovery support, and harm reduction services as well as the development of a member navigation program for pregnant and parenting members; and
- Supporting Comprehensive Harm Reduction programs to increase enrollment and access to treatment for members as they access harm reduction services.

Emergency Department Bridge Clinic Program

One of the main goals for the SUPPORT Act was to address a key gap in the continuum of care for individuals with OUD in the Commonwealth – the transition from post-overdose ED care to community-based treatment (for those individuals who chose to begin their recovery). The Bridge Clinic model utilize care coordination, electronic health records integration, telehealth, and other means to provide a direct link for an individual to follow-up community-based care, including a follow-up appointment that is scheduled for the individual before they leave the ED. Telehealth-compliant devices can also be provided to the individual to facilitate their participation in the follow-up appointment. The SUPPORT Act Grant engaged with two separate hospitals in the Commonwealth – Carilion Clinic in Roanoke and VCU Health in Richmond to support the implementation of this bridge clinic model.

DMAS has worked to continue the development of the bridge clinic model by applying to the Opioid Abatement Authority for ongoing implementation of this model of care. DMAS has been awarded funds to provide ongoing training and technical assistance focused on the bridge clinic model and intends to apply for funding in the future to incentivize hospitals and health systems to implement the model in their locations.

Access to Peer Recovery Support Services

Several strategies have been implemented over the past years by DMAS, in partnership with public and private partners, to increase the utilization of Peer Recovery Support Services (PRSS). One of the main strategies was an increase in the reimbursement rate for PRSS that was passed by the Virginia General Assembly in the 2022 session, allowing the Commonwealth to significantly increase the amount that providers receive for providing PRSS, from $6.50 to $19.50 per 15 minutes for individuals and from $2.70 to $8.10 per 15 minutes for groups. Through the SUPPORT Act Grant, DMAS provided both general and provider-specific training and technical assistance to help providers navigate the challenges of onboarding PRSS as part of their continuum of care. DMAS held a PRSS symposium in October 2022 to continue to publicize this rate change and help providers implement this important service.

Reduction of Drug Overdoses

Strategies that DMAS focused on to impact fatal and non-fatal overdoses include but are not limited to the following: 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 experiencing incarceration; increasing access to harm reduction services; increasing access to peer recovery support services; and adding treatment options for polysubstance use. The Commonwealth has been able to make important advances in these strategies. DMAS supported these strategies through the efforts of the SUPPORT Act Grant.

Review of Emerging Treatment Opportunities

As part of Governor Youngkin's *Right Help. Right Now* Initiative, DMAS prepared an innovations brief, highlighting emerging opportunities that could improve the effectiveness and overall outcomes of treatment for individuals with SUD, including additional dosing options for buprenorphine, contingency management for individuals with stimulant use disorder, and starting buprenorphine treatment in other settings such as emergency response and inpatient hospital settings.

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

DMAS is monitoring expenditures for ARTS services and measuring quality of care through 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. VCU also ARTS evaluation reports from previous years that provide more details about evaluation activities, which can be found here: https://hbp.vcu.edu/policy-briefs/arts-policy-briefs/.

7. Funding recommendations based on these analyses.

- Continued expansion of ARTS services as aligned with *Right Help Right Now* through provider and community engagement efforts
- Expanded person-centered treatment approaches that address the social and psychological risk factors for the recurrence of drug use
- Continued workforce training for evidence-based practices for SUD treatment and recovery
- Continued expansion of ED Bridge Clinic programs
- Continued partnership with state and local legal/carceral organizations to strengthen transitions for members through carceral settings
- Continued expansion of access to and provider/member understanding of best practices in telemedicine treatment services
- Continued expansion of Peer Recovery Support Services provider capacity and service utilization
- Support harm reduction providers to promote Medicaid enrollment and service engagement for eligible individuals