

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850



State Demonstrations Group

May 6, 2021

Karen Kimsey
Director
Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Ms. Kimsey:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Substance Use Disorder (SUD) and Former Foster Care Youth (FFCY) components of the Evaluation Design, which is required by the Special Terms and Conditions (STC) of Virginia's section 1115 demonstration, "Building and Transforming Coverage, Services, and Supports for a Healthier Virginia" (Project No: 11-W-00297/3), effective through December 31, 2024. CMS has determined that the evaluation design, which was submitted on June 24, 2020 and revised on April 29, 2021, meets the requirements set forth in the STCs and our evaluation design guidance, and therefore, approves the SUD and FFCY components of the demonstration's evaluation design.

CMS added the approved evaluation design covering the SUD and FFCY components of the demonstration to the STCs as Attachment C. A copy of the STCs, which includes the new attachment, is enclosed with this letter. In accordance with 42 CFR 431.424, the approved evaluation design may now be posted to the state's Medicaid website within thirty days. CMS will also post the approved evaluation design as a standalone document, separate from the STCs, on Medicaid.gov. The state is continuing to work with CMS to finalize the evaluation design focused on one remaining component, i.e., the High Needs Supports program, of the Building and Transforming Coverage, Services, and Supports for a Healthier Virginia demonstration. Once finalized and approved by CMS, that evaluation design component will also be appended to Attachment C of the STCs.

Please note that an interim evaluation report, consistent with the approved evaluation design, is due to CMS one year prior to the expiration of the demonstration, or at the time of the extension application, if the state chooses to extend the demonstration. Likewise, a summative evaluation report, consistent with this approved design, is due to CMS within 18 months of the end of the

demonstration period. In accordance with 42 CFR 431.428 and the STCs, we look forward to receiving updates on evaluation activities in the demonstration monitoring reports.

We appreciate our continued partnership with Virginia on the state’s Building and Transforming Coverage, Services, and Supports for a Healthier Virginia section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

**Danielle
Daly -S**

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Danielle Daly -S
Date: 2021.05.06
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Danielle Daly
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cc: Margaret Kosherzenko, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

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

NUMBER: 11-W-00297/3

TITLE: Building and Transforming Coverage, Services, and Supports for a Healthier Virginia

AWARDEE: Virginia Department of Medical Assistance Services (DMAS)

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.

1. Expenditures for the Addiction and Recovery Treatment Services (ARTS) Delivery Transformation Program.

Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution of mental diseases (IMD).

2. Expenditures related to the Former Foster Care Youth.

Expenditures to extend Medicaid state plan benefits and benefits under the ARTS component of this demonstration for former foster care youth (FFCY) 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.

3. Expenditures for High Needs Supports.

Expenditures for home and community-based services (HCBS) and related support services for Medicaid beneficiaries age 18 or older who are eligible under the Medicaid state plan and enrolled in the managed care delivery system and for those who are eligible under the out-of-state FFCY component of this demonstration age 18 up to 26 and enrolled in the managed care delivery system, and who meet specific needs based criteria and risk factors, as described in Section VI of these special terms and conditions (STC).

Title XIX Requirements Not Applicable to the Demonstration Eligible Populations

All requirements of the Medicaid program expressed in law, regulation, and policy statement not expressly identified below as not applicable to these expenditure authorities shall apply to the demonstration.

1. Amount, Duration, Scope and Service

Section 1902(a)(10)(B)

To permit the state to offer a varying set of benefits to beneficiaries eligible for the High Needs Supports, as described in these STCs.

2. Freedom of Choice

Section 1902(a)(23)(A)

To the extent necessary to enable the state to restrict freedom of choice of provider for beneficiaries who receive High Needs Supports under the demonstration and to restrict High Needs Supports to the beneficiaries enrolled in the Medicaid managed care delivery system.

3. Reasonable Promptness

Section 1902(a)(8)

To the extent necessary to enable the state to limit the number of beneficiaries receiving High Needs Supports, as described in these STCs.

