



September 22, 2017

Cynthia B. Jones
Medicaid Director
Virginia Department of Medical Assistance Services
Suite 1300
600 East Broad Street
Richmond, VA 23219

Dear Ms. Jones:

We are pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request to amend Virginia's section 1115 demonstration, "The Virginia Governor's Access Plan (GAP) and Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation" (Project No. 11-W-00297/3). This approval is effective as of the date of the approval letter, through December 31, 2019. This amendment authorizes the Commonwealth to increase the GAP program income eligibility threshold criterion from 80 percent to 100 percent of the federal poverty level (FPL), provide additional substance use disorder (SUD) services to the GAP benefit package, and provide Medicaid coverage to former foster care youth who were in foster care and Medicaid in a different state. This demonstration is likely to promote the purposes of Medicaid because the GAP/ARTS Delivery System Transformation section 1115 demonstration will increase coverage of low income individuals in the state by providing benefits to a certain population that is not eligible for Medicaid under the state plan. The state will implement the amendment request on October 1, 2017.

CMS approval of this section 1115 demonstration amendment is subject to the limitations specified in the approved waiver authorities and compliance with the enclosed Special Terms and Conditions (STCs) defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been waived or specifically listed as not applicable to the expenditure authority. The approval is subject to CMS receiving your written acknowledgment of the award and acceptance of these STCs within 30 days of the date of this letter. A copy of the revised STCs and expenditure authorities are enclosed.

Please send your written acceptance and any communications or official correspondence concerning the demonstration to your project officer, Mr. Felix Milburn. Mr. Milburn can be reached at (410) 786-1315, Felix.Milburn@cms.hhs.gov or at the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

Ms. Cynthia Jones – Page 2

Please send official communications regarding program matters simultaneously to Mr. Milburn and to Mr. Francis McCullough, Associate Regional Administrator for the Division of Medicaid and Children's Health Operations in our Philadelphia Regional Office. Mr. McCullough's contact information is:

Mr. Francis McCullough
Associate Regional Administrator
Division of Medicaid and Children's Health Operations Program
Suite 216, The Public Ledger Building
150 South Independence Mall West
Philadelphia, PA 19106

If you have questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid & CHIP Services, at (410) 786-9686.

We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Brian Neale
Director

Enclosures

cc: Francis McCullough, Associate Regional Administrator, CMS Region III

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00297/3

TITLE: Virginia Governor's Access Plan (GAP) and Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation Demonstration

AWARDEE: Virginia Department of Medical Assistance Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Virginia for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of this demonstration, be regarded as expenditures under the state's title XIX plan.

These expenditure authorities are required to implement this demonstration project, which promotes the objectives of title XIX in the following ways:

- Increase and strengthen overall coverage of low-income individuals in the state; and
- Improve health outcomes for Medicaid and other low-income populations in the state.

1. Expenditures for a targeted benefit package for the Seriously Mentally Ill (SMI) population eligible for services under the Governor's Access Plan (GAP) component of the demonstration.

Expenditures for coverage of health care services for individuals aged 21 through 64 without health insurance coverage, with effective household incomes up to 80 percent of the Federal poverty level (FPL) using the modified adjusted gross income (MAGI) methodology who meet all Medicaid non-financial eligibility criteria but are otherwise ineligible for Medicaid, who are not institutionalized and who have been diagnosed with a qualifying severe disabling mental illness as set forth by the state and reflected in Attachment A to the Special Terms and Conditions. This includes expenditures for services to individuals who are short-term residents in facilities that meet the definition of an institution for mental disease (IMD) for the treatment of substance use disorder and withdrawal management.

2. Expenditures related to the Addition and Recovery Treatment Services (ARTS) Delivery Transformation Demonstration.

Expenditures not otherwise eligible for federal financial participation may be claimed for otherwise covered services furnished to otherwise eligible individuals (eligible under the state Plan or Former Foster Care Youth components of this demonstration), including services for individuals who are short-term residents in facilities that meet the definition of an IMD for the treatment of substance use disorder and withdrawal management.

3. Expenditures related to the Former Foster Care Youth component of the demonstration.

Expenditures to extend Medicaid State Plan benefits and benefits under the ARTS component of this demonstration for former foster care youth who are under age 26, were in foster care under

the responsibility of another state or tribe from such state on the date of attaining 18 years of age or such higher age as the state has elected, and were enrolled in Medicaid on that date.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the Virginia GAP portion of this demonstration (Expenditure Authority #1 – Expenditures for the seriously mentally ill population) for the period of approval. There are no waivers or requirements made not-applicable for the ARTS and Former Foster Care Youth components of the demonstration; all Medicaid requirements are applicable to the populations and benefits under those components.

1. Methods of Administration: Transformation **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary, to enable the state to not assure transportation to and from providers for the demonstration-eligible GAP population.

2. Retroactive Eligibility **Section 1902(a)(34)**

To the extent necessary to enable the state to not provide coverage for the demonstration-eligible GAP population prior to the first day of the month in which the application was received by the state.

3. Freedom of Choice **Section 1902(a)(23)(A)**

To enable the state to restrict freedom of choice of provider for populations made eligible under the GAP component of the demonstration, through the use of mandatory enrollment in managed care entities (primary care case management) for the receipt of applicable demonstration covered services.

4. Amount, Duration, and Scope of Services **Section 1902(a)(10)(B)**

To the extent necessary to enable the state to offer a reduced benefit to populations made eligible under the GAP component of the demonstration.

5. Reasonable Promptness **Section 1902(a)(8)**

To enable the state to amend the demonstration in order to modify eligibility thresholds in order to maintain enrollment up to the limit established in budget neutrality.

6. Comparability **Section 1902(a)(17)**

To the extent necessary to enable the state to vary cost sharing requirements for GAP demonstration enrollees from cost sharing requirements in the state plan.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00297/3

TITLE: Virginia Governor's Access Plan for the Seriously Mentally Ill (GAP) and Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation Demonstration

AWARDEE: Virginia Department of Medical Assistance Services (DMAS)

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Virginia Governor's Access Plan (GAP) for the Seriously Mentally Ill Section 1115 Demonstration and the Addiction Recovery Treatment Services Delivery System Transformation demonstration (hereinafter "demonstration"). The parties to this agreement are the Virginia Department of Medical Assistance Services (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. All requirements of the Medicaid and CHIP programs expressed in law, regulation and policy statement, not expressly waived or made not applicable in the list of waivers and expenditure authorities, shall apply to the demonstration project. The STCs are effective January 12, 2015, unless otherwise specified. This demonstration will be statewide and is approved through December 31, 2019.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility for the GAP Component of the Demonstration
- V. Benefits for the GAP Component of the Demonstration
- VI. Cost Sharing for the GAP Component of the Demonstration
- VII. Delivery Systems for the GAP Component of the Demonstration
- VIII. General Reporting Requirements
- IX. General Financial Requirements
- X. Monitoring Budget Neutrality for the Demonstration
- XI. Evaluation of the GAP Component of the Demonstration
- XII. Health Information Technology
- XIII. T-MSIS Requirements
- XIV. Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation Component of the Demonstration
- XV. Evaluation of the ARTS Component of the Demonstration
- XVI. Evaluation of the Former Foster Care Youth Component of the Demonstration
- XVII. Schedule of State Deliverables

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A: Diagnoses Eligible for Virginia GAP Demonstration

Attachment B: Demonstration Benefits Specifications

Attachment C: Informal Network of Benefits

Attachment D: GAP Demonstration Evaluation Plan

Attachment E: Timeline for Establishing Standards for Substance Use Disorder System

Attachment F: ARTS Delivery System Transformation Demonstration Evaluation Plan (Reserved)

Attachment G: Former Foster Care Youth Evaluation (Reserved)

Attachment H: Developing the Evaluation Design

Attachment I: Preparing the Interim and Summative Evaluation Reports

II. PROGRAM DESCRIPTION AND OBJECTIVES

Effective October 1, 2017, the Virginia GAP demonstration provides a specified benefits package to childless adults and non-custodial parents 21 through 64 who have household incomes at or below 100 percent of the federal poverty level (FPL) using the MAGI methodology, who have been diagnosed with a serious mental illness (SMI). The demonstration extends access to a limited package of behavioral and physical health services to adults who are not otherwise eligible for Medicaid, CHIP, or Medicare and are uninsured.

The Virginia GAP Demonstration will evaluate the outcomes of providing a targeted benefits package to an uninsured population. The three (3) key goals of the GAP component of the demonstration are to:

- Improve access to behavioral health outpatient medical care for a segment of the uninsured population in Virginia who have serious behavioral and medical needs;
- Improve health and behavioral health outcomes of demonstration participants; and
- Serve as a bridge to closing the insurance coverage gap for Virginians.

In May 2015, the demonstration was amended to reduce the GAP eligibility levels from 100 percent of the FPL to 60 percent of the FPL. In June 2016, the demonstration was amended to increase the GAP eligibility levels from 60 percent to 80 percent of the FPL. In September 2017, the demonstration was amended to increase the GAP eligibility levels from 80 percent to 100 percent of the FPL. In September 2017, the GAP component of the demonstration was amended to provide the following substance use disorder (SUD) services to the GAP benefit package:

- Partial day hospitalization (ASAM Level 2.5);
- Residential treatment (ASAM Level 3.1, 3.3, 3.5 and 3.7); and
- Withdrawal management.

December 2016 Amendment

The ARTS amendment expanded substance use disorder (SUD) benefits for all Virginia Medicaid recipients eligible under the State Plan or under the Former Foster Care Youth component of this demonstration to cover the full continuum of SUD treatment; introduces quality of care and programmatic features for the successful integration of SUD services into comprehensive managed care for all managed care enrollees; incorporates industry standard SUD treatment criteria into program standards; improves the quality and availability of medication-assisted treatment services; and introduces policy, practice and system reforms consistent with CMS State Medicaid Director (SMD) Letter #15-003. The terms and conditions of the ARTS amendment are set out in section XV of this document.

The goals of the ARTS component of the demonstration are to:

- Improve quality of care and population health outcomes for the Medicaid population;
- Increase Medicaid recipients' access to and utilization of community-based and outpatient ARTS;
- Decrease medically unnecessary or preventable utilization of high-cost emergency department and hospital services by Medicaid recipients with SUDs by expanding treatment in more cost-effective community-based residential and outpatient settings;
- Improve care coordination and care transitions for Medicaid recipients with SUDs; and
- Increase the number and type of health care clinicians providing ARTS to Medicaid recipients with SUDs.

September 2017 Amendment

The September 2017 amendment added a former foster care youth component of the demonstration. Under this amendment, the state receives authority to cover former foster care youth who aged out of foster care under the responsibility of another state and are now applying for Medicaid in the Commonwealth of Virginia.

The goals of the former foster care youth demonstration component are to:

- Increase and strengthen coverage of former foster care youth who were in Medicaid and foster care in a different state; and
- Improve health outcomes for these youth.

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

- 2. Compliance with Medicaid and Children’s Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.
- 3. Changes in Federal Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state thirty (30) days in advance of the expected approval date of the amended STCs to provide the state with additional notice of the changes.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change.
 - b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
- 5. State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs.

As outlined in CMS’ November 21, 2016, CMCS Informational Bulletin to Allow Medicaid Coverage to Former Foster Care Youth Who Have Moved to a Different State, the state shall submit a conforming amendment to the Medicaid State Plan for the “out-of-state” former foster care youth affected by the implementation of this demonstration. After the associated Medicaid State Plan amendment is effectuated, the state will not be required to submit any additional title XIX SPAs for changes affecting this former foster care youth population made eligible solely through this demonstration.

- 6. Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, and budget neutrality must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.
- 7. Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
- a. An explanation of the public process used by the state, consistent with the requirements of STC 15 to reach a decision regarding the requested amendment;
 - b. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
 - c. An up to date CHIP allotment neutrality worksheet, if necessary;
 - d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
 - e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.
- 8. Option to Continue Demonstration beyond DY 2.** If the state intends to continue operating this demonstration beyond demonstration year (DY) two (2), the state must submit a letter of intent to CMS no later than six (6) months prior

to the end of each DY for which the state seeks continuation of the demonstration.

9. Extension of the Demonstration. No later than twelve (12) months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS a demonstration extension request that meets federal requirements at 42 Code of Federal Regulations (CFR) §431.412(c) or a phase-out plan consistent with the requirements of STC 10..

10. Demonstration Phase Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. **Notification of Suspension or Termination.** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft plan to CMS. To be assured of approval, if the phase-out of the demonstration will be accompanied by the termination of coverage, the state must submit the notification letter and a draft plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination.

Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a thirty (30) day public comment period. In addition, the state must conduct tribal consultation in accordance with 42 CFR 431.408. Once the thirty (30) day public comment period has ended, the state must provide a summary of each public comment received the state's response to the comment and how the state incorporated the received comment into the revised plan. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of activities must be no sooner than fourteen (14) days after CMS approval of the plan.

b. **Transition and Phase-out Plan Requirements.** The state must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries determined eligible, as well as any community outreach activities including community resources that are available.

c. **Phase-out Procedures.** The state must comply with all notice requirements found in 42 CFR Section 431.206, Section 431.210, and Section 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR Section 431.220 and Section 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR Section

431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as described in 42 CFR Section 435.916.

- d. **Exemption from Public Notice Procedures 42 CFR Section 431.416(g).** CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR Section 431.416(g).
- e. **Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of disenrolling beneficiaries.

11. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Quarterly Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

12. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a transition plan to CMS no later than six (6) months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

- a. **Expiration Requirements.** The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- b. **Expiration Procedures.** The state must comply with all notice requirements found in 42 CFR Sections 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR Section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility

under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

- c. **Federal Public Notice.** CMS will conduct a thirty (30) day federal public comment period consistent with the process outlined in 42 CFR Section 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the thirty (30) day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than fourteen (14) days after CMS approval of the plan.
- d. **Federal Financial Participation (FFP).** FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of disenrolling participants.

13. Withdrawal of Waiver Authority. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

14. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state public notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the public notice procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates. If applicable, the state must also comply with the tribal consultation requirements as set forth in section 1902(a)(73) of the Act and implemented in regulation at 42 CFR Section 431.408(b), and the tribal consultation requirements contained in the state's approved Medicaid state plan,

when any program changes to the demonstration, either through amendment as defined in STC 6 or extension, are proposed by the state.

16. Federal Financial Participation (FFP). No federal matching for administrative or service expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY FOR THE GAP COMPONENT OF THE DEMONSTRATION

The Virginia GAP Demonstration provides a specified benefits package to uninsured adults age 21 to 64 with SMI who have household incomes described in STC 17(d). Specific diagnoses which may qualify a person for eligibility in the demonstration are included in Attachment A.

17. Demonstration population. The enrollees described below who are made eligible for the GAP component of the demonstration by virtue of the expenditure authorities expressly granted in this demonstration are subject to Medicaid laws or regulations only as specified in the expenditure authorities for this demonstration.

The eligibility criteria for the Virginia GAP Demonstration are as follows:

- a. Adult ages 21 through 64 years old;
- b. SMI criteria, including documentation related to the duration of the mental illness and the level of disability based on the mental illness, as described in Attachment A;
- c. Not otherwise enrolled for any state or federal full benefits program including: Medicaid, Children's Health Insurance Program/Family Access to Medical Insurance Security Plan (CHIP/FAMIS), or Medicare;
- d. Household income:
 - i. Effective January 12, 2015 through May 14, 2015, applications received with household income that is at or below 95 percent of the FPL using MAGI methodology;
 - ii. Effective beginning May 15, 2015, applications received with household income that is at or below 60 percent of the FPL using MAGI methodology; and
 - iii. Effective beginning July 1, 2016, applications received with household income that is at or below 80 percent of the FPL using MAGI methodology.
 - iv. Effective beginning October 10, 2017, applications received with household income that is at or below 100 percent of the FPL using MAGI methodology.
- e. Uninsured; and,

- f. Not residing in a long term care facility, mental health facility, or long-stay hospital, defined as hospital care that is a slightly higher level of care than Nursing Facilities. The placement criteria for the long-stay hospital is similar to a specialized care nursing facility but allows for more individualized placements. A long-stay hospital is a facility is not an IMD, it is a nursing facility for those who require a long term and higher level of care than is offered in the nursing home level of care. The population to be served includes individuals requiring mechanical ventilation, ongoing intravenous medication or nutrition administration, comprehensive rehabilitative therapy services and individuals with communicable diseases requiring universal or respiratory precautions.

GAP members who are subject to a temporary detention order (legal status allowing law enforcement to transport an individual to a facility for an emergency psychiatric evaluation) will not lose their GAP eligibility. However, the state will not claim for services while the individual is subject to the temporary detention order.

GAP members who have a co-occurring SUD diagnosis are eligible to receive covered SUD-related treatment services in facilities that the state has assessed as meeting the provider competencies and capacities described in the ASAM Criteria for Levels 3.5 and 3.7. This will not affect their GAP eligibility.

18. Continuity of Enrollment and Eligibility. Enrollees have twelve (12) months of continuous coverage regardless of income changes or enrollment in private insurance.

V. BENEFITS FOR THE GAP COMPONENT OF THE DEMONSTRATION

19. GAP Demonstration Benefits. The targeted benefits package is designed to serve as many enrollees as possible with a limited set of health care services, as described below.

The following categories of services are included in the limited benefit for Virginia GAP Demonstration enrollees, which are further detailed in Attachment B:

Category of Service
Outpatient Hospital Coverage
Outpatient Medical
Mental Health Case Management
Crisis Stabilization
Psychiatric evaluation and outpatient individual, family, and group therapies (mental health and substance abuse)

Category of Service
Peer Supports
Prescription Drugs
Medication Assisted Treatment (MAT) – See full service definition in STC 72 and STC 73.
Intensive Outpatient Services (ASAM 2.1) – See full service definition in STC 68.
Partial day hospitalization (ASAM Level 2.5) – See full service definition in STC 69.
Residential treatment services (ASAM Levels 3.1 through 3.7) – See full service definition in STC 70.
Withdrawal management – See full service definition in STC 71.

20. Benefits Provided by Informal Network. For benefits that the GAP demonstration excludes, an informal network furnishes participants with necessary health care, diagnostic services and treatment for physical and mental health illnesses. The benefits, network providers and funding sources are listed in Attachment C.

21. Minimum Essential Coverage. As the GAP demonstration is limited to a specific category of benefits to treat specific medical conditions, the demonstration is not recognized as Minimum Essential Coverage (MEC), consistent with the guidance set for in State Health Official Letter #14-002, issued by CMS on November 7, 2014.

VI. COST SHARING FOR THE GAP COMPONENT OF THE DEMONSTRATION

22. Premiums and Cost Sharing. Demonstration enrollees will be subject to no premiums or cost sharing for demonstration services.

VII. DELIVERY SYSTEMS FOR THE GAP COMPONENT OF THE DEMONSTRATION

23. Service Delivery. Services for the demonstration are provided using a blend of fee-for-service (FFS) delivery system and a managed fee-for-service delivery system through an Administrative Services Organization (ASO), as represented in the table below.