4. Statewideness

Section 1902(a)(1)

To the extent necessary to enable the state to limit eligibility for the High Needs Supports in geographically limited areas of the state, as described in these STCs.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00297/3

TITLE: Building and Transforming Coverage, Services, and Supports for a Healthier Virginia

AWARDEE: Virginia DMAS

I. PREFACE

The following are the STCs for the “Building and Transforming Coverage, Services, and Supports for a Healthier Virginia” (formerly Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation) section 1115(a) Medicaid demonstration (hereinafter demonstration) to enable the Virginia DMAS to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted the state expenditure authorities authorizing federal matching of demonstration costs that are not otherwise matchable, and which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS related to this demonstration. The demonstration extension is approved for a 5-year period, from January 1, 2020 through December 31, 2024.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Demonstration Eligibility
- V. Benefits
- VI. High Needs Supports
- VII. Cost Sharing
- VIII. Delivery System
- IX. General Reporting Requirements
- X. General Financial Requirements Under Title XIX
- XI. Monitoring Budget Neutrality for the Demonstration
- XII. Evaluation of the Demonstration
- XIII. ARTS Delivery System Transformation Demonstration
- XIV. Schedule of Deliverables for the Demonstration

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

- Attachment A: Developing the Evaluation Design
- Attachment B: Preparing the Evaluation Report
- Attachment C: Evaluation Design (reserved)
- Attachment D: Timeline for Establishing Standards for ARTS System
- Attachment E: ARTS Monitoring Protocol (reserved)

II. PROGRAM DESCRIPTION AND OBJECTIVES

Approved January 9, 2015, the Virginia Governors Access Plan (GAP) demonstration provided a specified benefits package to childless adults and non-custodial parents ages 21 through 64 with household incomes at or below 100 percent of the FPL using the Modified Adjusted Gross Income (MAGI) methodology, and who had been diagnosed with a serious mental illness (SMI). The demonstration extended access to a limited package of behavioral and physical health services to adults who were not otherwise eligible for Medicaid, Children's Health Insurance Program (CHIP), or Medicare, and were uninsured.

December 2016 Amendment

The ARTS amendment expanded SUD benefits for all Virginia Medicaid recipients eligible under the state plan to cover the full continuum of SUD treatment; introduced quality of care and programmatic features for the successful integration of SUD services into comprehensive managed care for all managed care enrollees; incorporated industry standard SUD treatment criteria into program standards; improved the quality and availability of medication-assisted treatment services; and introduced policy, practice and system reforms consistent with CMS State Medicaid Director Letter (SMDL) #15-003. The terms and conditions of the ARTS amendment are set out in Section XII of this document.

September 2017 Amendment

The September 2017 amendment added an out-of-state FFCY component of the demonstration. Under this amendment, the state receives expenditure authority to cover FFCY who aged out of foster care under the responsibility of another state and are now applying for Medicaid in the Commonwealth of Virginia. In addition to all State Plan services, out-of-state FFCY receive expanded SUD benefits under the ARTS benefit.

December 2019 Extension

The 2018 Virginia Acts of Assembly Chapter 2 (2018 Appropriations Act) was signed into law by Governor Ralph Northam on June 7, 2018. The legislation authorized the expansion of Medicaid and the addition of new Medicaid program features. Effective January 1, 2019, under authority approved in the state plan, Virginia began providing Medicaid coverage to the new adult group, individuals that are not pregnant, not eligible for Medicare, not eligible for Medicaid, under age 65, and with income under 133 percent of the FPL.

Through the 2018 Appropriations Act, the Virginia legislature directed the Virginia DMAS to submit a demonstration request to add new Medicaid program features to the existing 1115 demonstration. DMAS submitted its extension application on November 20, 2018. While the state previously had the GAP program as part of the demonstration, with the state's expansion of Medicaid it determined that the GAP program was no longer needed, so the state removed GAP from the extension. The extension request also included significant modifications, including a community engagement requirement, premium obligation, and housing and employment supports allowable under the HCBS benefit to Medicaid beneficiaries age 18 or older who are eligible under the Medicaid state plan and who meet certain needs-based criteria and risk factors.