Eligibility Group Name	Delivery System	Authority
SMI Group	Fee-For-Service (Medical)	State Plan
	Administrative Services Organization (Behavioral)	2011 Virginia Acts of Assembly Item 29, MMMM

24. Outreach Plan. The state shall submit a draft outreach plan to CMS no later than sixty (60) days after the award of the demonstration, which includes innovative efforts to identify and enroll individuals at the first indication of SMI including individuals who have presented at emergency departments.

VIII. GENERAL REPORTING REQUIREMENTS

25. General Financial Requirements. The state must comply with all general financial requirements under title XIX set forth in Section IX.

26. Reporting Requirements Related to Budget Neutrality. The state must comply with all reporting requirements for monitoring budget neutrality set forth in Section X.

27. Monitoring Calls. CMS will convene periodic conference calls with the state.

- a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, enrollment and access, budget neutrality, and progress on evaluation activities.
- b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
- c. The state and CMS will jointly develop the agenda for the calls.

28. Submission of Post-approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

29. Compliance with Federal Systems Innovation. As federal systems continue to evolve and incorporate 1115 waiver reporting and analytics, the state will work with CMS to:

- a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
- b. Ensure all 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to are provided; and,

- c. The state will submit all deliverables to the appropriate system as directed by CMS.

30. Monitoring Reports. The state must submit three (3) Quarterly Reports and one (1) compiled Annual Report each DY. The information for the fourth quarterly report should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60) days following the end of each demonstration quarter. The compiled Annual Report is due no later than ninety (90) days following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

- a. Operational Updates – Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.
- b. Performance Metrics – Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.
- c. Budget Neutrality and Financial Reporting Requirements – Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook that includes established baseline and member months data with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.

- d. Evaluation Activities and Interim Findings – Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

31. Close Out Report. Within 120 days prior to the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.

- a. The draft final report must comply with the most current Guidance from CMS.
- b. The state will present to and participate in a discussion with CMS on the Close Out report.
- c. The state must take into consideration CMS’s comments for incorporation into the final Close Out Report.
- d. The final Close Out Report is due to CMS no later than thirty (30) days after receipt of CMS’ comments.
- e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 57.

32. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration’s implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

IX. GENERAL FINANCIAL REQUIRMENTS

33. Quarterly Expenditure Reports. The state must provide quarterly Title XIX expenditure reports using Form CMS-64, to separately report total Title XIX expenditures for services provided through this demonstration under section 1115 authority. CMS shall provide Title XIX FFP for allowable demonstration expenditures, only as long as they do not exceed the pre-defined limits on the costs incurred, as specified in section X of the STCs.

34. Reporting Expenditures Subject to the Budget Neutrality Cap. The following describes the reporting of expenditures subject to the budget neutrality agreement:

- a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the state will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and

Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the State Medicaid Manual. All demonstration expenditures subject to the budget neutrality limit must be reported each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes cost settlements must be recorded on the appropriate prior period adjustment schedules (forms CMS-64.9 Waiver) for the summary line 10B, in lieu of lines 9 or 10C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the State Medicaid Manual. The term, “expenditures subject to the budget neutrality limit,” is defined below in STC 43.

- b. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (form CMS-64.9P Waiver) for the summary sheet line 10B, in lieu of lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the SMM.
- c. **Pharmacy Rebates.** The state may propose a methodology for assigning a portion of pharmacy rebates to the demonstration populations, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of those populations, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the demonstration and not on any other CMS-64.9 form to avoid double – counting. Each rebate amount must be distributed as state and Federal revenue consistent with the Federal matching rates under which the claim was paid.
- d. **Use of Waiver Forms for Medicaid.** For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit (section X of these STCs). The State must complete separate waiver forms for the following eligibility groups/waiver names:
 - i. MEG 1 – “SMI Group”
 - ii. MEG 2 – “SUD IMD”
 - iii. MEG 3 – “Former Foster Care Youth (FFCY) Group”

- e. **Demonstration Years.** The first Demonstration Year (DY1) began on January 1, 2015. Pursuant to STC 8, DMAS submitted a letter of intent to extend the demonstration past DY 2. Subsequent DYs are defined as follows:

Demonstration Year 1 (DY1)	January 1, 2015	12 months
Demonstration Year 2 (DY2)	January 1, 2016	12 months
Demonstration Year 3 (DY3)	January 1, 2017	12 months
Demonstration Year 4 (DY4)	January 1, 2018	12 months
Demonstration Year 5 (DY5)	January 1, 2019	12 months

- 35. Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name State and Local Administration Costs (“ADM”).
- 36. Claiming Period.** All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within two (2) years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within two (2) years after the conclusion or termination of the demonstration. During the latter two (2) year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 and Form CMS-21 in order to properly account for these expenditures in determining budget neutrality.
- 37. Reporting Member Months.** The following describes the reporting of member months for demonstration populations:
- a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 30, the actual number of eligible member months for the GAP demonstration populations defined in STC 17 and for the ARTS component described in section XIV. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information. To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

- b. The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three (3) months contributes three eligible member months to the total. Two (2) individuals who are eligible for two (2) months each contribute two (2) eligible member months to the total, for a total of four (4) eligible member months.
- c. For purposes of the ARTS component of the demonstration, a member month is defined as a calendar month in which a demonstration eligible received any ARTS expenditure authority services at any time during the month, including the short-term residential stay.

38. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

39. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below, subject to the limits described in Section IX:

- a. Administrative costs, including those associated with the administration of the demonstration.
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan.
- c. Medical assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

40. Sources of Non-Federal Share. The state must certify that the matching non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable

regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.
- c. The state assures that all healthcare-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

41. State Certification of Public Expenditures. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

- a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
- b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
- d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes,

(including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

X. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

42. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal Title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The GAP component limit is determined using a disabled diversion model. The budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS’ assessment of the state’s compliance with these annual limits will be done using the Schedule C report from the CMS-64.

43. Calculation of the Budget Neutrality Limit. The budget neutrality test includes three (3) components—a GAP component, an ARTS component, and a FFCY component.

- a. **GAP Component.** The aggregate financial cap for the GAP component is determined by applying the state historical trend rate to obtain annual budget limits for demonstration years one (1) and through five (5) (the approval period). The budget neutrality limit is determined using a disability diversion model, under which demonstration expenditures for the MEG in addition to expenditures for disabled adults with SMI are not to exceed the cost of disabled adults with SMI absent the demonstration. The budget neutrality limit for the GAP component will be for the total computable cost of \$11,615,737,822 for the life of the demonstration, which is the sum of the five (5) annual components shown in the chart below. If the state chooses to operate the demonstration for fewer than five (5) years, then the budget neutrality limit will be reduced on a pro rata basis to reflect the shortened approval period, and budget neutrality will be assessed based on the shortened period.

	DY 1/ CY 2015	DY 2/ CY 2016	DY 3/ CY 2017	DY 4/ CY 2018	DY 5/ CY 2019
GAP Annual limit (total computable)	\$1,915,051,787	\$2,100,298,546	\$2,303,461,873	\$2,526,279,263	\$2,770,646,354

b. **ARTS Budget Neutrality Limit.** The ARTS component of the demonstration has a separate budget neutrality test. The test includes an allowance for hypothetical services. The expected costs of the hypothetical services are reflected in the “without-waiver” budget neutrality expenditure limit. The state must not accrue budget neutrality “savings” from the hypothetical services. To accomplish this goal, a separate expenditure cap is established for the hypothetical services, to be known as Supplemental Budget Neutrality Test One (1).

i. The MEG listed in the table below is for the Supplemental Budget Neutrality Test One (1).

	Trend	DY 1/ CY 2015	DY 2/ CY 2016	DY 3/ CY 2017	DY 4/ CY 2018	DY 5/ CY 2019
SUD IMD PMPM	5.1%	n/a	n/a	\$6,709.50	\$7,051.68	\$7,411.32

ii. The Supplemental Cap One (1) is calculated by taking the PMPM cost projection for the group in each DY, times the number of eligible member months for that group and DY, and adding the products together across the DYs. The federal share of Supplemental Cap One (1) is obtained by multiplying the total computable Supplemental Cap One (1) by the Composite Federal Share.

iii. Supplemental Budget Neutrality Test One (1) is a comparison between the federal share of Supplemental Cap One (1) and total FFP reported by the state for the hypothetical group under the following Waiver Name (SUD).

If total FFP for the hypothetical group should exceed the federal share of Supplemental Cap One (1), the difference must be reported as a cost against the budget neutrality limit described in STC 44(a).

c. **FFCY Budget Neutrality Limit.** The FFCY component of the demonstration has a separate budget neutrality test that is constructed as a hypothetical or “pass-through” service model. The state is not permitted to utilize or accrue budget neutrality “savings” from a hypothetical budget model. The separate expenditure cap for FFCY is to be referred to as “Supplemental Budget Neutrality Test Two (2)” and the expected costs of the “without-waiver” budget neutrality expenditure limit are reflected in the table below.

i. The MEG listed in the table below is for the Supplemental Budget Neutrality Test Two (2).

	Trend	DY 1/ CY 2015	DY 2/ CY 2016	DY 3/ CY 2017	DY 4/ CY 2018	DY 5/ CY 2019
FFCY PMPM	5.3%	n/a	n/a	\$477.16	\$502.45	\$529.08

- ii. The Supplemental Cap Two (2) is calculated by taking the PMPM cost projection for the group in each DY, times the number of eligible member months for that group and DY, and adding the products together across the DYs. The federal share of Supplemental Cap Two (2) is obtained by multiplying the total computable Supplemental Cap Two (2) by the Composite Federal Share.
- iii. Supplemental Budget Neutrality Test Two (2) is a comparison between the federal share of Supplemental Cap Two (2) and total FFP reported by the state for the hypothetical group under the following Waiver Name (FFCY).

If total FFP for the hypothetical group should exceed the federal share of Supplemental Cap Two (2), the difference must be reported as a cost against the budget neutrality limit described in STC 44(a).

44. Composite Federal Share Ratio. The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the state on actual demonstration expenditures during the approval period, as reported through the Medicaid Budget and Expenditure System/State Children’s Health Insurance Program Budget and Expenditure System (MBES/CBES) and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see STC 8), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

- a. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.
- b. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state’s expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the

demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative target definition	Percentage
DY 1	Cumulative budget neutrality limit plus:	3.0%
DY 2	Cumulative budget neutrality limit plus:	1.5%
DY 3	Cumulative budget neutrality limit plus:	1.0%
DY 4	Cumulative budget neutrality limit plus:	0.5%
DY 5	Cumulative budget neutrality limit plus:	0%

- c. **Exceeding Budget Neutrality.** If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.
- d. **Use of Budget Neutrality Savings.** The state must submit an amendment to invest any portion of savings below the budget neutrality expenditure cap. CMS will only consider initiatives that would enhance and improve care for the SMI population enrolled in the demonstration.
- e. **Budget Neutrality and Medicaid Expansion.** If the state expands Medicaid to include those who may be covered under Section 1902(a)(10)(A)(i)(VIII) of the Act during the demonstration’s approval period, then the demonstration will end and the budget neutrality test will be deemed to have been met.

XI. EVALUATION OF THE GAP COMPONENT OF THE DEMONSTRATION

45. Independent Evaluator. Upon approval of the demonstration, the state must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved, draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

- 46. Submission of Draft Evaluation Design.** The state shall submit a revised draft evaluation design to CMS no later than 120 days after the award of the demonstration amendment. The revised evaluation design should include the original evaluation design, as well as a proposal for evaluating the new elements of the demonstration, to include increasing the eligibility to 100 percent of the FPL, the added services to the GAP benefit package (partial day hospitalization, residential treatment, and withdrawal management), The state must also submit an evaluation of the FFCY component of the demonstration as described in STC 89.
- 47. Submission of Final Evaluation Design.** The state shall provide the Final Evaluation Design within sixty (60) days of receipt of CMS comments of the Draft Evaluation Design. If CMS finds that the Final Evaluation Design adequately accommodates its comments, then CMS will approve the Final Evaluation Design within and attach to these STCs as Attachment D. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's Medicaid website within thirty (30) days of CMS approval.
- 48. Evaluation Budget.** A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.
- 49. Evaluation Questions and Hypotheses.** Consistent with attachments H and I (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF). CMS recommends hypotheses include an assessment of the objectives of SUD section 1115 demonstrations, to include (but is not limited to): initiation and compliance with treatment, appropriate utilization of health services (emergency department and inpatient hospital settings), and a reduction in key outcomes such as deaths due to overdose.

- 50. Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.
- a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.
 - b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
 - c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
 - d. The state must submit the final Interim Evaluation Report sixty (60) days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
 - e. The Interim Evaluation Report must comply with attachment I (Preparing the Evaluation Report) of these STCs.

51. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with attachment I (Preparing the Evaluation Report) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within eighteen (18) months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

- a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within sixty (60) days of receiving comments from CMS on the draft.
- b. The final Summative Evaluation Report must be posted to the state's Medicaid website within thirty (30) days of approval by CMS.

- 52. State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the interim evaluation, and/or the summative evaluation.
- 53. Public Access.** Per 42 CFR 431.428(b), the state shall post the draft Annual Monitoring Reports and other final documents (e.g., Monitoring Reports, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state’s Medicaid website within thirty (30) days of approval by CMS.
- 54. Additional Publications and Presentations.** For a period of twenty-four (24) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party (an entity which is not the state or contractor) over which the state Medicaid agency has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given thirty (30) days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.
- 55. Deferral for Failure to Submit Timely Demonstration Deliverables.** The state agrees that CMS has the authority to issue deferrals in the amount of \$5,000,000 (federal share) for each item when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:
- a. Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.
 - b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Should CMS agree in writing to the state’s request, a corresponding extension of the deferral process described below can be provided.
 - c. CMS may agree to a corrective action as an interim step before applying the deferral, if requested by the state.
 - d. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.
 - e. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.

- f. As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required reports, evaluations, and other deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.
- g. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example what quarter the deferral applies to, and how the deferral is released.

56. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 57.

XII. HEALTH INFORMATION TECHNOLOGY

57. Health Information Technology (HIT). The state will use HIT to link services and core providers across the continuum of care to the greatest extent possible. The state is expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.

- a. Health IT: Virginia must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified electronic health record (EHR) technology and the ability to exchange data through the state's health information exchanges. If providers do not currently have this technology, there must be a plan in place to encourage adoption, especially for those providers eligible for the Medicare and Medicaid EHR Incentive Program.
- b. The state must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information exchange. Federal funding for developing health information exchange (HIE) infrastructure may be available, per the May 18, 2011, State Medicaid Director letter #11-004, to the extent that allowable costs are properly allocated among payers. The state must ensure that all new systems pathways efficiently prepare for 2014 eligibility and enrollment changes.

- c. All requirements must also align with Virginia’s State Medicaid HIT Plan and other planning efforts such as the Office of the National Coordinator (ONC) HIE Operational Plan.

XIII. T-MSIS REQUIREMENTS

On August 23, 2013, a State Medicaid Director Letter entitled, “Transformed Medicaid Statistical Information System (T-MSIS) Data,” was released. It states that all States are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data by July 1, 2014. Among other purposes, these data can support monitoring and evaluation of the Medicaid program in Virginia against which the Virginia GAP demonstration will be compared.

Should the MMIS fail to maintain and produce all federally required program management data and information, including the required T-MSIS, eligibility, provider, outcome measures, participant satisfaction, and managed care encounter data, in accordance with requirements in the SMM Part 11, FFP may be suspended or disallowed as provided for in federal regulations at 42 CFR 433 Subpart C, and 45 CFR Part 95.

XIV. ADDICTION RECOVERY TREATMENT SERVICES (ARTS) DELIVERY SYSTEM TRANSFORMATION DEMONSTRATION

58. Program Description and Objectives. The ARTS Delivery System Transformation is a demonstration program to test a new paradigm for the delivery of health care services for all Medicaid-eligible individuals with substance use disorders (SUD) (both those served via the managed care and fee-for-service delivery systems). No Medicaid state plan beneficiaries, nor the Former Foster Care Youth eligible under that component of this demonstration, are excluded from the ARTS demonstration. The ARTS demonstration provides an expanded SUD benefit package to all Medicaid recipients and introduces policy, practice and system reforms consistent with the programmatic requirements of the CMS State Medicaid Director (SMD) letter #15-003. The implementation date for the ARTS demonstration is April 1, 2017.

The ARTS program demonstrates how comprehensive and high quality substance use disorder care can improve the health of ARTS recipients while decreasing other health care system (such as Emergency Department and inpatient hospital) costs. Critical elements of the ARTS demonstration include providing a continuum of care modeled after the American Society of Addiction Medicine Criteria (ASAM Criteria) for SUD treatment services, introducing policy and program measures to ensure providers meet the ASAM Criteria standards of care, integrating SUD treatment services into a comprehensive managed care delivery system for those recipients receiving managed care; increasing reimbursement rates for SUD treatment services to increase provider capacity and access to services for members, creating utilization controls to improve care and ensure efficient use of resources, and implementing strategies to improve the quality of care through evidence-based best practices. This

approach is expected to provide Medicaid recipients with access to the care needed to achieve sustainable recovery.

The ARTS demonstration will evaluate the outcomes of introducing additional benefits and delivery systems transformations. The five key goals of the demonstration are to:

- Improve quality of care and population health outcomes for the Medicaid population;
- Increase Medicaid recipients' access to and utilization of community-based and outpatient ARTS;
- Decrease utilization of high-cost emergency department and hospital services by Medicaid recipients with SUDs by expanding treatment in more cost-effective community-based residential and outpatient settings;
- Improve care coordination and care transitions for Medicaid recipients with SUDs; and,
- Increase the number and type of health care clinicians providing ARTS to Medicaid recipients with SUDs.

59. ARTS Demonstration Basic Concepts

- a. Delivery System - The ARTS benefit is a Medicaid benefit package available to Virginia's Medicaid recipients. The ARTS benefit will be available to Medicaid recipients who meet the medical necessity criteria, will be delivered to individuals enrolled in managed care through their managed care organization (MCO), and will be delivered via fee-for-service (FFS) for individuals who are not enrolled in managed care through the behavioral health service administrator (BHSA). Each MCO and the BHSA must submit an ARTS Network Development Plan describing its current ARTS network and plan to develop a more comprehensive network by ASAM level of care in each region. Subsequently and upon DMAS approval of the ARTS Network Development Plan, each MCO and the BHSA must submit an ARTS Network Readiness Plan describing its ARTS network by region and specifying which ASAM levels of care will have adequate numbers of providers and which levels of care will require further provider development. For residential levels of care, at least one sublevel level of care is required to be available to beneficiaries upon implementation within each MCO and BHSA network. Within three years, all ASAM levels and sublevels of care delivering ARTS benefits will be required to be available to recipients within each MCO and BHSA network.
- b. Short-Term Resident - Any recipient receiving residential or inpatient SUD services pursuant to the ARTS demonstration, regardless of the length of stay or the bed size of the facility, is a "short-term resident" of the residential or inpatient facility in which they are receiving the services. Short-term residential treatment is defined as an average length of stay of thirty (30) days. The state must track member months for these individuals.