On December 30, 2019, CMS approved a five year extension of the demonstration to allow Virginia to maintain the ARTS program and associated authorities, as well as authority to provide eligibility to FFCY who aged out of foster care under the responsibility of another state and are now applying for Medicaid in Virginia.

July 2020 Amendment

On July 9, 2020, CMS approved an amendment to the demonstration to provide certain otherwise allowable 1915(i) state plan amendment (SPA) services, including: housing and employment supports HCBS for Medicaid beneficiaries age 18 or older who are eligible under the Medicaid state plan and enrolled in the managed care delivery system and for those who are eligible under the out-of-state FFCY component of this demonstration age 18 up to 26 and enrolled in the managed care delivery system, and who meet specific needs based criteria and risk factors.

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The state must comply with applicable federal civil rights laws relating to non-discrimination in services and benefits in its programs and activities. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Such compliance includes providing reasonable modifications to individuals with disabilities under the ADA, Section 504, and Section 1557 in eligibility and documentation requirements, to ensure they understand program rules and notices.
- 2. Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, 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 Medicaid 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 30 calendar days in advance of the expected approval date of the amended STCs to allow the state to provide comment. The state must accept the changes in writing.
- 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, a modified budget neutrality agreement for the demonstration as necessary to comply with such

change. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.

- b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, 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 federal law, whichever is sooner.

5. **State Plan Amendments.** The state will not be required to submit title XIX state plan amendments (SPA) 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 is required, except as otherwise noted in these STCs. In all such instances, the Medicaid state plans govern.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements 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 no FFP of any kind, including for administrative or medical assistance expenditures, will 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 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 the failure by the state to submit required elements of a viable amendment request as found in this STC, and failure by the state to submit required reports and other deliverables 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 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
 - b. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation;
 - c. 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;

- d. An up-to-date CHIP allotment worksheet, if necessary; and
- e. The state must provide updates to existing demonstration reporting, quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. Extension of the Demonstration. States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, 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 either a demonstration extension request that meets federal requirements at 42 Code of Federal Regulations (CFR) 431.412(c) or a transition and phase-out plan consistent with the requirements of STC 9.

9. 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 transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 13, if applicable. Once the 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 transition and phase-out plan.
- b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out 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 beneficiaries whether currently enrolled or determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.
- c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 days after CMS approval of the transition and phase-out plan.
- d. Transition and Phase-out Procedures. The state must comply with all notice requirements found in 42 CFR 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to demonstration beneficiaries as outlined in 42 CFR 431.220 and 431.221. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 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.

- e. Exemption from Public Notice Procedures, 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR Section 431.416(g).
- f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.
- g. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of suspending beneficiaries.

10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/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 must 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, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11. 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.

12. 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 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.

The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

13. Federal Financial Participation (FFP). No federal matching for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

- 14. Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, managed care organizations (MCOs), and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.
- 15. Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid program – including procedures for obtaining Medicaid benefits or services, possible changes in or alternatives to Medicaid programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. DEMONSTRATION ELIGIBILITY

- 16. Eligibility Groups Affected by the Demonstration.** Only beneficiaries eligible for Medicaid under an eligibility group listed in Table 1 are subject to the provisions within this demonstration. State plan groups derive their eligibility through the Medicaid state plan, and coverage for these groups is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived in this demonstration and as described in these STCs.

Table 1. Medicaid Eligibility Groups Affected by the Demonstration		
Demonstration Feature	Eligibility Group	Citations
Out-of-State Former Foster Care Youth (FFCY)	Former foster care youth up to age 26 who aged out of foster care in another state	<ul style="list-style-type: none"> Expenditure Authority
Addiction and Recovery Treatment Services (ARTS) and High Needs Supports	New adult group	<ul style="list-style-type: none"> 1902(a)(10)(A)(i)(VIII) 42 CFR 435.119
	Aged, blind, and disabled	<ul style="list-style-type: none"> 42 CFR 435.121
	Parents and other caretaker relatives	<ul style="list-style-type: none"> 1902(a)(10)(A)(i)(I) 1931 (b) and (d) 42 CFR 435.110
	Pregnant women	<ul style="list-style-type: none"> 42 CFR 435.116
	Out of state FFCY	<ul style="list-style-type: none"> Expenditure Authority