- c. ARTS Medical Criteria - In order to receive ARTS, the recipient must be enrolled in Virginia Medicaid and meet the following medical necessity criteria.
- i. Must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; or be assessed to have a current substance use disorder, based on a diagnosis from the DSM to have the presence of a current substance disorder, based on a diagnosis from the DSM Substance-Related and Addictive Disorders (with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders) and an assessment which identifies treatment needs consistent with ASAM adult medical necessity criteria or for individuals under twenty-one (21), ASAM adolescent treatment criteria. Nothing in the ARTS demonstration waives or supersedes any EPSDT requirements.
 - ii. Must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.
 - iii. If applicable, must meet the ASAM adolescent treatment criteria. Recipients under age twenty-one (21) are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which includes all appropriate and medically necessary services needed to correct or ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Nothing in the ARTS demonstration waives or supersedes any EPSDT requirements.
 - iv. The determination of medical necessity, multidimensional ASAM assessment, placement of recipients at appropriate levels of care and recommendations for lengths of stay in residential treatment settings will be made by ARTS Care Coordinators or a licensed physician employed by the MCO or the BHSA. The ARTS Care Coordinators are licensed clinical psychologists, licensed clinical social workers, licensed professional counselors, licensed nurse practitioners or registered nurses with clinical experience in substance use disorders.
- d. Grievances and Appeals - Each MCO and the BHSA shall have an internal grievance process that allows a recipient, or a provider on behalf of the recipient, to challenge a denial of coverage of services or denial of payment for services. The Virginia Department of Medical Assistance (DMAS) will provide beneficiaries access to a state fair hearing process.

60. ARTS Delivery System Transformation Demonstration Benefits. The comprehensive ARTS benefits package guarantees access to a full continuum of care for SUD treatment. Standard SUD services approved through the state plan benefit as well as ARTS benefit services approved through this demonstration will be available to all Virginia Medicaid recipients. The following service categories outlined in Table One and for which the licensing standards are outlined in Table Two are included in the ARTS benefit package for Virginia Medicaid enrollees:

Table One: ARTS Benefits (with Expenditure Authority)

ASAM Level of Care	ARTS Benefit	Medicaid Authority	Costs Not Otherwise Matchable
N/A	SUD Case Management	State plan	
N/A	Crisis Intervention	State plan	
0.5	Screening, Brief Intervention and Referral to Treatment	State plan	
1	Outpatient	State plan	
1	Peer Recovery Supports	State plan	
2.1	SUD Intensive Outpatient	State plan	
2.5	SUD Partial Hospitalization	State plan	
3.1	Clinically Managed Low Intensity Residential	Section 1115 demonstration	Services provided to short-term residents
3.3	Clinically managed Population-Specific High Intensity Residential	Section 1115 demonstration	Services provided to short-term residents
3.5	Clinically Managed High Intensity Residential Services	Section 1115 demonstration	Services provided to short-term residents
3.7	Medically Monitored Intensive Inpatient Services	Section 1115 demonstration and State plan	Services provided to short-term residents
4	Medically Managed Intensive Inpatient	State plan	
OTP	Opioid Treatment Program	State plan	
OBOT	Office Based Opioid Treatment	State plan	

Table Two: Licensing Standards by ASAM Level of Care

ASAM Level of Care	ASAM Description	State Licensing Standard
1	Outpatient	Outpatient Services
2.1	SUD Intensive Outpatient	Substance Abuse Intensive Outpatient Service for Adults, Children, and Adolescents
2.5	SUD Partial Hospitalization	Substance Abuse Partial Hospitalization or Substance Abuse/Mental Health Partial Hospitalization
3.1	Clinically Managed Low Intensity Residential	Mental Health & Substance Abuse Group Home Service for Adults or Children; Substance Abuse Halfway House for Adults
3.3	Clinically managed Population-Specific High Intensity Residential	Supervised Residential Treatment Services for Adults; Substance Abuse Residential Treatment for Adults
3.5	Clinically Managed High Intensity Residential Services	Substance Abuse Residential Treatment Services for Adults or Children; Psychiatric Unit
3.7	Medically Monitored Intensive Inpatient Services	Psychiatric Unit within an acute care general hospital; Acute/freestanding psychiatric hospital with a Medical Detox license; Substance Abuse Residential Treatment Services for Adults or Children with a Medical Detox license; Residential Crisis Stabilization Units with a detox license
4	Medically Managed Intensive Inpatient	Acute care general hospital (12-VAC5-410)
OTP	Opioid Treatment Program	Opioid Treatment Services

61. SUD Case Management

Assists children, adults and their families with accessing needed medical, psychiatric, SUD, social, educational, vocational and other supports essential to meeting basic needs.

The components of SUD Case management are:

- a. Enhancing community integration through increased opportunities for community access and involvement and creating opportunities to enhance community living skills to promote community adjustment including, to the maximum extent possible, the use of local community resources available to the general public;
- b. Making collateral contacts with the individual's significant others with properly authorized releases to promote implementation of the individual's individual service plan (ISP) and community adjustment;
- c. Assessing needs and planning services to include developing a case management ISP. The ISP shall utilize accepted placement criteria and shall be fully completed within thirty (30) calendar days of initiation of service.
- d. Linking the individual to those community supports that are most likely to promote the personal habilitative or rehabilitative and life goals of the individual as developed in the ISP;
- e. Assisting the individual directly to locate, develop, or obtain needed services, resources, and appropriate public benefits;
- f. Assuring the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments.
- g. Monitoring service delivery through contacts with individuals receiving services and service providers and periodic site and home visits to assess the quality of care and satisfaction of the individual;
- h. Providing follow-up instruction, education, and counseling to guide the individual and develop a supportive relationship that promotes the ISP;
- i. Advocating for individuals in response to their changing needs, based on changes in the ISP;
- j. Planning for transitions in the individual's life;

- k. Knowing and monitoring the individual's health status, any medical conditions, medications and potential side effects, and assisting the individual in accessing primary care and other medical services, as needed; and
- l. Understanding the capabilities of services to meet the individual's identified needs and preferences and to serve the individual without placing the individual, other participants, or staff at risk of serious harm.

62. Crisis Intervention

Immediate care due to acute dysfunction requiring immediate clinical attention to prevent exacerbation of condition, prevent injury to member or other and provide treatment in least restrictive setting. Crisis Intervention will be covered using mental health crisis intervention services and subsequent referrals to ARTS benefits would be covered as an ARTS service.

The components of SUD Crisis Intervention are:

- a. Assessing the crisis situation;
- b. Providing short-term counseling designed to stabilize the individual;
- c. Providing access to further immediate assessment and follow-up; and,
- d. Linking the individual and family with ongoing care for the beneficiary to prevent future crises.

63. Early Intervention Services (ASAM Level 0.5)

Early Intervention is comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. The purpose of early intervention services, including screening, brief intervention and referral to treatment (SBIRT), is to identify individuals who may have alcohol and/or other substance use problems. Following a screening, a brief intervention is provided to educate individuals about their use, alert them to possible consequences and, if needed, begin to motivate them to take steps to change their behavior.

The components of Early Intervention are:

- a. Identifying individuals who may have alcohol or other substance use problems using an evidence-based screening tool.
- b. Following the evidence-based screening tool, a brief intervention by a licensed clinician shall be provided to educate individuals about their use, alert them to possible consequences, and, if needed, begin to motivate them to take steps to change their behavior or behaviors.

- c. Referral: Health care providers will make referrals to the MCO, the BHSA or providers for assessment and treatment through the ARTS demonstration.

64. Outpatient Services (ASAM Level 1)

Counseling services are provided to recipients with an SUD diagnosis (up to nine (9) hours per week for adults, and less than six (6) hours per week for adolescents) based on an evaluation by a certified addiction treatment professional and in accordance with an individualized service plan. Outpatient Services include professionally directed screening, evaluation, treatment and ongoing recovery and disease management services.

Services can be provided by a certified addiction treatment professional in any appropriate setting in the community. Services can be provided in-person, by telephone or by telehealth.

The components of Outpatient Services are:

- a. Services shall include professionally directed screening, evaluation, treatment, and ongoing recovery and disease management services.
- b. A multidimensional assessment shall be used and shall be documented to determine that an individual meets the medical necessity criteria and shall include the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. The assessment shall include a physical examination and laboratory testing necessary for substance use disorder treatment as necessary.
- c. Individual counseling between the individual and a credentialed addiction treatment professional shall be provided. Services provided face-to-face or by telehealth shall qualify as reimbursable.
- d. Group counseling by a credentialed addiction treatment professional, with a maximum of ten (10) individuals in the group shall be provided. Such counseling shall focus on the needs of the individuals served.
- e. Counseling services involving the beneficiary's family and significant others to advance the beneficiary's treatment goals, when (1) the counseling with the family member and significant others is for the direct benefit of the beneficiary, (2) the counseling is not aimed at addressing treatment needs of the beneficiary's family or significant others, and (3) the beneficiary is present except when it is clinically appropriate for the beneficiary to be absent in order to advance the beneficiary's treatment goals.

- f. Evidenced-based patient education on addiction, treatment, recovery and associated health risks shall be provided.
- g. Medication services shall provide the prescription of or administration of medication related to substance use treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and order laboratory testing within their scope of practice or licensure.
- h. Collateral services shall be provided. These services will be for the direct benefit of the beneficiary, will not be aimed at addressing treatment needs of individuals other than the beneficiary, and the beneficiary will be present except when it is clinically appropriate for the beneficiary to be absent in order to advance the beneficiary's treatment goals.

65. Peer Recovery Supports (ASAM Level 1.0)

Peer-provided support services for adults, adolescents and family support partner services to impacted family members to initiate clinical utilization and self-determination strategies. Peer Providers have supervisory arrangements with licensed clinicians and certification with organization deemed acceptable by the Virginia Department of Behavioral Health and Developmental Services (DBHDS). Peers must register with the Virginia Counseling Board in order to become eligible to provide reimbursable services. Peers may work under supervision, in a variety of service settings.

68. SUD Intensive Outpatient Services (ASAM Level 2.1)

Structured programming services provided to recipients with an SUD diagnosis (a minimum of nine (9) hours with a maximum of nineteen (19) hours per week for adults, and a minimum of six (6) hours with a maximum of nineteen (19) hours per week for adolescents) when determined to be medically necessary by an ARTS Care Coordinator, physician or medical director employed by the MCO or BHSA and in accordance with an individualized service plan. Services are provided before/after work/school, in evening and/or weekends to meet complex needs of people with addiction and co-occurring conditions. SUD Intensive Outpatient Services arrange medical and psychiatric consultation, psycho-pharmacological consultation, addiction medication management and twenty-four (24) hour crisis services.

Lengths of treatment can be extended when determined to be medically necessary. Services can be provided by a licensed professional or a certified counselor in any appropriate setting in the community. Services can be provided in-person, by telephone or by telehealth.

The components of SUD Intensive Outpatient Services are (see Outpatient Services for definitions):

- a. Psychiatric and other individualized treatment planning.
- b. Individual and group counseling, medication management, family therapy, and psychoeducation. The services will be for the direct benefit of the beneficiary. Counseling, psychoeducation, and related services will not be aimed at addressing treatment needs of individuals other than the beneficiary, and the beneficiary will be present except when it is clinically appropriate for the beneficiary to be absent in order to advance the beneficiary's treatment goals.
- c. Withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, an individual's use of alcohol and other drugs.
- d. Occupational and recreational therapies, motivational interviewing, enhancement, and engagement strategies.
- e. Psycho-pharmacological consultation.
- f. Addiction medication management and twenty-four (24) hour crisis services are available.
- g. Medical, psychological, psychiatric, laboratory, and toxicology services.
- h. Emergency services within twenty-four (24) hours by telephone and within 72 hours in person.
- i. Direct affiliation with (or close coordination through referrals to) more and less intensive levels of care.

69. SUD Partial Hospitalization Services (ASAM Level 2.5)

Structured programming services provided to recipients with an SUD diagnosis (twenty (20) or more hours of clinically intensive programming per week) when determined to be medically necessary by an ARTS Care Coordinator, physician or medical directly employed by the MCO or BHSA and in accordance with an individualized service plan. SUD Partial Hospitalization Services include direct access to psychiatric, medical, laboratory and toxicology services, physician consultation within eight (8) hours by phone and forty-eight (48) hours in person, emergency services available 24/7, and coordination with more and less intensive levels of care.

Lengths of treatment can be extended when determined to be medically necessary. Services can be provided by a licensed professional or a certified counselor in any appropriate setting in the community. Services can be provided in-person, by telephone or by telehealth.

The components of SUD Partial Hospitalization Services are (see Outpatient Services for definitions):

- a. Individualized treatment planning.
- b. Medical, psychological, psychiatric, laboratory, and toxicology services, which are available by consult or referral.
- c. Withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, an individual's use of alcohol and other drugs.
- d. Psychiatric and medical formal agreements to provide medical consult within eight hours by telephone, forty-eight (48) hours in person.
- e. Emergency services which are available twenty-four (24) hour and seven (7) days a week.
- f. Direct affiliation with or close coordination through referrals to more and less intensive levels of care.
- g. Therapies shall include a minimum of twenty (20) hours per week and at least six hours per day of skilled, clinically intensive treatment services with a planned format including individual and group counseling, medication management, family therapy, education groups, occupational and recreational therapy and other therapies. The services will be for the direct benefit of the beneficiary. Counseling, education groups, and related services will not be aimed at addressing treatment needs of individuals other than the beneficiary, and the beneficiary will be present except when it is clinically appropriate for the beneficiary to be absent in order to advance the beneficiary's treatment goals.
- h. Family therapies involved family members, guardians, or significant other in the assessment, treatment, and continuing care of the individual.
- i. Planned format of therapies, delivered in individual or group setting must be adapted to the individual's developmental stage and comprehension level.
- j. Motivational interviewing, enhancement, and engagement strategies shall be used.

70. Residential Services (ASAM Level 3)

Rehabilitation services provided to recipients with an SUD diagnosis who are short-term residents when determined to be medically necessary by an ARTS Care Coordinator, physician or medical director employed by the MCO or BHSA and in accordance with an individualized service plan. ARTS Care Coordinators, physicians

or medical directors will perform independent assessments to determine level of care and length of stay recommendations based upon the ASAM Criteria multidimensional assessment criteria and matrices to match severity and level of function with type and intensity of service for adults and adolescents. ARTS Care Coordinators, physicians or medical directors will document the use of the ASAM multidimensional assessment and matrices for matching severity with type and intensity of services in a uniform service review request form. The MCOs and the BHSA must provide prior authorization for residential services within twenty-four (24) hours of the prior authorization request being submitted by the provider for residential and inpatient services.

Virginia Medicaid recipients that are short-term residents will receive all medically necessary services, regardless of the bed size of the facility. The Commonwealth's average length of stay for individuals admitted into all Virginia Department of Behavioral Health and Developmental Services (DBHDS)-licensed ASAM Level 3.1, 3.3, 3.5 and 3.7 programs is thirty (30) days. Residential services are provided in a DBHDS-licensed facility that has been issued an ASAM Level of Care certification for Levels 3.1, 3.3, 3.5, and/or 3.7, credentialed and enrolled by an MCO or the BHSA as a network provider.

One ASAM Level 3 sublevel of care is required for DMAS' approval of an ARTS Network Readiness Plan submitted by an MCO or the BHSA. Each MCO and BHSA network must demonstrate all ASAM Level 3 sublevels of care within three years of implementation.

The components of Residential Services are (see Outpatient Services for definitions):

- a. Physician consultation and emergency services shall be available twenty-four (24) hours a day, seven (7) days per week.
- b. Having direct affiliations or referral sources to lower levels of care such as intensive outpatient services, vocational resources, literacy training, and adult education.
- c. Ability to arrange for medically necessary procedures including laboratory and toxicology tests which are appropriate to the severity and urgency of individual's condition.
- d. Ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications.
- e. Direct affiliation with (or close coordination through referral to) more and less intensive levels of care and other services such as sheltered workshops, literacy training, and adult education.

Therapies shall include:

- a. Clinically-directed treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies. Services shall promote personal responsibility and re-integration of the individual into the network systems of work, education, and family life;
- b. Addiction pharmacotherapy and drug screening;
- c. Motivational enhancement and engagement strategies;
- d. Counseling and clinical monitoring;
- e. Withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, an individual's use of alcohol and other drugs;
- f. Regular monitoring of the individual's medication adherence;
- g. Recovery support services;
- h. Services involving the individual's family and significant others, as appropriate to advance the individual's treatment goals and objectives identified in the ISP; (the services will be for the direct benefit of the beneficiary, will not be aimed at addressing treatment needs of individuals other than the beneficiary, and the beneficiary will be present except when it is clinically appropriate for the beneficiary to be absent in order to advance the beneficiary's treatment goals) and,
- i. Education on benefits of medication assisted treatment and referral to treatment as necessary.

Residential Services are delivered in the following ASAM Level 3 sublevels of care and Inpatient Services are defined as ASAM Level 4:

ASAM Level of Care	ASAM Description	State Licensing Standard
3.1	Clinically Managed Low Intensity Residential: Supportive living environment with 24-hour staff that provides rehabilitation services to beneficiaries with an SUD diagnosis (5 or more hours of low-intensity treatment per week) when determined to be medically necessary by an	Mental Health & Substance Abuse Group Home Service for Adults or Children; Substance Abuse Halfway House for Adults

	ARTS Care Coordinator and in accordance with an individualized service plan.	
3.3	Clinically Managed Population-Specific High Intensity Residential: Clinically managed therapeutic rehabilitative facility for adults with cognitive impairment including developmental delay. Staffed by credentialed addiction professionals, physicians/physician extenders, and credentialed mental health professionals.	Supervised Residential Treatment Services for Adults; Substance Abuse Residential Treatment for Adults
3.5	Clinically Managed High Intensity Residential Services: Clinically managed therapeutic community or residential treatment facility providing high intensity services for adults or medium intensity services for adolescents. Staffed by licensed/credentialed clinical staff, including addiction counselors, licensed clinical social workers, licensed professional counselors, physicians/physician extenders, and credentialed mental health professionals.	Substance Abuse Residential Treatment Services for Adults or Children; Psychiatric Unit
3.7	Medically Monitored Intensive Inpatient Services: Medically monitored inpatient services in a freestanding residential facility or inpatient unit of an acute care hospital or psychiatric unit. Includes 24-hour clinical supervision including physicians, nurses, addiction counselors and behavioral health specialists.	Psychiatric Unit within an acute care general hospital; Acute/freestanding psychiatric hospital with a Medical Detox license; Substance Abuse Residential Treatment Services for Adults or Children with a Medical Detox license; Residential Crisis Stabilization Units with a detox license

4	<p>Medically Managed Intensive Inpatient: Acute care general or psychiatric hospital with 24/7 medical management and nursing supervision and counseling services 16 hours per day. Managed by addiction specialist physician with interdisciplinary team of credentialed clinical staff knowledgeable of biosychosocial dimensions of addictions.</p>	<p>Acute care general hospital (12-VAC5-410)</p>
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71. Withdrawal Management Services

Withdrawal management services are provided to recipients with an SUD diagnosis when determined to be medically necessary by an ARTS Care Coordinator, physician, or medical director employed by the MCO or BHSA and in accordance with an individualized service plan.