Children with Title IV-E adoption assistance, foster care, or guardianship care	<ul style="list-style-type: none"> • 473(b)(1) • 1902(a)(10)(A)(i)(I) • 42 CFR 435.145
Children under age 19	<ul style="list-style-type: none"> • 1902(a)(10)(A)(ii)(XIV) • 1905(u)(2)(B) • 42 CFR 435.229 and 435.4
Transitional medical assistance	<ul style="list-style-type: none"> • 1902(a)(52) • 1902(e)(l) • 1925(a)(b)(c) • 42 CFR 435.112
Extended Medicaid due to spousal support collections	<ul style="list-style-type: none"> • 408(a)(11)(B) • 1902(a)(10)(A)(i)(I) • 1921(c) • 42 CFR 435.115
Former foster care youth up to age 26 who aged out of foster care in Virginia	<ul style="list-style-type: none"> • 42 CFR 435.150 • 1902(a)(10)(A)(i)(IX)

V. BENEFITS

17. **Overview.** Beneficiaries who are eligible for the demonstration will receive the same benefits as set forth in the Medicaid state plan. Additionally, the state will provide the SUD benefits established under the demonstration as described in section XII, and the High Needs Supports benefit established under the demonstration as described in section VI.

VI. HIGH NEEDS SUPPORTS

18. **Overview.** The state will provide a limited set of housing and employment supports to certain high needs Medicaid beneficiaries enrolled in the managed care delivery system, including those with a behavioral health need, need for assistance with activities of daily living (ADLs), or a complex physical health need. Qualifying beneficiaries must be expected to benefit from supports necessary to obtain and maintain employment or stable housing.
19. **High Needs Supports Benefits.** The state will provide housing and employment supports otherwise allowable under a 1915(i) SPA, including the services below, and described in greater detail in Attachment G:
- a. Individual housing and pre-tenancy services, individual housing and tenancy sustaining services, and community transition services; and
 - b. Pre-employment and employment sustaining services.

- 20. High Needs Supports Eligibility.** Medicaid beneficiaries age 18 or older who are eligible under the Medicaid state plan and enrolled in the managed care delivery system and those who are eligible under the out-of-state FFCY component of this demonstration and enrolled in the managed care delivery system will be eligible for the benefits described in this section, provided they meet the needs-based criteria and risk factors, as outlined in Attachment G. The High Needs Supports benefit will be limited to individuals who are not receiving housing or employment support services through an existing 1915(c) developmental disability (DD) waiver. Being on a 1915(c) DD waiver waitlist will not preclude eligible individuals from receiving the High Needs Supports benefit.
- 21. High Needs Supports Waitlist.** At its discretion, the state may impose a waitlist for beneficiaries eligible to receive High Needs Supports.
- 22. High Needs Supports Eligibility and Services.** Attachment G: High Needs Supports Eligibility and Services describes the services and requirements that would otherwise be documented in a 1915(i) SPA, including needs-based eligibility criteria, risk factors, covered services, service definitions, payment methodology, administrative approach, and minimum provider qualifications.
- 23. High Needs Supports HCBS Requirements.** For High Needs Supports HCBS, the state assures that its MCO Quality Assessment and Performance Improvement program must encompass long-term services and supports (LTSS) specific measures set forth in the federal managed care rule at 42 CFR 438.330, and will assess and improve performance as described below in the following areas:
- a. Administrative Authority: A performance measure must be developed and tracked for authorities that the State Medicaid Agency (SMA) delegates to another agency or MCOs, unless already captured in another performance measure, including: the review and monitoring of interagency agreements (IAG)/contract evaluations and the MCO quality management review (QMR) reports submitted in accordance with requirements. The SMA is responsible for operations and oversight, and will monitor and track the MCOs' delegated activities.
 - b. Eligibility Based on 1115 Requirements: A performance measure is required for the following: tracking of all new enrollees who receive an evaluation for HCBS eligibility prior to receiving services. While a performance measure to track annual eligibility determinations is not required since the state is not required to report to CMS, the state is expected to ensure annual eligibility determinations are completed.
 - c. Qualified Providers: The state must have performance measures that track that providers meet licensure/certification standards, that non-certified providers are monitored to assure adherence to demonstration requirements, and that the state verifies that training is given to providers in accordance with the demonstration.
 - d. Service Plan: The state must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for HCBS participants. Performance measures are required for individuals who have support plans that address their assessed needs, capabilities and desired outcomes; individuals whose service plan was updated/revised at least annually; and individual records that indicate that a risk assessment was completed as required.

- e. Health and Welfare: The state must assure that it has designed and implemented an effective system for assuring HCBS participants' health and welfare. The state must have performance measures that track participants for whom critical incidents were reported in which appropriate action was taken; unexplained deaths in which appropriate action was taken; and critical incidents reported to the MCO within the required timeframes.
- f. Financial Accountability: The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the HCBS program. The state must demonstrate actuarial soundness on an annual basis pursuant to 42 CFR 438.
- g. HCBS Settings Requirements: The state must assure compliance with the HCBS settings requirements for those services that could be authorized under section 1915(i) in accordance with 42 CFR 441.710.

24. High Needs Supports Reporting. The state must submit a report to CMS as an attachment to its quarterly and annual monitoring reports described in STC 32 that includes performance measure evidence of compliance at or above 86 percent with the HCBS quality assurances and measures.

25. High Needs Supports Reporting Deficiencies. The state must report, as an attachment to its quarterly and annual monitoring report described in STC 32, the deficiencies found below 86 percent compliance during the monitoring and evaluation of the HCBS demonstration assurances, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect, exploitation and/or death, the actions taken regarding the incidents and how they were resolved.

26. High Needs Supports Beneficiary Protections:

- a. The state assures there is a person-centered service plan for each individual determined to be eligible for HCBS. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR 441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR 441.725(b). The person-centered service plan is reviewed, and revised upon reassessment of functional need as required by 42 CFR 441.725(c), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.
- b. The state agrees that the entity that authorizes the services is external to the agency or agencies that provide the HCBS services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.
- c. The state, either directly or through its MCO contracts, must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant.
- d. Beneficiaries may change MCOs if their residential or employment support provider is no longer available through their current plan.

VII. COST SHARING

27. **Cost Sharing.** All cost sharing must be in compliance with Medicaid requirements that are set forth in federal statute, regulation, the state plan, and policies, except as modified by the waivers and STCs granted for this demonstration. There are no additional cost sharing requirements for beneficiaries receiving SUD services.

VIII. DELIVERY SYSTEM

28. **Delivery System.** The demonstration will utilize the current statewide managed care delivery system and fee for service (FFS) delivery system. Beneficiaries may be enrolled in FFS for months prior to being enrolled into managed care.

IX. GENERAL REPORTING REQUIREMENTS

29. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of \$5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singularly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

- a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submission of required deliverable(s).
- b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state’s anticipated date of submission. Should CMS agree to the state’s request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state’s written extension request.
- c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.
- d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

- 30. Submission of Post-Approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.
- 31. Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, 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, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
 - c. Submit deliverables to the appropriate system as directed by CMS.
- 32. Monitoring Reports.** The state must submit three (3) Quarterly Reports and one (1) Annual Report each Demonstration Year (DY). The fourth-quarter information that would ordinarily be provided in a separate quarterly report should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Report (including the fourth-quarter information) is due no later than ninety (90) calendar 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 to be provided by CMS, which will be organized by milestones. The framework is subject to change as monitoring systems are developed/evolve, and will be provided in a structured manner that supports federal tracking and analysis.
 - a. Operational Updates. The operational updates will focus on progress towards meeting the milestones identified in CMS' framework. Additionally, 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. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the milestones identified in CMS' framework, and the performance metrics will reflect all components of the state's demonstration.

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 the Monitoring Reports, and will follow the CMS 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 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 for this demonstration should be reported separately on the CMS-64.
- 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.