Withdrawal Management services shall be provided when medically necessary, as a component of the Medically Managed Intensive Inpatient Services (ASAM Level 4); Substance Use Residential/Inpatient Services (ASAM Levels 3.3, 3.5, and 3.7); Substance Use Intensive Outpatient and Partial Hospitalization Programs (ASAM Level 2.1 and 2.5); Opioid Treatment Services ((Opioid Treatment Programs (OTP) and Office Based Opioid Treatment (OBOT)); Substance Use Outpatient Services (ASAM Level 1).

72. Opioid Treatment Program (OTP) Services

Physician-supervised daily or several times weekly opioid agonist medication and counseling services provided to maintain multidimensional stability for those with severe opioid use disorder in DBHDS-licensed CSBs and private methadone clinics in accordance with an individualized service plan determined by a licensed physician or licensed prescriber and approved and authorized according to the Commonwealth of Virginia requirements.

Opioid Treatment Programs may provide care coordination services as a distinct reimbursable service when the provider meets the Opioid Treatment Program enrollment criteria.

The components of Opioid Treatment Programs are:

- a. Linkage to psychological, medical, and psychiatric consultation.

- b. Access to emergency medical and psychiatric care through connections with more intensive levels of care.
- c. Access to evaluation and ongoing primary care.
- d. Ability to conduct or arrange for appropriate laboratory and toxicology tests including urine drug screenings.
- e. Availability of licensed physicians to evaluate and monitor use of methadone, buprenorphine products or naltrexone products and of pharmacists and nurses to dispense and administer these medications.
- f. Individualized, patient-centered assessment and treatment.
- g. Assessing, ordering, administering, reassessing, and regulating medication and dose levels appropriate to the individual; supervising withdrawal management from opioid analgesics, including methadone, buprenorphine products or naltrexone products; overseeing and facilitating access to appropriate treatment for opioid use disorder.
- h. Medication for other physical and mental health illness is provided as needed either on-site or through collaboration with other providers.
- i. Cognitive, behavioral, and other substance use disorder-focused therapies, reflecting a variety of treatment approaches, provided to the individual an individual, group, or family basis.
- j. Optional substance use care coordination provided including integrating behavioral health into primary care and specialty medical settings through interdisciplinary care planning and monitoring individual progress and tracking individual outcomes; supporting conversations between buprenorphine-waivered practitioners and behavioral health professionals to develop and monitor individualized service plans; linking individuals with community resources to facilitate referrals and respond to social service needs; tracking and supporting individuals when they obtain medical, behavioral health, or social services outside the practice.
- k. Referral for screening for infectious diseases such as HIV, Hepatitis B and C, and Tuberculosis at treatment initiation and then at least annually or more often based on risk factors.

73. Office-Based Opioid Treatment (OBOT) Services

Physician-supervised medication and counseling services provided to maintain multidimensional stability for those with severe opioid use disorder by primary care providers and other physician offices in accordance with an individualized service

plan determined by a licensed physician or licensed prescriber and approved and authorized according to the Commonwealth of Virginia requirements.

Office Based Opioid Treatment Programs may provide care coordination services as a distinct reimbursable service when the provider meets the Office Based Opioid Treatment enrollment criteria.

The components of Office-Based Opioid Treatment (OBOT) Services are:

- a. Access to emergency medical and psychiatric care.
- b. Affiliations with more intensive levels of care such as intensive outpatient programs and partial hospitalization programs that unstable individuals can be referred to when clinically indicated.
- c. Individualized, patient-centered assessment and treatment.
- d. Assessing, ordering, administering, reassessing, and regulating medication and dose levels appropriate to the individual; supervising withdrawal management from opioid analgesics; overseeing and facilitating access to appropriate treatment for opioid use disorder and alcohol use disorder.
- e. Medication for other physical and mental illnesses shall be provided as needed either on-site or through collaboration with other providers.
- f. Cognitive, behavioral, and other substance use disorder-focused therapies, reflecting a variety of treatment approaches, shall be provided to the individual on an individual, group, or family basis and shall be provided by Credentialed Addiction Treatment Professionals working in collaboration with the buprenorphine-waivered practitioner who is prescribing buprenorphine products or naltrexone products to individuals with moderate to severe opioid use disorder.
- g. Care coordination provided including interdisciplinary care planning between buprenorphine-waivered physician and the licensed behavioral health provider to develop and monitor individualized and personalized treatment plans that are focused on the best outcomes for the individual, monitoring individual progress and tracking individual outcomes, linking individual with community resources to facilitate referrals and respond to social service needs, and tracking and supporting individuals when they obtain medical, behavioral health, or social services outside the practice.
- h. Referral for screening for infectious diseases such as HIV, Hepatitis B and C, and Tuberculosis at treatment initiation and then at least annually or more often based on risk factors.

74. Incorporation of Industry Standards of Care

Through revisions of its contract requirements for MCOs and the BHSA, Medicaid state plan, state regulations and provider manuals, DMAS will establish standards of care for ARTS that incorporate industry standard benchmarks from the ASAM Criteria for defining medical necessity criteria, covered services and provider qualifications. An estimated timeline for completion of draft and final revisions to the Medicaid state plan, state regulations, MCO and BHSA contracts, and provider manuals is included as Attachment E.

Each provider of ARTS must be assessed to meet the provider competencies and capacities described in the ASAM Criteria for the requisite level or sublevel of care prior to participating in the Virginia Medicaid program under the ARTS demonstration. The following processes will be implemented to verify that ARTS providers deliver care consistent with the ASAM Criteria:

- a. All DBHDS-licensed residential treatment services will provide a self-attestation to DMAS as comporting with ASAM Level 3.1, 3.3, 3.5 and/or 3.7.
- b. DMAS will contract with a vendor with expertise in the ASAM Criteria to conduct site visits to verify the self-attestation and certify residential treatment providers as ASAM Level 3.1, 3.3, 3.5 and/or 3.7 programs based on site visits.
- c. Providers will receive site visit reports from the DMAS contractor verifying that their programs meet ASAM criteria for Level 3.1, 3.3, 3.5, and/or 3.7 that they will submit to the MCOs and the BHSA as a requirement to become credentialed as residential treatment providers.
- d. The MCOs and the BHSA will provide preliminary credentialing for ASAM Levels 3.1, 3.3, 3.5 and/or 3.7, contingent on the providers receiving certification from the external vendor with expertise in ASAM. The MCOs and BHSA will finalize their credentialing after the providers submit their site visit reports verifying they are ASAM Level 3.1, 3.3, 3.5 and/or 3.7 programs.
- e. State regulations will be issued to define service structure and provider requirements consistent with the ASAM Criteria. The MCO and BHSA contracts will be modified to reference these regulations and reflect the ASAM Criteria within provider credentialing and networking requirements.

The ASAM certification process will be continued by the DMAS contractor or by another state agency pending legislative approval.

All Virginia Medicaid recipients referred to or seeking ARTS Levels of Care 2.1 through 4.0 will receive multidimensional assessments, level of care and length of stay recommendations based upon the ASAM Criteria.

ARTS Care Coordinators are as follows: licensed clinical psychologists, licensed clinical social workers, licensed professional counselors, nurse practitioners, or registered nurses with substance use disorder experience and the necessary competencies to use the ASAM multidimensional assessment criteria and matrices, to match severity and level of function with type and intensity of service for adults and adolescents.

For ASAM Levels 2.1, 2.5 and 3.1an ARTS service provider will conduct an assessment of the recipient's clinical needs and submit clinical information to either the MCO or the BHSA for review. ARTS Care Coordinators or a licensed physician will document the use of the ASAM multidimensional assessment and matrices for matching severity with type and intensity of services in a uniform service review request form. Each service review will assess service needs, coordination needs and ensure appropriate placement in the appropriate level of care based on the recipient's needs as demonstrated in the ASAM Criteria multidimensional assessment tool. The MCOs and the BHSA must provide reimbursement authorization decisions for intensive outpatient and partial hospitalization within three (3) calendar days of the authorization request being submitted by the provider.

For ASAM Levels 3.3-4.0, ARTS service providers will complete a preadmission assessment of the recipient's clinical needs and submit the clinical information to either the MCO or the BHSA for prior authorization. ARTS Care Coordinators or a licensed physician will document the use of the ASAM multidimensional assessment and matrices for matching severity with type and intensity of services in a uniform service review request form. Each service review will assess service needs, coordination needs and ensure appropriate placement in the appropriate level of care based on the recipient's needs as demonstrated in the ASAM Criteria multidimensional assessment tool. The MCOs and the BHSA must provide prior authorization for residential and inpatient services within one (1) calendar day of the prior authorization request being submitted by the provider.

75. Responsibilities of MCOs and the BHSA for ARTS Benefits

The responsibilities of the MCOs and the BHSA for the ARTS benefit shall be consistent with the requirements defined in the DMAS Addiction and Recovery Treatment Services Provider Manual, the executed managed care organization contract or the behavioral administrative service organization contract. The ARTS Network Development Plan and ARTS Network Readiness Plan will be implemented as defined in the MCO and BHSA contracts with DMAS to include the responsibilities listed below:

76. Responsibilities of MCOs and the BHSA—Provider Network Development

- a. The MCO and BHSA contracts will be modified to incorporate ASAM requirements into provider credentialing and networking, utilization management and service coordination processes to ensure that service provision is reviewed based on the ASAM Criteria and that care coordination structures match the ASAM Criteria.
- b. The MCOs and the BHSA will credential and enroll network providers licensed within the scope of practice as defined by Virginia state licensure authorities. The MCOs and the BHSA will use a standardized provider credentialing checklist developed by DMAS for OTPs and OBOTs that align with the ASAM Criteria. State licensure requirements for Outpatient Services (ASAM Level 1.0), Intensive Outpatient (ASAM Level 2.1), and Partial Hospitalization (ASAM Level 2.5) currently align with ASAM Criteria. The DMAS contractor which will perform site visits to Residential Treatment providers will ensure that MCO and BHSA credentialing for the Residential Services (ASAM Levels 3.1 through 3.7) aligns with ASAM Criteria.
- c. Each MCO and the BHSA must submit an ARTS Network Development Plan describing its current ARTS network and its plan to develop a more comprehensive network for each ASAM level of care in each region. DMAS will compare the submitted plans with a list of all providers who meet each ASAM level of care in the region to verify that each MCO and the BHSA have developed the most comprehensive networks possible. Subsequently and upon DMAS approval of the ARTS Network Development Plan, each MCO and the BHSA must submit an ARTS Network Readiness Plan describing its ARTS services network by region and specifying which ASAM levels of care will have adequate numbers of providers and which levels of care will require further provider development.
 - i. For residential levels of care, at least one sublevel level of care is required to be available to recipients upon implementation within each MCO and the BHSA network. Within three (3) years, all ASAM levels and sublevels of care delivering ARTS benefits will be required to be available to recipients within each MCO and the BHSA network.
 - ii. Access standards and timeliness requirements, including number of days to first ARTS service at appropriate level of care after referral, will be specified in the ARTS Network Development Plans and the ARTS Network Readiness Plans and referenced in the managed care organization and administrative service organization contracts.
- d. The MCOs and the BHSA will deliver monthly network files to DMAS to provide updates on network development progress as required in the MCO and BHSA contract.

- e. The MCOs and the BHSA will adhere to dashboard data submission requirements to ensure that administrative oversight is effective and that service delivery is monitored in accordance with MCO and BHSA business rules as defined in the MCO and BHSA procedural manuals.
- f. The BHSA must select only providers that, prior to the furnishing of services under this demonstration, have enrolled with, or revalidated their current enrollment with, DMAS under applicable federal and state regulations, have been screened in accordance with 42 CFR 455.450, pursuant to a designated categorical risk level, have signed a Medicaid provider agreement with DMAS as required by 42 CFR 431.107, and have complied with the ownership and control disclosure requirements of 42 CFR 455.104. DMAS shall deny enrollment and certification to any provider, or person with ownership or control interest in the provider (as defined in 42 CFR 455.101), that, at the time of the application, is under investigation for fraud or abuse pursuant to 42 CFR 455, unless DMAS determines that there is good cause not to deny enrollment upon the same bases enumerated in 42 CFR 455.23(e).
- g. The same requirement described at (f) above will apply to network providers of MCOs no later than the rating period for contracts beginning on or after July 1, 2018, pursuant to 42 CFR 438.602(b)(1), whereby state Medicaid agencies must screen, enroll and periodically revalidate all network providers of MCOs consistent with the screening and enrollment regulations at 42 CFR 455 Subparts B and E.

77. Responsibilities of MCOs and the BHSA—Provider Requirements

Each MCO and the BHSA will include the following provider requirements within their contracts with ARTS providers:

- a. Telehealth and in-home assessments: Each MCOs and the BHSA will ensure that network providers performing patient assessments have telehealth capabilities that care managers are knowledgeable about the telehealth delivery system, and that Virginia Medicaid recipients in rural areas or areas with provider shortages are able to receive patient assessments through telehealth delivery. For Virginia Medicaid recipients that are unable to receive telehealth or in-person assessments at the provider location due to transportation, psychosocial or other health issue, the MCOs and the BHSA will provide in-home patient assessments and evaluations.
- b. Culturally Competent Services: The MCOs and the BHSA will ensure that providers deliver services in a manner that demonstrates cultural and linguistic competency. Recipients will be able to select programs and providers within those programs that meet their needs for self-determination, recovery, community integration and cultural competency. To ensure that programs and services meet the cultural and linguistic needs of recipients, the MCOs and the BHSA will utilize resources such as census data and

enrollment files to identify member language, race and ethnicity when possible to determine additional languages for written materials, compatibility with practitioner networks, cultural and linguistic needs of recipients and other potential healthcare needs that might be associated with cultural beliefs and healthcare behaviors. Translation services must be available for recipients as needed.

- c. Medication Assisted Treatment (MAT): Providers will have procedures for linkage/integration for recipients requiring MAT. Provider staff will regularly communicate with physicians of recipients who are prescribed these medications unless the client refuses to consent to sign a 42 CFR part 2-compliant release of information for this purpose.

78. Responsibilities of MCOs and the BHSA—Care Coordination

Each MCO and the BHSA will implement structured care coordination plans designed to assess the whole person, including physical health, mental health, and substance use, and achieve seamless transitions of care, including transitions between ARTS providers, transitions between delivery systems (i.e. FFS and managed care), and transitions between systems of care (i.e. physical and behavioral).

- a. The MCOs and the BHSA shall have a 24/7 toll-free number for recipients to call to access ARTS providers. Oral interpretation services must be made available for recipients as needed.
- b. The MCOs and the BHSA will use data from multiple sources (including utilization data, health risk assessments, state agency aid categories, demographic information, and Health Department epidemiology reports) to identify recipients with complex health needs, including recipients who need help navigating the health system to receive appropriate delivery of care and services.
- c. When clinically indicated, the MCOs and the BHSA will assign each recipient to a care manager to provide care management support throughout the course of treatment, ensuring that all relevant information is shared with the treating providers through care transitions. MCOs that are participating in the Commonwealth Coordinated Care dual eligible financial alignment demonstration are permitted to utilize existing care coordinators and Plans of Care for ARTS-related treatment planning and care coordination, where applicable.
- d. All providers are required to engage in discharge planning, including coordination with the provider at the next level of care, to ensure the new provider is aware of the progress from the prior level of care. The MCOs and the BHSA will provide ongoing education to providers regarding these requirements and conduct chart reviews to ensure compliance and identify opportunities to improve quality of care. The MCOs and the BHSA will

facilitate the transfer of clinical information between treating practitioners to foster continuity of care and progress towards recovery.

- e. The MCOs will refer to and collaborate with the BHSA for mental health services not specifically related to SUD. BHSA case management staff will assess recipient needs for psychiatric or psychosocial services and refer as necessary to providers. The BHSA will ensure communication via medical records and other appropriate means to enable the MCOs to adequately track member progress.
- f. The MCOs and the BHSA will inform stakeholders and partners, including CSBs, private behavioral health care providers, FQHCs, primary care physicians, emergency departments and hospitals of the resources available to them when integrating services or developing comprehensive plans of care for recipients. The MCOs and the BHSA will work with these stakeholders and partners to develop workflows and operational protocols for assisting recipients to access necessary care.
- g. The MCOs and the BHSA are encouraged to develop care management and coordination structures to manage pregnant and post-partum populations with histories of or current substance use, focusing on planning strategies to facilitate a recovery environment addressing improvements in maternal and child health, positive birth outcomes and addiction and recovery treatment approaches.

79. ARTS Provider Specifications

The following requirements will apply to providers furnishing ARTS:

- a. Professional staff must be licensed, registered, certified or recognized under Virginia scope of practice statutes. Professional staff shall provide Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioner of the Healing Arts includes: credentialed addiction treatment professionals " consisting of addiction-credentialed physician or physician with experience in addiction medicine; licensed psychiatrist; licensed clinical psychologist; licensed clinical social worker; licensed professional counselor; licensed psychiatric clinical nurse specialist; licensed psychiatric nurse practitioner; licensed marriage and family therapist; licensed substance abuse treatment practitioner; or "Residents" under supervision of licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10) or licensed substance abuse treatment practitioner (18VAC115-60-10) approved by the Virginia Board of Counseling; "Residents in psychology" under supervision of a licensed clinical psychologist approved by the Virginia Board of Psychology (18VAC125-20-10); "Supervisees in social work" under the supervision of a licensed clinical social worker approved by the Virginia Board of Social

Work (18VAC140-20-10); and an individual with certification as a substance abuse counselor (CSAC) (18VAC115-30-10) or certified substance abuse counselor-assistant (CSAC-A) (18VAC115-30-10) under supervision of licensed provider and within scope of practice.(§ 54.1-3507.1 & § 54.1-3507.2).

- b. Non-professional staff shall receive appropriate on-site orientation and training prior to performing assigned duties. Non-professional staff will be supervised by professional and/or administrative staff as required in Virginia state licensing authorities.
- c. Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring as required in Virginia state licensing authorities.

80. Prescription Drug Abuse and Opioid Strategy

The ARTS demonstration contributes to a comprehensive statewide strategy to combat prescription drug abuse and opioid use disorders. Concurrent to this demonstration, DMAS and sister state agencies will implement a number of measures to prevent opioid-related harms, introduce robust pharmacy benefit management strategies to ensure appropriate opioid pain medication utilization, improve the availability of evidence-based treatment, and increase the provision of naloxone to reverse opioid overdose and reduce overdose deaths, including the following:

- a. Following the Prescription Monitoring Program requirements as defined in Title 54.1, Chapter 25.2 of the Code of Virginia and in the MCO and BHSA contracts.
- b. Requiring hospice settings to notify pharmacies of a patient's death to prevent diversion of prescription opioid pain medication
- c. Introducing targeted provider education requirements regarding pain management, prescribing, and the diagnosis and management of addiction based on prescribing history data.
- d. Expanding a regional pilot making naloxone available to family members and friends statewide, thereby granting pharmacists the ability to dispense naloxone under protocol and allowing laypersons to possess and administer naloxone.
- e. Disseminating naloxone kits and training to health care professionals, law enforcement officers, firefighters, advocates and others through Project *REVIVE!*, the state's opioid overdose reversal program. This activity is not eligible for FFP.

- f. Encouraging prescribers to offer naloxone to any recipient taking greater than 50 morphine milligram equivalents (MME) of a prescription opioid per day, and encouraging prescribers to give prescriptions for naloxone to any patient taking greater than 90 MME per day.
- g. Integrating the *CDC Guidelines for Prescribing Opioids for Chronic Pain (CDC Guidelines)* into the DMAS FFS Preferred Drug List and MCO formularies, including covering all non-opioid pain relievers and removing prior authorization requirements for non-opioid pain relievers and for naloxone.
- h. Requiring Medicaid MCOs and the FFS to implement uniform prior authorizations for short and long-acting opioids that require urine drug screens and checks of the Virginia Prescription Monitoring Program and are consistent with the *CDC Guidelines*.
- i. Recommending that all prescribers in the Commonwealth follow the recommendations in the *CDC Guidelines*, and educating prescribers on these guidelines.
- j. Continuing to implement patient review and restriction programs within the managed care delivery system (commonly called a “lock-in program”) to identify members with or at risk of prescription drug abuse or opioid use disorder and refer them to case management or ARTS services, including the Patient Utilization Management and Safety Program operated by the MCOs.
- k. Introducing claims edits for concurrent opioid and benzodiazepine prescriptions.
- l. Reducing administrative barriers to prescribing MAT products, including removing the service authorization requirement for extended-release naltrexone and buprenorphine products.
- m. Pursuing alternative payment models for MAT services to improve care quality, including a substance use care coordination payment to OBOTs and OTPs that will support interdisciplinary care planning between buprenorphine-waivered physicians and licensed behavioral health providers to develop and monitor individualized and personalized treatment plans that are focused on the best outcomes for the individual.
- n. Developing state guidelines for best practices for buprenorphine providers.
- o. Developing a process for the MCOs and the BHSA to credential “gold card” OBOT providers that will provide high-quality, evidence-based treatment, including medication and psychosocial supports.

- p. Implementing a comprehensive statewide MAT training curriculum for OBOT providers, including a buprenorphine waiver training track for physicians, NPs and PAs, and a psychosocial counseling track for behavioral health providers. This activity is not eligible for FFP.

81. Services for Adolescents and Youth

DMAS will ensure that benefits are covered, services are available and access is timely for youth and adolescents with SUD as required under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. Care coordination efforts will include methods to ensure adolescent clinical issues are assessed within the context of the ASAM adolescent placement criteria. At a minimum, assessment and services for adolescents will follow the ASAM Criteria adolescent treatment criteria. In addition, the state will identify recovery services geared towards adolescents, such as those described in the January 26, 2015 CMS Informational Bulletin “Coverage for Behavioral Health Services for Youth with Substance Use Disorder.”

82. State Oversight, Monitoring and Reporting

- a. Monitoring Plan: The State shall maintain a plan for oversight and monitoring of ARTS providers, the MCOs and the BHSA to ensure compliance and corrective action with standards, access, and delivery of quality care and services.
 - i. Through revisions to the contract requirements, DMAS will require the MCOs and the BHSA to monitor providers in accordance with NCQA credentialing standards.
 - ii. The state will monitor the MCOs at least once per year through the External Quality Review Organizations (EQRO).
 - iii. If significant deficiencies or significant evidence of noncompliance with the terms of this demonstration, the ARTS Network Development Plan or the ARTS Network Readiness Plan, DMAS will engage the MCO or the BHSA to determine if there are challenges that can be addressed with facilitation and technical assistance. If the MCO or the BHSA remains noncompliant, the MCO or the BHSA must submit a corrective action plan (CAP) to DMAS. The CAP must detail how and when the MCO or the BHSA will remedy the issue(s) as defined in the MCO and BHSA contracts.
- b. Timely Access: The state must ensure that the MCOs and the BHSA comply with network adequacy and access requirements as defined in the MCO contracts and the BHSA contracts. Medical attention for emergency and crisis medical conditions must be provided according to NCQA access standards.

- c. Reporting of Activity: The State will report activity consistent with the General Financial Requirements, the Reporting Requirements Related to Budget Neutrality and the Demonstration Annual Report as set forth in this demonstration, Section VIII General Reporting Requirements. In addition to the requisite information described in STC 30, the annual report shall include all of the following:
 - i. Summary of operational, policy development, issues, complaints, grievances and appeals. The State will also include any trends discovered, the resolution of complaints and any actions taken or to be taken to prevent such issues, as appropriate.
 - ii. Number of days to first ARTS treatment at appropriate level of care after referral.
 - iii. Existence of a 24/7 telephone access line with prevalent non-English language(s).
 - iv. Access to ARTS with translation services in the prevalent non-English language(s).
 - v. Number, percentage and time period of service authorization requests approved or denied.

83. Quality Improvement, Monitoring and Reporting.

Each MCO and the BHSA will use, and expand as necessary, their existing quality improvement infrastructures, quality improvement processes and performance measurement data systems to ensure continuous quality improvement of ARTS. At a minimum, each MCO and the BHSA must have an Annual Quality Management Plan that includes the MCO's or the BHSA's plan to monitor the service delivery, capacity as evidenced by a description of the current number, types and geographic distribution of substance use disorder services.

- a. The monitoring of accessibility of services outlined in the Quality Improvement Plan will at a minimum include:
 - i. Timeliness of first initial contact to face-to-face appointment.
 - ii. Timeliness of first initial contact to the initial provision of OTP, OBOT or MAT services.
 - iii. Access to after-hours care.
 - iv. Responsiveness of the beneficiary access line in answering calls, and in successfully resolving requests for assistance.

- v. Strategies to reduce avoidable hospitalizations.
 - vi. Assessment of the recipients' experiences through a patient satisfaction survey.
 - vii. Telephone access line and services in the prevalent non-English languages.
 - viii. Number, percentage of total requests denied, and waiting period for decisions on service authorization requests, whether approved or denied.
- b. The quality improvement processes outlined in the Quality Improvement Plan will at a minimum include:
- i. Monitoring system-wide issues and performance issues.
 - ii. Identifying opportunities for improvement.
 - iii. Determining the root causes of performance issues.
 - iv. Exploring alternatives and developing and approving a plan of action; and
 - v. Activating the plan, measuring the results, evaluating effectiveness of actions, and modifying the approach as needed.
- c. The MCOs and the BHSA will adhere to regular dashboard data submission requirements to ensure that administrative oversight is effective and that service delivery is monitored in accordance with MCO and BHSA contractual requirements. DMAS will require the MCOs and the BHSA to provide quarterly quality dashboards with the following data:
- i. Process measures
 - 1. Number of Medicaid recipients served.
 - 2. Number of licensed and credentialed providers of each ARTS service and peer supports.
 - 3. Recipient and provider grievances and appeals.
 - ii. Outcome measures
 - 1. ED utilization rate.
 - 2. Hospitalization rate.

3. Hospital readmission rate and ARTS readmission rate for ASAM Levels 2.1 through 4.0.
 4. Utilization rates for each service, including data pm denials of services, including peer supports.
- d. The MCOs and the BHSA will implement procedures for evaluating successful care transitions between ARTS levels of care as well as linkages with primary care upon discharge. Evaluations of care transitions and linkages with primary care may be captured through established processes including the following:
- i. Collaboration with providers, including the setting of expectations for successful transition planning;
 - ii. Provider education and training;
 - iii. Treatment record reviews to assess coordination with the primary care physician and referring provider(s), as well as discharge planning to appropriate providers;
 - iv. Care management and medical necessity review processes, e.g.,
 1. Monitoring for appropriate transitions of care and avoidance of gaps in service provision.
 2. Provider outreach calls to assist in effective transition planning.
- e. The MCOs and the BHSA will have a Utilization Management (UM) Program assuring that recipients have appropriate access to substance use disorder services; medical necessity has been established and the recipient is at the appropriate ASAM level of care and that the interventions are appropriate for the diagnosis and level of care. The MCOs and the BHSA shall have a documented system for collecting, maintaining and evaluating accessibility to care and waiting list information, including tracking the number of days to first ARTS treatment at an appropriate level of care following initial request or referral for ARTS.
- f. The MCOs and the BHSA will provide the necessary data and information required in order to comply with the evaluation required by the ARTS demonstration.
- g. How does the demonstration affect the clinician ARTS training and ARTS services provision?

- i. To what extent are efforts to prepare and train health care clinicians successful in getting them to appropriately provide ARTS benefits?
 - ii. How do the new ARTS benefit and demonstration affect the number and type of health care clinicians providing ARTS to Virginia Medicaid recipients with SUD?
- h. How does the demonstration affect recipients' access to and utilization of ARTS?
 - i. To what extent do the new ARTS benefit and demonstration increase the percentage of Medicaid recipients living in communities with an adequate supply of clinicians offering ARTS to Medicaid recipients?
 - ii. How do the new ARTS benefit and demonstration affect the type and quantity of ARTS used by Medicaid recipients with SUD?
- i. How does the demonstration affect recipient health outcomes and quality of care?
 - i. What is the impact of the availability of ARTS residential treatment on emergency department visits, inpatient admissions, and readmissions to the same level of care or higher for ARTS (e.g. inpatient admissions, community-based high intensity residential and community-based low intensity residential)?
 - ii. Are there spillover effects of the new ARTS benefit on utilization and cost for other physical and behavioral health care services, such as emergency department visits, inpatient admissions and readmissions for non-addiction treatment-related services?
 - iii. What is the impact of the new ARTS benefit on fatal and nonfatal drug overdoses among Virginia Medicaid recipients?
 - iv. What is the impact of the new ARTS benefit and demonstration on the number of Medicaid babies born with neonatal abstinence syndrome (NAS) and the average length of NICU admission to treat NAS?
 - v. What is the impact of the "carve-in" of ARTS benefits into managed care plans on health care utilization and the coordination of care with other behavioral and physical health problems?
- j. How does the ARTS demonstration affect member costs, particularly costs associated with emergency department visits, inpatient stays, inpatient readmissions, and NICU admissions to treat infants with NAS?

XV. EVALUATION OF THE ARTS COMPONENT OF THE DEMONSTRATION

84. Independent Evaluator. At the beginning of the SUD component, the state must acquire an independent party to conduct an evaluation of the SUD component of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in accord with the CMS-approved, draft evaluation plan. For scientific integrity, every effort should be made to follow the approved methodology, but requests for changes may be made in advance of running any data or due to mid-course changes in the operation of the demonstration.

85. Evaluation Design Approval and Updates. Within 120 days of the demonstration amendment award, the state must submit a Draft Evaluation Design to CMS for comment and approval. The state's Draft Evaluation Design may be subject to multiple revisions until a format is agreed upon by CMS. The state must submit a revised Draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the Draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation research and submit their evaluation implementation progress in each of the Quarterly Reports and Annual Reports (per STC 30), including any required Rapid Cycle Assessments.

86. Evaluation Budget. A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.

87. Evaluation Requirement

- a. The demonstration evaluation will meet the prevailing standards of scientific evaluation and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings.
 - i. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.
 - ii. The state shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the state's process for

obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the state will assure no conflict of interest, and a budget for evaluation activities.

The evaluation shall assess the impact of the SUD component of the demonstration on the following outcomes among beneficiaries in need of substance use disorder treatment:

- i. Emergency room utilization for consequences of substance use disorders including opioid overdoses;
 - ii. Access to acute inpatient and residential treatment for substance use disorders;
 - iii. Lengths of stay in acute inpatient and residential settings for treatment of substance use disorders;
 - iv. Access to community-based treatment for substance use disorders including medication assisted treatment;
 - v. Quality of substance use disorder treatment including medication assisted treatment;
 - vi. Quality of discharge planning in making effective linkages to community- based care;
 - vii. Readmissions to the same level of care or higher;
 - viii. Cost of treatment for substance use disorder conditions;
 - ix. Overall cost of care for individuals with substance use disorders including co-morbid physical and mental health conditions;
 - x. Opioid prescribing patterns; and
 - xi. Drug overdose deaths.
- b. The state expects to address the following questions in its evaluation:
- i. How does the demonstration affect the clinician ARTS training and ARTS services provision?
 - ii. To what extent are efforts to prepare and train health care clinicians successful in getting them to appropriately provide ARTS benefits? How do the new ARTS benefit and demonstration affect the number

and type of health care clinicians providing ARTS to Virginia Medicaid recipients with SUD?

- iii. How does the demonstration affect recipients' access to and utilization of ARTS? To what extent do the new ARTS benefit and demonstration increase the percentage of Medicaid recipients living in communities with an adequate supply of clinicians offering ARTS to Medicaid recipients?
 - iv. How do the new ARTS benefit and demonstration affect the type and quantity of ARTS used by Medicaid recipients with SUD? How does the demonstration affect recipient health outcomes and quality of care?
 - v. What is the impact of the availability of ARTS residential treatment on emergency department visits, inpatient admissions, and readmissions to the same level of care or higher for ARTS (e.g. inpatient admissions, community-based high intensity residential and community-based low intensity residential)?
 - vi. Are there spillover effects of the new ARTS benefit on utilization and cost for other physical and behavioral health care services, such as emergency department visits, inpatient admissions and readmissions for non-addiction treatment-related services?
 - vii. What is the impact of the new ARTS benefit on fatal and nonfatal drug overdoses among Virginia Medicaid recipients?
 - viii. What is the impact of the new ARTS benefit and demonstration on the number of Medicaid babies born with neonatal abstinence syndrome (NAS) and the average length of NICU admission to treat NAS?
 - ix. What is the impact of the "carve-in" of ARTS benefits into managed care plans on health care utilization and the coordination of care with other behavioral and physical health problems?
 - x. How does the ARTS demonstration affect member costs, particularly costs associated with emergency department visits, inpatient stays, inpatient readmissions, and NICU admissions to treat infants with NAS?
- c. DMAS will collect reliable and valid data from the MCOs and the BHSA to enable reporting of the quality measures listed in the table below:

Table Two: ARTS Quality Measures

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

88. State Must Separately Evaluate Components of the Demonstration. The outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the state met the demonstration goal, with recommendations for future efforts regarding all components.

- a. At a minimum, the Draft Evaluation Design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those outlined in STC 46. The draft design shall discuss:
 - i. The outcome measures that must be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population;
 - ii. It shall discuss the data sources and sampling methodology for assessing these outcomes; and,
 - iii. The Draft Evaluation Design must include a detailed analysis plan that describes how the effects of the demonstration are isolated from other initiatives occurring in the state.
- b. The evaluation must outline and address evaluation questions for all of the following components:
 - i. GAP component;

- ii. ARTS component; and
- iii. FFCY component.

XVI. Evaluation of the FFCY Component of the Demonstration. The state's evaluation design and final plan must also include an evaluation of the FFCY component of the demonstration that meets all the standards and requirements outlined in these STCs for conducting an evaluation of the demonstration. The state must submit a FFCY evaluation design component within 120 days of award that identifies how it will test the hypothesis aimed at evaluating the extent to which the demonstration increases and strengthens overall coverage of former foster care youth and improves health outcomes for these youth. This evaluation component will be incorporated in these STCs as Attachment G.

89. Evaluation Standards. The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

90. Draft Interim Evaluation Reports. In the event the state requests to extend the demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the state must submit a draft interim evaluation report for the completed years of the approval period represented in these STCs, as outlined in 42 CFR 431.412(c)(2)(vi). The state must submit an Interim Evaluation Report to CMS as part of any future request to extend the demonstration. The state will provide a final interim report thirty (30) days after receiving comments from CMS.

- a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.
- b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
- c. If the state requests changes to the demonstration, it must identify research questions and hypotheses related to the changes requested and an evaluation design for addressing the proposed revisions.

91. Summative Evaluation Report. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period represented in these STCs within eighteen (18) months following the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved evaluation design.

- a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within thirty (30) days of receiving comments from CMS.

92. State Presentations for CMS. The state will present to and participate in a discussion with CMS on the final design plan, post approval, in conjunction with Section XVI. The state shall present on its interim evaluation in conjunction with STC 90. The state shall present on its summative evaluation in conjunction with STC 91

93. Public Access. The state shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the state Medicaid website within thirty (30) days of approval by CMS.

- a. For a period of twenty-four (24) months following CMS approval of the Interim and Summative Evaluation Reports, CMS will be notified prior to the public release or presentation of these reports and related journal articles, by the state, contractor or any other third party directly connected to the demonstration. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given thirty (30) days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

XVII. SCHEDULE OF STATE DELIVERABLES

The state is held to all reporting requirements outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Reference	Deliverable
Per award letter - Within 30 days of the date of award	Confirmation Letter to CMS Accepting Demonstration STCs
Per STC 24	Submit Outreach Plan
Per STC 46	Submit Draft Evaluation Design
Per STC 9	Submit Demonstration Extension Application
Per STC 46 Within 120 days of the amendment	Submit the revised evaluation design reflecting the increase in FPL amendment and additional SUD services
Per STC 85	Submit ARTS draft evaluation design
Per Section XVI	Submit the former foster care youth draft evaluation design
Quarterly	Deliverable

Per STC 30	Quarterly Monitoring Reports
Per STC 33	Quarterly Expenditure Reports
Annual	Deliverable
Per STC 11	Annual Forum Transparency deliverable
Per STC 30	Demonstration Annual Report
Renewal/Close Out	Deliverable
Per STC 50	Interim Evaluation Report
Per STC 51	Summative Report

ATTACHMENT A
DIAGNOSES ELIGIBLE FOR VIRGINIA GAP DEMONSTRATION

To be considered as meeting the criteria as a GAP Seriously Mentally Ill individual, the individual must have had a diagnostic evaluation within the past year, or at the time of the screening, by a Licensed Mental Health Professional, including Residents and Supervisees, (LMHP means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist; or a Resident or Supervisee that is registered with the appropriate board, under the direct supervision of a licensed clinical psychologist, licensed professional counselor (LPC), licensed clinical social worker (LCSW), licensed substance abuse treatment practitioner, or licensed marriage and family therapist.) that results in one of the following diagnoses:

- 296.7 Bipolar Disorder, Most Recent Episode Unspecified
- 296.8 Bipolar Disorder, NOS
- 296.20 Major Depressive Disorder, Single Episode, Unspecified
- 296.21 Major Depressive Disorder, Single Episode, Mild
- 296.22 Major Depressive Disorder, Single Episode, Moderate
- 296.23 Major Depressive Disorder, Single Episode, Severe, Without Psychotic Features
- 296.24 Major Depressive Disorder, Single Episode, Severe, with Psychotic Features
- 296.25 Major Depressive Disorder, Single Episode, in Partial Remission
- 296.26 Major Depressive Disorder, Single Episode, in Full Remission
- 296.30 Major Depressive Disorder, Recurrent, Unspecified
- 296.31 Major Depressive Disorder, Recurrent, Mild
- 296.32 Major Depressive Disorder, Recurrent, Moderate
- 296.33 Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features
- 296.34 Major Depressive Disorder, Recurrent, Severe, With Psychotic Features
- 296.35 Major Depressive Disorder, Recurrent, in Partial Remission
- 296.36 Major Depressive Disorder, Recurrent, in Full Remission
- 296.40 Bipolar I Disorder, Most Recent Episode Manic, Unspecified
- 296.40 Bipolar I Disorder, Most Recent Episode Hypomanic
- 296.41 Bipolar I Disorder, Most Recent Episode Manic, Mild
- 296.42 Bipolar I Disorder, Most Recent Episode Manic, Moderate
- 296.43 Bipolar I Disorder, Most Recent Episode Manic, Severe, Without Psychotic
Features
- 296.44 Bipolar I Disorder, Most Recent, Episode Manic, Severe With Psychotic Features
- 296.45 Bipolar I Disorder, Most Recent Episode Manic, In Partial Remission
- 296.46 Bipolar I Disorder, Most Recent Episode Manic, In Full Remission
- 296.50 Bipolar I Disorder, Most Recent Episode Depressed, Unspecified
- 296.51 Bipolar I Disorder, Most Recent Episode Depressed, Mild
- 296.52 Bipolar I Disorder, Most Recent Episode Depressed, Moderate
- 296.53 Bipolar I Disorder, Most Recent Episode Depressed, Severe Without Psychotic
Features
- 296.54 Bipolar I Disorder, Most Recent Episode Depressed, Severe, With Psychotic
Features
- 296.55 Bipolar I Disorder, Most Recent Episode Depressed, In Partial Remission

296.56	Bipolar I Disorder, Most Recent Episode Depressed, In Full Remission
297.1	Delusional Disorder
298.8	Brief Psychotic Disorder
298.9	Psychotic Disorder, NOS
300.01	Panic Disorder
300.22	Agoraphobia
300.3	Obsessive Compulsive Disorder
309.81	Posttraumatic Stress Disorder
307.1	Anorexia Nervosa
307.51	Bulimia Nervosa
295.90	Schizophrenia
295.70	Schizoaffective disorder
298.8	Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
298.9	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
296.89	Other Specified Bipolar and Related Disorder
296.8	Unspecified Bipolar and Related Disorder

In addition, the diagnostic evaluation must include documentation related to the duration of the mental illness and the level of disability based on the mental illness:

1. Duration of Illness: The person must meet at least one of these criteria:
 - a. Is expected to require services of an extended duration.
 - b. Has undergone psychiatric treatment more intensive than outpatient care, such as crisis response services, alternative home care, partial hospitalization, or inpatient hospitalization, more than once in his or her lifetime.
 - c. Has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.