33. Corrective Action. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where monitoring data indicate substantial sustained directional change, inconsistent with state targets (such as substantial, sustained trends indicating increases in disenrollment, difficulty accessing services, or unpaid medical bills). A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS will withdraw an authority, as described in STC 10, when metrics indicate substantial, sustained directional change, inconsistent with state targets, and the state has not implemented corrective action. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

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

- a. The draft 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' comments for incorporation into the final Close Out Report.
- d. The final Close Out Report is due to CMS no later than thirty (30) calendar 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 29.

- 35. 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, trends in reported data on metrics and associated mid-course adjustments, 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.
- 36. 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.

X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

- 37. Allowable Expenditures.** This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.¹
- 38. Unallowable Expenditures.** In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:
- a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.
 - b. Costs for services provided in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.
- 39. Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical

¹ For a description of CMS's current policies related to budget neutrality for Medicaid demonstration projects authorized under section 1115(a) of the Act, see State Medicaid Director Letter #18-009.

assistance payments (MAP) and state and local administration costs (ADM). CMS shall 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 shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

- 40. Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in section X.
- c. Administrative costs, including those associated with the administration of the demonstration;
 - d. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
 - e. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.
- 41. Sources of Non-Federal Share.** The state certifies that its match for the non-federal share of funds for this section 1115 demonstration are state/local monies. The state further certifies that such funds must not be used to 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. The state acknowledges that CMS has authority to 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. The state acknowledges that any amendments that impact the financial status of this section 1115 demonstration must require the state to provide information to CMS regarding all sources of the non-federal share of funding.
- 42. State Certification of Funding Conditions.** 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 expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies that are allowable under 42 CFR §433.51 to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority, the federal matching funds received cannot then be used as the state share needed to receive other federal matching funds under 42 CFR 433.51(c). 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 (IGT) to the extent that such funds are derived from state or local monies 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.
- e. Under all circumstances, health care providers must retain 100 percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local government to return and/or redirect to the state 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.

43. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

44. Medicaid Eligibility Groups (MEG). MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 2. Master MEG Chart					
MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
ARTS-SUD	Hypo 1	X		X	See Expenditure Authority #1

Out-of-state FFCY	Hypo 2	X		X	See Expenditure Authority #2
High Needs Supports	Hypo 3	X		X	See Expenditure Authority #3

45. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00297/3). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

- f. Cost Settlements. The state will report any cost settlements attributable to the demonstration 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 State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
- g. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.
- h. Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.
- i. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

- j. Member Months. As part of the Quarterly and Annual Monitoring Reports described in Section VIII, the state must report the actual number of “eligible member months” for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term “eligible member months” refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.
- k. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state’s Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 3. MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
ARTS-SUD	See expenditure authority #1	Refer to STC 38 for unallowable expenditures	ARTS-SUD	Date of Service	MAP	Y	12/15/16	12/31/24
Out-of-state FFCY	See expenditure authority #2	N/A	FFCY	Date of Service	MAP	Y	06/02/17	12/31/24
High Needs Support Services	See expenditure authority #3	N/A	High Needs Supports	Date of Service	MAP	Y	7/9/20	12/31/24

46. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

Table 4. Demonstration Years		
Demonstration Year 6	January 1, 2020 to December 31, 2020	12 months

Demonstration Year 7	January 1, 2021 to December 31, 2021	12 months
Demonstration Year 8	January 1, 2022 to December 31, 2022	12 months
Demonstration Year 9	January 1, 2023 to December 31, 2023	12 months
Demonstration Year 10	January 1, 2024 to December 31, 2024	12 months

47. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the “Schedule C Report” for comparing demonstration’s actual expenditures to the budget neutrality expenditure limits described in section X. CMS will provide technical assistance, upon request.²
48. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
49. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:
- l. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.
 - m. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified

² 42 CFR §431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and §431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS’s current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall 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 federal law.

- n. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

- 50. Limit on Title XIX Funding.** The state shall be subject to limits on the amount of federal Medicaid Title XIX funding that the state may receive over the course of demonstration approval. 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 budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit may consist of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, as described below. 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 tests will be based on annual limits will be done using the Schedule C report from the CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.
- 51. Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.
- 52. Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which projected fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum

amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

- 53. **Main Budget Neutrality Test.** This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests. Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.