2. Level of Disability: The person must meet at least two of these criteria on a continuing or intermittent basis. There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitation in major life activities. Due to the person's mental illness:
 - a. Is unemployed; employed in a sheltered setting or a supportive work situation; has markedly limited or reduced employment skills; or has a poor employment history.
 - b. Requires public and family financial assistance to remain in the community and may be unable to procure such assistance without help.
 - c. Has difficulty establishing or maintaining a personal social support system.
 - d. Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.
 - e. Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.

And in addition, due to mental illness, the person requires assistance to consistently access and to utilize needed medical and/or behavioral health services/supports. (Required).

One of the two screening types listed below must be completed in order to determine GAP SMI eligibility.

1. Limited Screening: Conducted for individuals who have had a diagnostic evaluation completed by a LMHP (including Supervisees and Residents) within the past 12 months and this evaluation is available to the screener. The GAP SMI Screening Tool (DMAS-P-603) may be completed by either an LMHP (including Supervisees and Residents), Qualified Mental Health Professional-Adult (QMHP-A), or QMHP- Eligible (E). The available evaluation is submitted to the state's contractor as the required attachment along with the signed and dated DMAS-P-603 form.
2. Full Screening: Conducted for individuals who have not had a diagnostic evaluation completed by an LMHP (including Supervisees and Residents) within the past twelve (12) months or for whom the evaluation is not available to the screener. The signed and dated GAP SMI Screening Tool (DMAS-P-603) and diagnostic evaluation conducted at the time of the screening must be completed by an LMHP (including Supervisees and Residents) and submitted to Magellan.

(QMHP-A and QMHP-E mean the same as defined in 12VAC35-105-20 as a QMHP-Adult or QMHP-Eligible. DMAS requirements for QMHP-A and QMHP-E are equivalent to the Department of Behavioral Health and Developmental Services provider requirements for Qualified Mental Health Professionals.)

**ATTACHMENT B
DEMONSTRATION BENEFITS SPECIFICATIONS**

GAP Benefits, Scope of Service, and Provider Qualifications				
Benefit	Provider Qualifications	Scope and Limitations	Differences from current VA Medicaid Program	Authority
GAP Services to be provided through the Department's Behavioral Health Services Administrator (BHSA) – Administrative Costs ONLY				
Care Coordination	Same as the current VA Medicaid Program; services will be provided through the Department's BHSA, Magellan. Magellan care managers are all licensed mental health professionals.	Care managers will provide information regarding covered benefits, provider selection, and how to access all services including behavioral health and medical and using preferred pathways. Magellan care managers will work closely with CSB providers of mental health case management services to assist GAP recipients in accessing needed medical, psychiatric, social, educational, vocational, and other supports as appropriate	None	State Plan for Medical Assistance Services
Crisis Line	Same as the current VA Medicaid Program (BHSA)	The crisis line will be available to GAP recipients within the same manner as currently provided to the Medicaid and CHIP populations through Magellan. The crisis line is available 24	None	State Plan for Medical Assistance Services

GAP Benefits, Scope of Service, and Provider Qualifications				
Benefit	Provider Qualifications	Scope and Limitations	Differences from current VA Medicaid Program	Authority
		hours per-day, 7 days per-week and includes access to a licensed care manager during a crisis.		
Recovery Navigator (administrative function)	Initially recovery navigator services will be provided through the Department's BHSA; however, the Department may transition these to allow coverage and reimbursement through trained peer support providers as certified by the Department of Behavioral Health and Developmental Services (DBHDS), and consistent with CMS guidance issued on August 15, 2007 in State Medicaid	Magellan Recovery Navigator services are provided by trained Recovery Navigators, who self-disclose as living with or having lived with a behavioral health condition. The goal of Recovery Navigator services is to make the transition back into the community a successful one and avoid future inpatient stays. It is expected that there will be more frequent face-to-face engagement via the Recovery Navigator team compared to clinical team recipients. These voluntary services are designed to facilitate connections with local peer-run organizations, self-help groups, other natural supports, and to engage them in treatment with the appropriate community-based	Not a service provided under the current VA Medicaid program.	Section 1115 waiver demonstration.

GAP Benefits, Scope of Service, and Provider Qualifications				
Benefit	Provider Qualifications	Scope and Limitations	Differences from current VA Medicaid Program	Authority
	<p>Director (SMD) Letter #07-011. Should the state's program comply with SMD Letter #07-011, then peer supports would be covered as a medical service versus an administrative cost.</p>	<p>resources to prevent member readmissions, improve community tenure and meaningful participation in communities of their choice.</p> <p>The scope of services provided through Recovery Navigator will include services in the home, community, or provider setting including but not limited to:</p> <ul style="list-style-type: none"> • Visiting recipients in inpatient settings to develop the peer relationship that is built upon mutual respect, unique shared experiential knowledge, and facilitates a foundation of hope and self-determination to develop, or enhance, a recovery-oriented lifestyle. • Exploring peer and natural community 		

GAP Benefits, Scope of Service, and Provider Qualifications				
Benefit	Provider Qualifications	Scope and Limitations	Differences from current VA Medicaid Program	Authority
		<p>support resources from the perspective of a person who has utilized these resources and navigated multi-level systems of care. These linkages will expand to educating recipients about organizations and resources beyond the health care systems.</p> <ul style="list-style-type: none"> • Initiating dialogue and modeling positive communication skills with recipients to help them self-advocate for an individualized discharge plan and coordination of services that promotes successful community integration upon discharge from adult inpatient settings. • Assisting in decreasing the need for future hospitalizations by 		

GAP Benefits, Scope of Service, and Provider Qualifications				
Benefit	Provider Qualifications	Scope and Limitations	Differences from current VA Medicaid Program	Authority
		<p>offering social and emotional support and an array of individualized services.</p> <ul style="list-style-type: none"> • Developing rapport and driving engagement in a personal and positive supportive relationship, demonstrating and inspiring hope, trust, and a positive outlook, both by in-person interactions on the inpatient unit and a combination of face-to-face and ‘virtual’ engagement for GAP participants in the community. • Providing social, emotional and other supports framed around the 8 dimensions of wellness as defined by SAMHSA*. • Brainstorming to identify strengths and needs post-discharge, assisting member to be better self-advocates, and ensure that the 		

* <http://www.samhsa.gov/wellness-initiative/eight-dimensions-wellness>

GAP Benefits, Scope of Service, and Provider Qualifications				
Benefit	Provider Qualifications	Scope and Limitations	Differences from current VA Medicaid Program	Authority
		<p>discharge plan is comprehensive and complete.</p> <ul style="list-style-type: none"> • Brainstorming with the member to identify the triggers and/or stressors that led to the psychiatric hospitalization. • Direct face-to-face as well as toll-free warm-line services to eligible GAP recipients 7 days per week. The warm-line is a telephonic Recovery Navigator resource staffed by as needed Recovery Navigators, trained specifically in warm-line operations and resource referrals. The warm-line associated with the Recovery Navigator GAP services program would offer extended hours, toll-free access, and dedicated data collection capabilities. 		

<p>ARTS Peer Support Services and ARTS Family Support Partners</p>	<p>Same as the current VA Medicaid Program</p>	<p>Mental Health Peer Support Services or Mental Health Family Support Partners shall not be rendered at the same time as ARTS Peer Support Services or ARTS Family Support Partners</p>	<p>None</p>	<p>State Plan for Medical Assistance Services (contingent on SPA 17-019 approval)</p>
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Mental Health Peer Support Services and Mental Health Family Support Partners	Same as the current VA Medicaid Program (BHSA)	Mental Health Peer Support Services or Mental Health Family Support Partners shall not be rendered at the same time as ARTS Peer Support Services or ARTS Family Support Partners	None	State Plan for Medical Assistance Services (contingent on SPA 17-019 approval)
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GAP Benefits, Scope of Service, and Provider Qualifications				
Benefit	Provider Qualifications	Scope and Limitations	Differences from current VA Medicaid Program	Authority
GAP Services to be provided through the Department's Medicaid provider network				
Outpatient physician, FQHC/ RHC, clinic, specialty care, consultation, and treatment; includes evaluation, diagnostic and treatment procedures performed in the physician's office; includes therapeutic or diagnostic injections.	Same as the current VA Medicaid Program	No exclusions where the place of treatment is the physician's office except as shown in Table 9 of the original demonstration application reflecting non-covered services; otherwise, the scope of coverage is within the current Virginia Medicaid coverage guidelines.	No emergency room or inpatient coverage; no coverage for excluded services per Table 9 of the original demonstration application reflecting non-covered services.	State Plan for Medical Assistance Services
Outpatient hospital coverage, including diagnostic and radiology services electrocardiogram, authorized CAT and MRI scans.	Same as the current VA Medicaid Program	No exclusions where the place of service is the physician's office except as shown in Table 9 of the original demonstration application reflecting non-covered services; otherwise, the scope of coverage is within current Virginia Medicaid coverage guidelines.	No emergency room or inpatient coverage. Outpatient hospital treatment coverage is limited; see exclusions in Table 9 of the original demonstration application reflecting non-covered services.	State Plan for Medical Assistance Services

Outpatient laboratory	Same as the current VA Medicaid Program	No exclusions where the place of service is the physician's office except as shown in Table 9 of the original demonstration application reflecting non-covered services; otherwise, the scope of coverage is within current Virginia Medicaid coverage guidelines.	None	State Plan for Medical Assistance Services
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GAP Benefits, Scope of Service, and Provider Qualifications				
Benefit	Provider Qualifications	Scope and Limitations	Differences from current VA Medicaid Program	Authority
Outpatient pharmacy	Same as the current VA Medicaid Program	Coverage is within the current Virginia Medicaid coverage guidelines.	None	State Plan for Medical Assistance Services
Telemedicine	Same as the current VA Medicaid Program	No exclusions where the place of service is the physician's office except as shown in Table 9 of the original demonstration application reflecting non-covered services; otherwise, the scope of coverage is within current Virginia Medicaid coverage guidelines.	None	State Plan for Medical Assistance Services
Outpatient medical equipment and supplies	Same as the current VA Medicaid Program	Coverage is limited to certain diabetic equipment and supply services, where the scope of coverage is shown in Appendix A.	Limited to certain diabetic equipment and supply services.	State Plan for Medical Assistance Services
GAP Mental Health Case Management	Same as the current VA Medicaid Program for targeted mental health case management	GAP Case Management (GCM) will be provided statewide and does not include the provision of direct services. GCM will have two tiers of service, regular and	Primary differences between GCM and Mental Health Targeted Case Management :	State Plan for Medical Assistance Services

GAP Benefits, Scope of Service, and Provider Qualifications				
Benefit	Provider Qualifications	Scope and Limitations	Differences from current VA Medicaid Program	Authority
	for individuals with serious mental illness.	high intensity. Regardless of the level of service, GCM will work with Magellan care managers to assist GAP recipients in accessing needed medical, behavioral health (psychiatric and substance abuse treatment), social, educational, vocational, and other support services. Individuals who need a higher intensity of service will receive face to face GCM provided in the community. Higher intensity GCM will be paid at the high intensity rate. GAP case managers will work closely with Magellan care coordinators. GCM service registration will be required with Magellan.	<ul style="list-style-type: none"> • GCM (regular intensity) does not require face to face visits. • GCM requires monthly collaboration with Magellan care management • GCM reimbursement rates are different: <ul style="list-style-type: none"> - \$95.90- Regular - \$220.80- High Intensity 	
Crisis Intervention	Same as the current VA Medicaid Program	Scope of coverage is within current Virginia Medicaid coverage guidelines.	None	State Plan for Medical Assistance Services
Crisis Stabilization	Same as the current VA Medicaid	Scope of coverage is within current Virginia Medicaid coverage	Service authorization will be	State Plan for Medical Assistance

GAP Benefits, Scope of Service, and Provider Qualifications				
Benefit	Provider Qualifications	Scope and Limitations	Differences from current VA Medicaid Program	Authority
	Program	guidelines.	required to enable effective coordination.	Services
Psychosocial Rehab Assessment and Psychosocial Rehab Services	Same as the current VA Medicaid Program	Scope of coverage is within current Virginia Medicaid coverage and reimbursement guidelines and limitations.	None	State Plan for Medical Assistance Services
Substance Abuse Intensive Outpatient (IOP) Treatment	Same as the current VA Medicaid ARTS ASAM Level 2.1 Program	Scope of coverage is within current Virginia Medicaid coverage and reimbursement guidelines and limitations.	None	State Plan for Medical Assistance Services
Methadone	Same as the current VA Medicaid ARTS Program	Scope of coverage is within current Virginia Medicaid coverage and reimbursement guidelines and limitations.	None	State Plan for Medical Assistance Services
Office based Opioid Treatment administration (OBOT)	Same as the current VA Medicaid ARTS Program	Scope of coverage is within current Virginia Medicaid coverage and reimbursement guidelines and limitations.	None	State Plan for Medical Assistance Services
Partial Hospitalization services for substance use disorders	Same as the current VA Medicaid ARTS ASAM	Scope of coverage is within current Virginia Medicaid coverage and reimbursement guidelines and limitations.	None	State Plan for Medical Assistance Services

Residential Services for substance use disorders	Same as the current VA Medicaid ARTS ASAM Levels 3.1, 3.3, 3.5, 3.7	Scope of coverage is within current Virginia Medicaid coverage and reimbursement guidelines and limitations as outlined in the Medicaid state plan and section 1115 demonstration.	None	State Plan for Medical Assistance Services (1115 expenditure authority for IMD exclusion)
Psychiatric evaluation and outpatient individual, family, and group therapies (mental health and substance abuse treatment)	Same as the current VA Medicaid Program	No exclusions except as shown in Table 9 of the original demonstration application reflecting non-covered services.	None	State Plan for Medical Assistance Services

HCPCS Code	Description	Billing Unit	SA Type	Limit
Supplies				
A4250	Urine test or reagent strips or tablet	Tablets or Strips – 100	N	3/2 Months
A4253	Blood glucose test or reagent strips for home blood glucose monitor,	Strips - 50	N	3/Month
A4256	Normal, low, and high calibrator solution/chips	Pkg.5 ml vials	N	1/Month
A4258	Spring-powered device for lancet	Each	N	1/month
A4259	Lancets	Box of 100	N	3/2 Months
S8490	Insulin Syringes	Box of 100	N	1/Month
A4245	Alcohol wipes	Box of 100	N	1/Month
Glucose Monitors				
E0607	Home blood glucose monitor	Each	N	1/36 Months
E2100	Blood glucose monitor with integrated voice synthesizer	Each	Y	
E2101	Blood glucose monitor with integrated lancing/blood sample	Each	N	
E0607 RR	Home blood glucose monitor	Day	N	3 Months
E2100 RR	Blood glucose monitor with integrated voice synthesizer	Day	N	
E2101 RR	Blood glucose monitor with integrated lancing/blood sample	Day	N	
Replacement Batteries				
A4233	Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each	Each	N	1/6 Months

GAP Demonstration Benefits Crosswalk with CMS-64 Reporting Criteria

GAP Benefit	FFP Rate%	CMS Report#	CMS-64 Line#	CMS-64 Line Label	Proc. Code	Provider Class	Provider Class Description
Crisis Intervention, Crisis Stabilization, Psychosocial Rehab Assessment, Psychosocial Rehab Services, Substance Abuse Treatment, Intensive Outpatient, Methadone, Opioid Treatment & Admin	50%	64.9	49	Other Care Services	H0020, H0032, H0036, H2016, H2017, H2019, S0109, 99408, 99409, 90846, 90847, 90853, 96372, 96374		
GAP Case Management	50%	64.9	24A	Targeted Case Mgmt. Services	H0023		

SMI Assessments - LIMITED	50%	64.10	49	Other Financial Participation	H0032	001, 002, 003, 007, 012, 091, 052, 056	
SMI Assessments - FULL	75%	64.10	3B	Skilled Professional Medical Personnel - Other Agency	H0032	001, 002, 003, 007, 012, 091, 052, 056	
Care Coordination - Claims/Netw	50%	64.10	49	Other Financial Participation			
Care Coordination - Auth/QI	75%	64.10	6	Quality Improvement Organizations (QIO)			
Outpatient physician and clinic services, FQHC/RHC services, Outpatient specialty care, consultation and	50%	64.9	5A 2A	Physician & Surgical Services - Regular Payments		020, 095, 040	Physicians, Out of State Physicians, Dentist

treatment and telemedicine	50%	64.9	9A	<i>Other Practitioner Services - Regular Payments</i>		023, 030, 031, 078	Nurse Practitioner, Podiatrist, Optometrist, LCSW
	50%	64.9	10	Clinic Services		051, 093	Health Dept. Clinic, Out of State Clinic
	50%	64.9	16	Rural Health		052	Rural Health Clinics
	50%	64.9	28	FQHC		053	FQHCs
Outpatient diagnostic & radiology, outpatient laboratory	50%	64.9	11	Laboratory/ Radiological		070, 098, 001, 091	Independent Laboratory, Out of State Laboratory, Hospital in-state General, Out of State Hospital,
Outpatient pharmacy	50%	64.9	7	Prescribed Drugs		060, 096	Pharmacy, Out of State Pharmacy
Outpatient medical equipment and supplies	50%	64.9	49	Other Care Services		062, 090	Durable Medical Equipment/Supplies , Out of State Supply/Equipment

ATTACHMENT C INFORMAL NETWORK OF BENEFITS

Preferred Pathways – Network of Care Not Covered through GAP Demonstration

The GAP Demonstration includes a voluntary network of community providers that are already actively a part of providing care to the uninsured population in Virginia. The services they will provide to GAP Participants (as a *Preferred Pathway* partner) are not reimbursable directly through any DMAS funding stream; however, these entities create a network of *Preferred Pathways* for individuals who may need services outside of the benefit package available through GAP.