- 54. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), CMS considers these expenditures to be “hypothetical;” that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. This approach reflects CMS’s current view that states should not have to “pay for,” with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid state plan or other title XIX authority; however, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures. That is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state’s WW hypothetical spending exceeds the supplemental test’s expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending by savings elsewhere in the demonstration or to refund the FFP to CMS.

- 55. **Hypothetical Budget Neutrality Test: ARTS-SUD and Out-of-State FFCY.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 5. Hypothetical Budget Neutrality Test									
MEG	PC or Agg *	WOW Only, WW Only, or Both	BASE YEAR	TREND	DY 6	DY 7	DY 8	DY 9	DY 10

ARTS-SUD	PC	Both	\$7411.32	4.9%	\$7774.47	\$8155.42	\$8555.04	\$8974.24	\$9413.98
Out-of-State FFCY	PC	Both	\$529.08	4.9%	\$555.00	\$582.20	\$610.73	\$640.66	\$672.05
High Needs Supports	PC	Both	\$3684.14	4.9%	\$3864.66	\$4054.03	\$4252.68	\$4461.06	\$4679.65

- 56. Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. 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 by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration’s approval period, 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 to method. Each Main or Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.
- 57. Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from 2020 to 2024. If at the end of the demonstration approval period the 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 demonstration period, the budget neutrality test will be based on the time period through the termination date.
- 58. Mid-Course Correction.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 6. Hypothetical Budget Neutrality Test Mid-Course Correction Calculations		
Demonstration Year	Cumulative Target Definition	Percentage
DY 6	Cumulative budget neutrality limit plus:	2.0 percent
DY 6 through DY 7	Cumulative budget neutrality limit plus:	1.5 percent
DY 6 through DY 8	Cumulative budget neutrality limit plus:	1.0 percent
DY 6 through DY 9	Cumulative budget neutrality limit plus:	0.5 percent
DY 6 through DY 10	Cumulative budget neutrality limit	0.0 percent

XII. EVALUATION OF THE DEMONSTRATION

- 59. 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; providing data and analytic files to CMS; 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 that collect, produce, or maintain data and files for the demonstration, a requirement that they make 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 29.
- 60. 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 state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accord with the CMS-approved 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.
- 61. Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than 180 calendar days after approval of the demonstration.

Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable.

The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

- a. All applicable evaluation design guidance, including guidance about SUD. Hypotheses applicable to the demonstration as a whole, and to all key policies referenced above, will include (but will not be limited to): the effects of the demonstration on health outcomes; the financial impact of the demonstration (for example, such as an assessment of medical debt and uncompensated care costs).
 - b. Attachment A (Developing the Evaluation Design) of these STCs, technical assistance for developing SUD Evaluation Designs (as applicable, and as provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a Draft Evaluation Design.
- 62. Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as Attachment C 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 Design and submit a description of its evaluation implementation progress in each of the Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval.

- 63. Evaluation Questions and Hypotheses.** Consistent with attachments A and B (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, CMS’s measure sets for eligibility and coverage, 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).

The state must also investigate cost outcomes for the demonstration as a whole, including but not limited to: administrative costs of demonstration implementation and operation, Medicaid health service expenditures, and provider uncompensated costs. In addition, the state must use results of hypothesis tests and cost analyses to assess demonstration effects on Medicaid program sustainability.

- 64. Evaluation Budget.** A budget for the evaluation must 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.

- 65. 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 60 calendar 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 B (Preparing the Evaluation Report) of these STCs.

66. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Evaluation Report) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 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 60 calendar 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 30 calendar days of approval by CMS.

67. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial, sustained directional change, inconsistent with state targets (such as substantial, sustained trends indicating increases in disenrollment, difficulty accessing services or unpaid medical bills). A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

68. 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 Report, and/or the Summative Evaluation Report.

69. Public Access. The state shall post the 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 30 calendar days of approval by CMS.

70. Additional Publications and Presentations. For a period of twelve (12) 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 directly connected to the demonstration over which the state 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

ten (10) business 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. This requirement does not apply to the release or presentation of these materials to state or local government officials.