As identified in the Section 1115 Application, these *Preferred Pathways* will be made up of local Community Services Boards, Federally Qualified Health Centers, Hospitals, and the Free Clinics. All of these entities have varied funding streams such as (but not limited to) federal, state, local, grant, patient pay (sliding fee scale or minimal co-payment) and donations. These entities serve in a critical role as the safety net providers for Virginia's uninsured. For those that are Medicaid providers, they will be able to bill Medicaid for GAP covered services, and be reimbursed for care otherwise would go uncompensated in the absence of GAP. DMAS' goal and commitment to CMS is to facilitate a greater emphasis on the interaction and exchange between GAP participants and the *Preferred Pathways* partners.

The *Preferred Pathways* partners will have their service level information available via a resource guide. In the event a GAP Participant needs services outside of what is covered through GAP, case managers will refer demonstration participants to local *Preferred Pathway partners*. Preferred partners are not asked to do anything different regarding the remarkable care they provide. This piece of the GAP Demonstration is meant to serve as a more streamlined resource for participants and providers, alike.

DMAS knows that many GAP Participants are currently served through existing indigent care avenues or pathways. Preferred Pathway partners will maintain their role as a community provider of health care for some of Virginia's most vulnerable adults. Understanding the importance of these partners and the role they play in Virginia's healthcare system, DMAS' application to CMS included a design of *Preferred Pathways* to ensure that GAP Demonstration participants will be given information regarding local entities that may be able to provide care for services not covered by the GAP Demonstration. Services not covered under the GAP Demonstration include: inpatient (medical and behavioral health), emergency room (ER), outpatient/ambulatory care surgery, and home care services as well as some community behavioral health services.

Services not covered through the GAP Demonstration and Preferred Pathway Partners who will be a source of reference if the GAP Participant needs these additional resources¹.

¹ GAP Participants who become pregnant will be directed to apply for full Medicaid or FAMIS MOMs coverage. Participants who have a condition that becomes significant enough to pursue a disability determination will be supported in that process.

Non-Covered Service	Preferred Pathway Resource
Emergency Department (it is anticipated that with the support of Case Managers, Peer Supports, access to primary care, behavioral health services, prescription drugs, crisis services, and other GAP covered treatment services, ED utilization will decrease.	Virginia Hospitals – in accordance with the Emergency Medical Treatment & Labor Act (EMTALA) regardless of ability to pay. GAP members will access indigent and charity care programs, where available, to mitigate financial hardship to GAP members.
	Virginia Free Clinics
Inpatient Hospital (medical and psychiatric)	Virginia Hospitals – indigent and charity care programs, consistent with EMTALA. In addition, for psychiatric treatment, members can access the State funded Temporary Detention Order (TDO) program or care in state facilities if no other alternative treatment option is available.
Outpatient Surgery (Clarification: GAP covers medically necessary procedures, including surgical procedures in a physician’s office within the amount, duration, and scope of coverage under the Virginia Medicaid program In addition, GAP covers diagnostic services in an outpatient hospital setting. For surgical or diagnostic procedures needed above the GAP realm of coverage, pathway providers will be utilized	Virginia Hospitals – indigent and charity care programs
Other – Durable Medical Equipment ² , Home Health, Rehabilitation, etc.	Virginia Assistive Technology Loan Fund Authority (www.atlfa.org) (DME)
	Indigent Care Home Health Providers (Instructive Visiting Nurses Association (IVNA)) (Home Health)
	Department for the Aging and Disability Services (DARS) (Physical Rehabilitation)

² If available in the medical office, equipment, such as crutches, can be billed as a GAP covered service through the Medical office visit.

Non-Covered Service	Preferred Pathway Resource
	Indigent Care Hospitals and Clinics (Physical Rehabilitation)
<p>Outpatient Behavioral Health Services not covered under GAP.</p> <p>Note: GAP covered services already include coverage for the full range of psychotherapy (individual, family, and group) through private and community based behavioral health providers, crisis intervention/stabilization, Recovery Navigators, psychosocial rehab, GAP case management (mental health and substance use disorder), substance abuse intensive outpatient treatment, methadone/opioid treatment,</p>	<p>Community Services Boards</p>

ATTACHMENT D

GAP DEMONSTRATION EVALUTION PLAN

Commonwealth of Virginia Department of Medical Assistance Services

Evaluation Design Plan II –

W – 00297/3

The Governor's Access Plan (GAP) for the Seriously
Mentally Ill

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GAP Demonstration Evaluation Design Plan

• Background on the Governor’s Access Plan (GAP)

All Virginians should have access to healthcare, and individuals with medical and behavioral health care needs should no longer go untreated. The Commonwealth is committed to providing services and supports to qualifying individuals, creating opportunities for individuals to recover, and live work, parent, learn, and participate fully in their communities. These opportunities will help to engage individuals in their own health care. To begin addressing this need, the Department of Medical Assistance Services (DMAS) (the Commonwealth’s, single state Medicaid agency), proposed and received a Section 1115 demonstration waiver, the *Virginia Governor’s Access Plan for the Seriously Mentally Ill (GAP)*. Effective May 15, 2015, Virginia offered a targeted package of benefits for individuals who have a serious mental illness (SM) and household income that is at or below 60 percent of the Federal Poverty Level (FPL) using the MAGI methodology. Effective July 1, 2016, Virginia is offering a targeted package of benefits for individuals who have a SMI and household income that is at or below 80 percent of the FPL using the MAGI.

The model builds on successful existing partnerships to provide and integrate basic medical and behavioral health care services. Enabling persons with SMI to access behavioral and primary health care services under a coordinated model will enhance treatment and increase the potential to significantly impact the severity of their symptoms.

The three key goals of this Demonstration are to:

1. Serve as a bridge to closing the insurance coverage gap for Virginians;
2. Improve access to health care for a segment of the uninsured population in Virginia who have significant behavioral and medical needs; and
3. Improve health and behavioral health outcomes of demonstration participants.

Populations Covered

GAP targets individuals who meet eligibility parameters resulting from a diagnosis related to SMI. In addition to having been screened as meeting the criteria for SMI, individuals must meet ALL of the requirements outlined below to be eligible for the demonstration:

1. Adult ages 21 through 64 years old;
2. SMI criteria, including documentation related to the duration of the mental illness and the level of disability based on the mental illness, as described in Attachment A;
3. Not otherwise eligible for any state or federal full benefits program including:
4. Medicaid, Children’s Health Insurance Program (CHIP/FAMIS), or Medicare;
5. Household income that is below 100 percent of the FPL plus a 5 percent income disregard (effectively 105 percent FPL);
6. Uninsured; and
7. Not residing in a long term care facility, mental health facility, or long-stay hospital.

Table 1 describes the populations that will enroll in GAP.

Table 1. GAP Populations

Eligibility Group Name	Social Security Act and CFR Citations	Income Level	Timeframe
Adults not otherwise eligible under the State plan	N/A	Household income at or below 95% FPL using the MAGI methodology	January 12, 2015 – May 14, 2015
Adults not otherwise eligible under the State plan	N/A	Household income at or below 60% FPL using the MAGI methodology	May 15, 2015 – June 30, 2016
Adults not otherwise eligible under the State plan	N/A	Household income at or below 100% FPL using the MAGI methodology	July 1, 2016 – December 31, 2019

Benefits

GAP offers a targeted benefit package of both medical and behavioral health services. The GAP demonstration does not include benchmark – equivalent coverage. The following categories of services are included in the limited benefit for Virginia GAP demonstration enrollees, which are shown in Table 2 below:

Table 2. Category of Services included in the limited benefit for Virginia GAP Demonstration enrollees

Category of Service
Outpatient Hospital Coverage, including physician services delivered in an outpatient setting
Outpatient Medical
Mental Health Case Management
Crisis Stabilization
Psychiatric evaluation and outpatient individual, family, and group therapies (mental health and substance abuse)
Peer Supports
Prescription Drugs

To review the complete benefit package for the GAP Demonstration, please refer to Attachment D of the Special Terms and Conditions.

For benefits that the GAP demonstration excludes, an informal network furnishes participants with necessary health care, diagnostic services and treatment for physical and mental health illnesses. A description of the Informal Network of Benefits can be found in Attachment C of the STCs.

Medical services including outpatient physician and clinic services, specialists, diagnostic procedures, laboratory procedures, and pharmacy services shall be covered as follows:

Outpatient physician services and medical office visits in a hospital outpatient setting includes evaluation and management, and diagnostic and treatment procedures performed in the physician's office or a hospital outpatient setting, and; therapeutic or diagnostic injections.

Outpatient clinic services include evaluation and management, treatment, and procedures performed in the clinic's office, and; medically necessary therapeutic and diagnostic injections.

Outpatient specialty care, consultation, management and treatment includes evaluation and treatment, and procedures performed in the physician's office, and; medically necessary therapeutic or diagnostic injections.

Outpatient diagnostic services include electrocardiogram, service-authorized CAT, MRI scans and diagnostic services that can be performed in a physician's office with the exception of colonoscopy procedures.

Outpatient laboratory is covered the same as Medicaid for services that are not otherwise excluded from GAP coverage.

Outpatient pharmacy services are provided consistent with the Virginia Medicaid program.

Outpatient family planning consistent with the Virginia Medicaid program as it pertains to GAP SMI covered services; sterilization procedures and abortions shall not be covered.

Outpatient telemedicine is covered the same as Medicaid for services that are not otherwise excluded from GAP coverage.

Outpatient durable medical equipment and supplies coverage shall be limited to diabetic equipment and supplies consistent with 12 VAC 30-50-165 as it pertains to GAP SMI covered services.

Outpatient hospital procedures shall be limited to: (i) diagnostic ultrasound procedures; (ii) EKG/ECG including stress tests; (iii) radiology procedures are covered except for PET scans and radiation treatment procedures.

II. Evaluation Design Requirements

CMS requires evaluations of all section 1115 demonstrations. The first step in the evaluation process is to develop and submit an evaluation design plan for CMS approval. The following information is in adherence to CMS regulations that require the design plan to include the following elements (42 CFR Section 431.424):

- Discussion of the demonstration hypotheses
- Description of the data that will be utilized and the baseline value for each measure
- Description of the methods of data collection
- Description of how the effects of the demonstration will be isolated from other changes occurring in the state
- Proposed date by which a final report on findings from activities conducted under the evaluation plan must be submitted to CMS
- Any other information pertinent to the state's research

The special terms and conditions of the GAP demonstration further specify that the design plan include descriptions of the following components:

- Research questions and hypotheses
- Study design
- Study population
- Outcome measures
- Data collection

- Data analysis
- Timeline
- Evaluator

III. Goals and Guiding Principles

The GAP Demonstration is driven by the following goals, which will guide the evaluation plan:

1. Serve as a bridge to closing the insurance coverage gap for Virginians;
2. Improve access to health care for a segment of the uninsured population in Virginia who have significant behavioral and medical needs; and,
3. Improve health and behavioral health outcomes of demonstration participants.

The GAP Demonstration further explains that the model of care builds on successful existing partnerships to provide and integrate basic medical and behavioral health care services. Enabling persons with SMI to access behavioral and primary health care services under an integrated model will enhance treatment and increase the potential to significantly impact the severity of their symptoms.

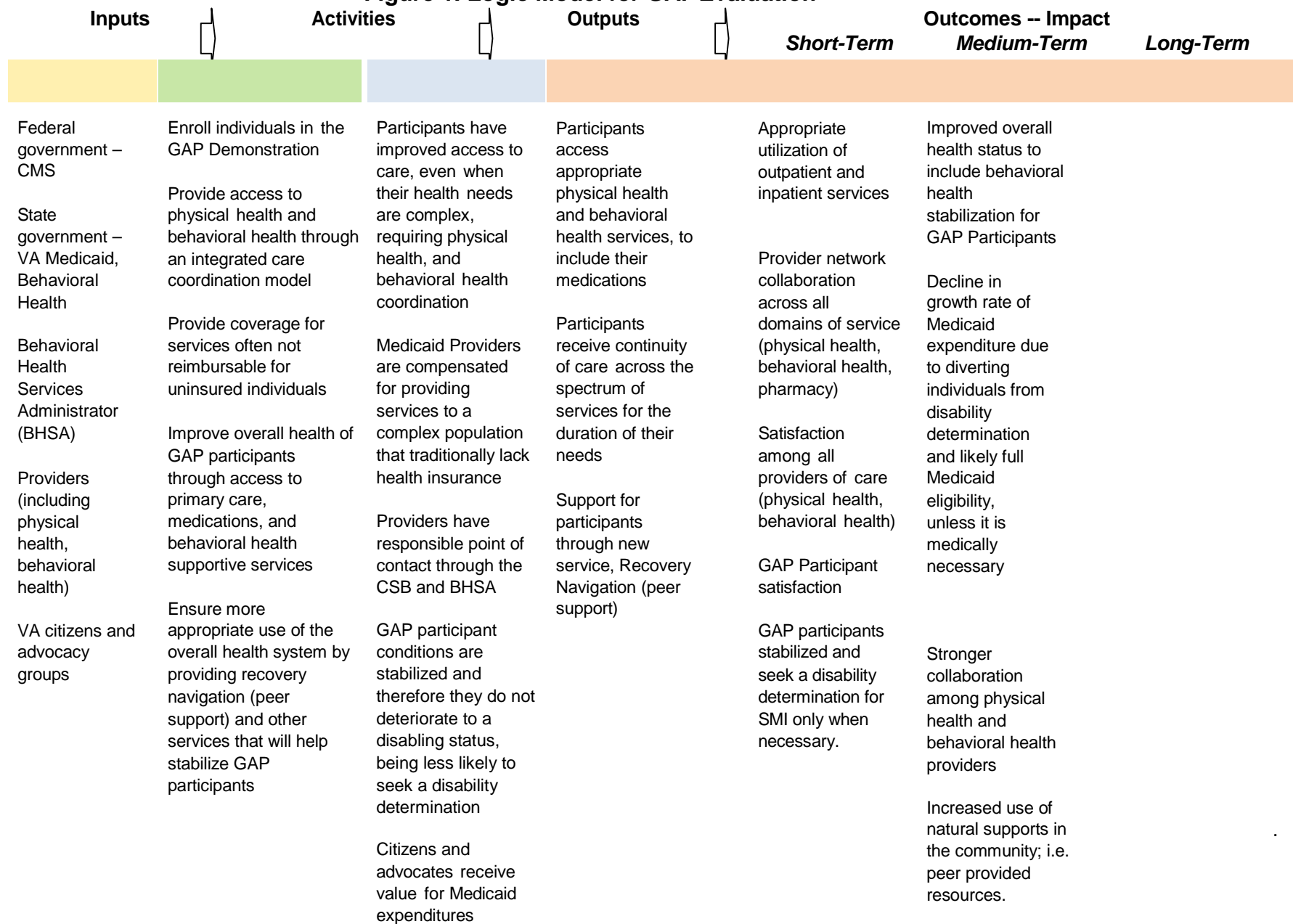
IV. Evaluation Design Plan

Logic Model

The logic model in Figure 1 describes the inputs or resources available to the GAP Demonstration, program activities, anticipated outputs, and the expected impacts of the program (short-, medium-, and long-term). The logic model conveys the relationships among the key inputs to the GAP Demonstration, the activities and outputs produced by these resources, and the expected outcomes of the activities, in relation to the goals of the demonstration.

The key inputs include; administrative oversight of the GAP Demonstration from CMS and DMAS; and the participation by enrollees, providers, and stakeholders/advocates. Activities include integration of care coordination for each participant and access to high quality outpatient physical health and behavioral health benefits and services. The outputs are the products of those activities, which then lead to outcomes that effectuate the ultimate goals of the GAP demonstration: to serve as a bridge to covering the health insurance coverage gap, improve access to health (physical and behavioral) care, and enhance health outcomes for participants

Figure 1. Logic Model for GAP Evaluation



Data Sources and Collection

The evaluation will draw on multiple data sources depending on the research question, variable being measured, and population. The study will require both individual-level and aggregate measures of relevant utilization, expenditures, health status, and other outcomes. These data sources include:

- **The Virginia Medicaid Management Information System (MMIS):** Virginia's MMIS contains information about enrollment, providers, and claims/encounters for health services. Encounter data, in measuring each participant's interaction with the health care system, will underlie many of the measures of cost and utilization of particular services by individual participants. Detailed data on participant characteristics maintained in the MMIS will allow analyses to be stratified by participants' demographic and health and pharmacy service use characteristics. The MMIS system will be used to generate specific reports required by the evaluation.
- **Behavioral Health Services Administrator (BHSA) -Specific Reports:** DMAS' contract with the Behavioral Health Services Administrator, Magellan of Virginia, requires the submission of extensive reporting on multiple aspects of participant and behavioral health care provider activity such as: specialized services, care coordination, utilization management, quality, and claims management. Many of these reports will supply information that answers research questions and provides or supplements the measures used to test research hypotheses with detailed specifications and uniform templates for reporting.
- **Peer Administered Survey:** Peer Recovery Navigator Program Metrics will capture primary measures of self-reported information valuable to the evaluation of the GAP Demonstration. Metrics include primary measures such as inpatient and outpatient hospital visits, engagement with the criminal justice system, and psycho-social indicators.
- **The National Committee for Quality Assurance (NCQA):** will be used and cross referenced when evaluating measures pertaining to improving access to health care for GAP members. The evaluation panel will draw from NCQA's large set of data elements that pertain to individuals who compare to the GAP member. An array of measures will be chosen ranging from prescription adherence to engagement of treatment.
- **Cover Virginia:** The Cover Virginia portal and call center is integral to the application process of the GAP demonstration. During the eligibility determination process and renewal, Cover Virginia will capture information pertaining to the GAP member. There is also an opportunity to use the database that supports Cover Virginia to determine a control group population.

- **Temporary Detainment Order (TDO) Claims:** DMAS serves as the payer of TDO claims in Virginia. Having access to these claims means that TDO Claims can be cross referenced with GAP Participants to measure success in reducing interactions with the criminal justice system, improving social and behavioral health outcomes of demonstration participants.
- **Virginia Health Information (VHI) Data:** VHI serves as Virginia's source of health care information, data and reporting. VHI was created to promote informed decision making by Virginia consumers and purchasers and to enhance the quality of Virginia's health care. DMAS will work with VHI to obtain hospital data, attempting to track hospital utilization of GAP participants.
- **Department of Behavioral Health and Developmental Services (DBHDS):** DBHDS is Virginia's state agency overseeing programs, supports, services, and providers for individuals and their families who experience behavioral health and developmental disabilities. In its support structure, DBHDS is responsible for the state hospitals, which will be a data source of hospital data. DMAS will work with DBHDS to obtain this and other necessary data, supporting the evaluation of the GAP demonstration.

Research Questions and Hypotheses

Given the previously stated goals of the demonstration, hypotheses and research questions are necessary to assess whether the GAP demonstration is achieving its purposes. Each of these goals is operationalized through specific measures found later in the evaluation plan.

Goal 1. The GAP demonstration will serve as a bridge to closing the insurance coverage GAP for Virginians.

Hypothesis 1.

Individuals who do not have health coverage will seek to gain access to health and behavioral health care by applying for the GAP demonstration.

Research Questions:

- What percentage of uninsured Virginians have applied for the GAP demonstration?
- What percentage of uninsured Virginians have applied and enrolled in the GAP demonstration?

Goal 2. The GAP demonstration will improve access to health care for a segment of the uninsured population in Virginia who have significant behavioral and medical needs

Hypothesis 2. Integrating care coordination, primary care, specialty care, pharmacy, and behavioral health care for individuals with SMI, who are otherwise uninsured and do not have adequate access to care, will result in better health for GAP participants.

(Table three describes a comparison population as being a control group)

Research Questions:

- Has the GAP demonstration impacted access to care for GAP eligible individuals through access to primary care, medications, and behavioral health supportive services?
- How many GAP participants have utilized their GAP coverage?
- Are there critical services that participants that do not have access to that are necessary for this population to achieve improved health and wellness outcomes?
- Have GAP participants utilized Recovery Navigation?
- Have GAP participants utilized Care Coordination?
- Have GAP participants had their care coordinated with a Medical Doctor?
- Has there been a reduction in claims costs as a result of improved quality of service and timely preventive services?

Goal 3. The GAP demonstration will improve social and behavioral health outcomes for demonstration participants.

Hypothesis 3. Through the provision of coverage and access, GAP participants will experience a better quality of life and better health outcomes.

Research Questions:

- Has the integration of physical and behavioral health services resulted in better quality of life and psycho-social outcomes?
- Has the integration of physical and behavioral health services resulted in better health outcomes of demonstration participants?
- Did GAP participants become eligible for full Medicaid as a result of a disability determination?

Measures

Table 3 presents the measures that will be used to determine whether each program goal has been achieved. This table describes the data source, stratification categories, comparison groups, and frequencies for each measure.

Table 3. Measures for GAP Evaluation

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
Goal 1. Serve as a bridge to closing the insurance coverage gap for Virginians					
What percentage of uninsured Virginians have applied for the GAP Demonstration?	Number of complete applications submitted to Cover Virginia for the GAP Demonstration compared to total uninsured SMI population in Virginia		Cover Virginia, DBHDS	Compared to number of uninsured SMI population in Virginia	Annually
What percentage of uninsured Virginians have applied and enrolled in the GAP Demonstration?	Number of approved applications submitted to Cover Virginia for the GAP Demonstration compared to total uninsured SMI population in Virginia		Cover Virginia, DBHDS	Compared to number of uninsured SMI population in Virginia	Annually
Goal 2. Improve access to health care for a segment of the uninsured population in Virginia who have significant behavioral and medical needs.					
Has the GAP Demonstration impacted access to care, through access to primary care, medications, and behavioral health supportive services?	Adults' Access to Preventive/Ambulatory Health Services (AAP)	The percentage of members 21 years and older who had an ambulatory or preventive care visit during the measurement year. ◆ 21 to 44 years of age ◆ 45 to 64 years of age	MMIS, NCQA National data	Compare to the preventive care services utilization of control group population	Annually

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	The percentage of members with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.	MMIS, NCQA National data	<ul style="list-style-type: none"> - Compare Virginia score to HEDIS Medicaid National Average. - Compare to the adherence of medication of control group population 	Annually
	NQF Measure 0105: Anti-depressant Medication Management	<p>The percentage of members with a diagnosis of major depression and treated with antidepressant medication, and remained on an antidepressant medication treatment.</p> <ul style="list-style-type: none"> ◆ Effective Acute Phase Treatment (on medication for at least 84 days/12 weeks) ◆ Effective Continuation Phase Treatment (for at least 180 days/6 months) 	MMIS, NCQA National data	<ul style="list-style-type: none"> - Compare Virginia score to HEDIS Medicaid National Average. - Compare to the adherence of medication of control group population 	Annually

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
	Drug utilization for chronic health condition	Members with chronic conditions such as diabetes, cardiovascular Health condition and hypertension utilizing drugs for these medical conditions.			
	NQF Measure 0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (National Committee for Quality Assurance)	The percentage of adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. <ul style="list-style-type: none"> - Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. - Engagement of AOD Treatment. The percentage of patients who initiated treatment and who 	MMIS, DBHDS, NCQA National data (TBD)	Compare it to control group population	Annually

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
		had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.			
How many GAP Participants have utilized their GAP Coverage?	Number of approved applicants who have a behavioral health services claim		Magellan/MMIS	Compare it to service utilization of control group population	Annually
	Number of approved applicants who have a physical health services claim		MMIS	Compare it to service utilization of control group population	Annually
	Number of approved applicants who have a Pharmacy claim		MMIS	Compare it to service utilization of control group population	Annually
Are there critical services participants do not have access to, that are necessary for this population to achieve improved health and wellness outcomes?	Measure access to common treatment elements to promote recovery including -Prevention and Wellness -Medications -Behavioral health services -Inpatient Services -Transportation	Percentage of claims denied because the service was not covered	MMIS	Compare the denied claims to approved claims and identify what services are not covered that are necessary for recovery.	Annually

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
Have GAP participants utilized Recovery Navigation?	Ensure more appropriate use of the overall health system by providing recovery navigation (peer support) and other services that will help stabilize GAP participants	Number of GAP participants with a claim for recovery navigation. What percentage of GAP enrollees participated in the recovery navigation program?	Magellan	Number of participants who have utilized recovery navigation compared to total number of GAP enrollees	Annually
Have GAP participants utilized Care Coordination?	Number/ percentage of GAP participants with a claim for Care Coordination	Number/percentage of GAP participants with a claim for care coordination.	Magellan	Number of GAP participants with a Referral for Care Coordination compared to Number of participants who engaged in Care Coordination	Annually
Have GAP participants had their care coordinated with a Medical Doctor?	Follow-up after Hospitalization for Mental Illness	The percentage of discharges for members who were hospitalized for treatment of selected mental health disorders and had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported as the percentage of discharges for which	MMIS, DBHDS, TBD		Annually

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
		<p>the member received follow-up within:</p> <ul style="list-style-type: none"> ◆ seven days of discharge ◆ 30 days of discharge 			
	Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications	The percentage of members 21 to 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	MMIS		Annually
	Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	The percentage of members 21 to 64 years of age with schizophrenia and diabetes, who had both an LDL-C test and an HbA1c test during the measurement year.	MMIS		Annually
	Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	The percentage of members 21 to 64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.	MMIS		Annually

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
	Integration of behavioral health and medical health	Percentage of providers who provide both behavioral health and medical services	MMIS		
Has there been a reduction in cost as a result of improved quality of service and timely preventive services?	Cost analysis of program - by age group - by diagnosis - by service type	Trending costs for the program			Annually beginning year 2
Goal 3. Improve health, social and behavioral health outcomes of demonstration participants					
Has the integration of physical and behavioral health services resulted in better quality of life and psycho-social outcomes?*	Measure reduction in the number of interactions with the criminal justice system for GAP Participants	Reduction in/no change in number of incarcerations/arrests in past 30 days from date of first service to date of last service.	DOC - TBD		Annually
	Reduction in Temporary Detainment Order (TDO) Claims and ECO orders		MMIS		Annually
	Show Reduced or No Substance Use		Magellan, DBHDS - TBD		Annually
	Are Not Homeless		Magellan, DBHDS		Annually
	Are Employed Full or Part-Time		Magellan, DBHDS		Annually

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
Has the integration of physical and behavioral health services resulted in better health outcomes of demonstration participants?*	Did GAP Participants become eligible for full Medicaid as a result of a disability determination?	GAP Participants who became eligible for full Medicaid as a result of a disability determination	MMIS	Number of GAP Participants who became eligible for full Medicaid as a result of a disability determination.	Annually
	Has there been a reduction in the number of emergency department visits for GAP Participants?	Self-reported through recovery navigation survey	Magellan, VHI	Self-reported peer navigator survey results compared over time	Annually
	Has there been a reduction in the number of hospital admissions for GAP Participants?	GAP Participants who have hospital admission	DBHDS - TBD	Number of GAP participants who have previous mental health hospital admissions compared to their hospital admissions while participating in the program	Annually

*DMAS is exploring whether we can acquire the historical data (prior to GAP enrollment) for these measures.

Isolating Effects of the Demonstration

A major concern within evaluation research and study design is whether the effects of a demonstration can be separated from other activities and external influences that may affect the measured outcomes. DMAS and the evaluation panel will do everything possible to ensure that when conducting the evaluation, the measures and outcomes will be as isolated as possible. As described earlier in section IV, the expert evaluation panel and DMAS have significant data sources and resources they are pulling information from in order to inform the demonstration evaluation. These partners and resources are sensitive to the importance of isolating data and will support the evaluation team in providing clean data to be manipulated and aggregated by the expert evaluation panel and DMAS evaluation team.

V. Next Steps: Evaluator and Timeline

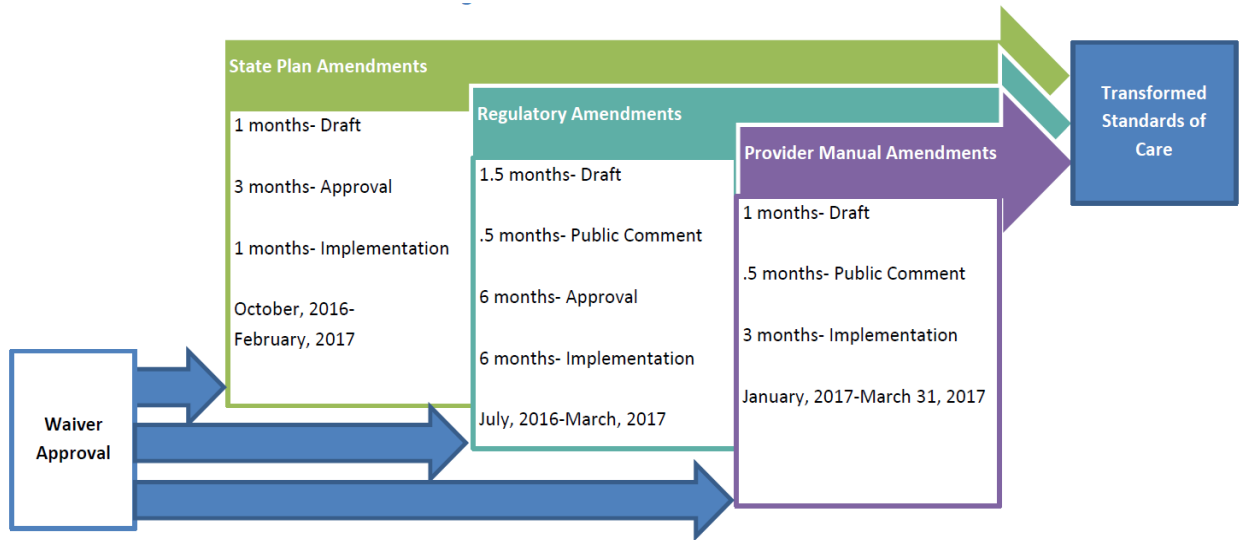
DMAS requested CMS to consider the utilization of an expert evaluation panel. CMS has verbally agreed to this model and DMAS is pursuing this evaluation model for the GAP demonstration. DMAS has a trusted relationship with [Dr. Len Nichols](#) and his affiliates and they have agreed to serve as the lead evaluator. Serving with him will be another nationally recognized data expert, [Dr. Peter Aiken](#). DMAS also has a panel member who is an expert in the field of Mental Health. This position is held by a Psychiatrist from Virginia Commonwealth University Health System, [Dr. Bela Sood](#), and additional support is provided by DMAS' sister state agency, the Department of Behavioral Health and Developmental Services (DBHDS).

- Submission of evaluation design to CMS – 30 days upon receiving feedback from draft submission (Due March 9, 2015), received feedback Summer of 2015 and offered resubmission Fall 2015
- Final CMS approval of evaluation design – Winter 2016
- Evaluation updates to CMS as specified in Section XI of the Special Terms and Conditions.
- Interim evaluation report – Submitted with demonstration application renewal
- Final evaluation report- Submitted 120 days following demonstration expiration

DMAS requests flexibility in the proposed design plan, as unanticipated events, policy changes, and the eventual evaluation contractor may impact the evaluation design.

ATTACHMENT E

Timeline for Establishing Standards of Care for Substance Use Disorder Services



**ATTACHMENT F: Addiction Recovery Treatment Services Delivery System
Transformation Demonstration Evaluation Plan (Reserved)**

Attachment G: Former Foster Care Youth Evaluation Plan (Reserved)

Attachment H: Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform both Congress and CMS about Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

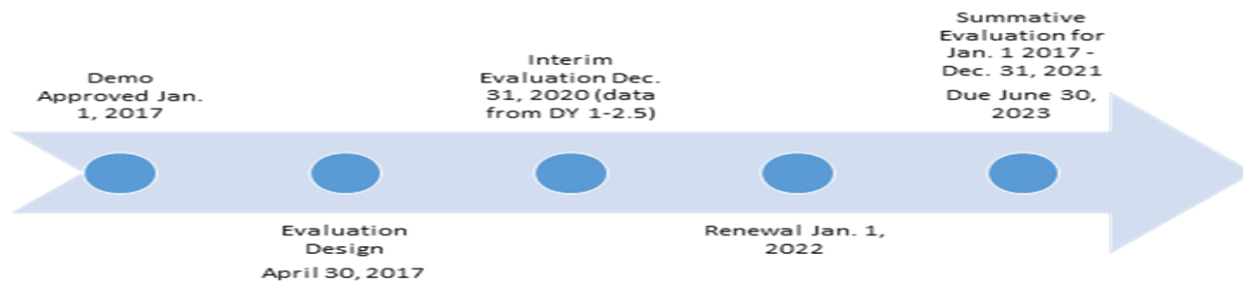
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals.

The format for the Evaluation Design is as follows:

General Background Information;
Evaluation Questions and Hypotheses;
Methodology;
Methodological Limitations;
Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state’s Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

- 1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
- 2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
- 3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;
- 4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.
- 5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Describe how the state’s demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
2. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes

information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams:

<https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf>

3. Identify the state's hypotheses about the outcomes of the demonstration:
4. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
5. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology– In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

- 1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?
- 2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
- 3) *Evaluation Period* – Describe the time periods for which data will be included.
- 4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by “owning”, defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
 - a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
 - b. Qualitative analysis methods may be used, and must be described in detail.
 - c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.

- d. Proposed health measures could include CMS’s Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
 - e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
 - f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.
- 5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

- 6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
- a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
 - b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
 - c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
 - d. The application of sensitivity analyses, as appropriate, should be considered.
- 7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				

Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review. For example:

- 1) When the state demonstration is:
 - a. Long-standing, non-complex, unchanged, or
 - b. Has previously been rigorously evaluated and found to be successful, or
 - c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

- 2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
 - a. Operating smoothly without administrative changes; and
 - b. No or minimal appeals and grievances; and
 - c. No state issues with CMS-64 reporting or budget neutrality; and
 - d. No Corrective Action Plans (CAP) for the demonstration.

E. Attachments

- A. Independent Evaluator.** The process the state will use for obtaining an independent entity to conduct the analysis and write the Evaluation Report, including a description of the qualifications the entity must possess. As soon as known, this section should be updated to include:
- a. Information about the organization conducting the evaluation;
 - b. Contact information for the organization, including how to obtain a copy of the evaluation;
 - c. The name and contact information of the Principal Investigator; and
 - d. Curriculum Vitae of the Principal Investigator.

- B. No Conflict of Interest.** Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. This includes “No Conflict of Interest” signed conformation statements.
- C. Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.
- D. Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

Attachment I: Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Guidance

The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Guidance is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

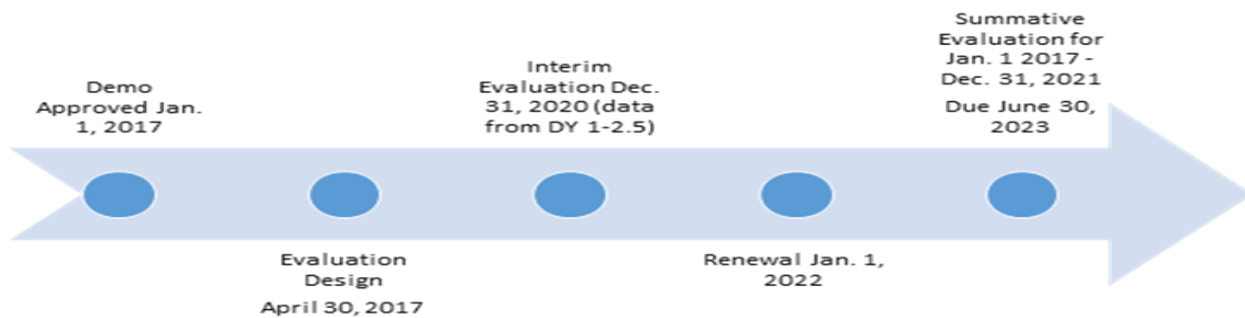
The format for the Interim and Summative Evaluation reports is as follows:

- A. Executive Summary;
- B. General Background Information;
- C. Evaluation Questions and Hypotheses;
- D. Methodology;
- E. Methodological Limitations;
- F. Results;
- G. Conclusions;
- H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;

- I. Lessons Learned and Recommendations; and
- J. Attachment(s).

Submission Timelines

There is a specified timeline for the state’s submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish to the state’s website the evaluation design within thirty (30) days of CMS approval, and publish reports within thirty (30) days of submission to CMS , pursuant to 42 CFR 431.424. CMS will also publish a copy to Medicaid.gov.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state’s Driver Diagram (described in the Evaluation Design guidance) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state’s submission must include:

- A. Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.
- B. General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:
 - 1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.

- 2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
- 3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
- 4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
- 5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

- 1) Describe how the state’s demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
- 2) Identify the state’s hypotheses about the outcomes of the demonstration;
 - a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
 - b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
 - c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The evaluation design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Evaluation Design* – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?
2. *Target and Comparison Populations* – Describe the target and comparison populations; include inclusion and exclusion criteria.
3. *Evaluation Period* – Describe the time periods for which data will be collected

4. *Evaluation Measures* – What measures are used to evaluate the demonstration, and who are the measure stewards?
5. *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data.
6. *Analytic methods* – Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

A. Methodological Limitations

This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

B. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

C. Conclusions – In this section, the state will present the conclusions about the evaluation results.

- 1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
- 2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
 - a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

D. Interpretations, Policy Implications and Interactions with Other State Initiatives –

In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state’s Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

E. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the “opportunities” for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

F. Attachment

Evaluation Design: Provide the CMS-approved Evaluation Design