XIII. ARTS DELIVERY SYSTEM TRANSFORMATION DEMONSTRATION

71. 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 SUD (both those served via the managed care delivery systems). No Medicaid state plan beneficiaries, nor the out-of-state FFCY eligible under 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 CMS State Medicaid Director (SMD) letter #17-003. The ARTS was implemented on April 1, 2017.

The ARTS program demonstrates how comprehensive and high quality SUD care can improve the health of Medicaid recipients while decreasing other health care system (such as ED 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, implementing policy and program measures to ensure providers meet the 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, 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 enhanced benefits and delivery systems transformations. In alignment with SMD letter #17-003, key goals of the ARTS demonstration are to:

- Increase rates of identification, initiation, and engagement in treatment;
- Increase adherence to and retention in treatment;
- Reduce overdose deaths, particularly those due to opioids;
- Reduce utilization of emergency departments and inpatient hospital settings through improved access to a continuum of care services;
- Reduce preventable readmissions to the same or higher level of care; and
- Improve access to care for physical health conditions among beneficiaries.

72. ARTS Demonstration Basic Concepts

- a. Delivery System - The ARTS benefit is available to Virginia's Medicaid recipients who meet the medical necessity criteria. Services are delivered to individuals enrolled in managed care through their MCO, and those recipients in FFS have services covered through the DMAS FFS contractor. MCOS and the DMAS FFS Contractor are required to submit monthly provider network reports to DMAS to ensure adequate networks are maintained.
- 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 a statewide length of stay of thirty 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 meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.
 - ii. If applicable, must meet the ASAM adolescent treatment criteria. Recipients under age twenty-one 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.
 - iii. The determination of medical necessity, multidimensional ASAM assessment, placement of recipients at appropriate levels of care and recommendations for lengths of stay in residential and inpatient treatment settings are made by ARTS Care Coordinators or a licensed clinician employed by the MCO or the DMAS FFS contractor. 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 SUDs.
- d. Grievances and Appeals - Each MCO and the DMAS FFS contractor 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 DMAS will provide beneficiaries access to a state fair hearing process.

73. 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 are available to all Virginia Medicaid recipients. The following service categories outlined in Table 7 and for which the licensing standards are outlined in Table 8 are included in the ARTS benefit package for Virginia Medicaid enrollees:

Table 7. ARTS Benefits (with Expenditure Authority)			
ASAM Level of Care	ARTS Benefit	Medicaid Authority	Costs Not Otherwise Matchable
N/A	SUD Case Management	State plan	
0.5	Screening, Brief Intervention and Referral to Treatment	State plan	
1	Outpatient	State plan	
N/A	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 Services	Section 1115 demonstration	Services provided to short-term residents
3.3	Clinically managed Population-Specific High Intensity Residential Services	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 Services	State plan	
OTP	Opioid Treatment Program	State plan	
OBOT	Office Based Opioid Treatment	State plan	

Table 8. Licensing Standards by ASAM Level of Care

ASAM Level of Care	ASAM Description	State Licensing Standard
N/A	Peer Recovery Support Services	Certified through the Department of Behavioral Health and Developmental Services (DBHDS) and registered with the Virginia Board of Counseling
N/A	SUD Case Management	DBHDS Case Management Services; or Substance Abuse Case Management Services.
1	Outpatient	Independent practitioners licensed by Department of Health Professionals
2.1	SUD Intensive Outpatient	DBHDS Substance Abuse Intensive Outpatient Service for Adults, Children, and Adolescents
2.5	SUD Partial Hospitalization	DBHDS Substance Abuse Partial Hospitalization or Substance Abuse/Mental Health Partial Hospitalization

3.1	Clinically Managed Low Intensity Residential	DBHDS Mental Health & Substance Abuse Group Home Service for Adults or Children; DBHDS Supervised Living Services
3.3	Clinically managed Population-Specific High Intensity Residential	<p>DBHDS Supervised Residential Treatment Services for Adults; DBHDS Substance Abuse Residential Treatment Services (RTS) for Women with Children.</p> <p>DBHDS Substance Abuse and Mental Health Residential Treatment Services (RTS) for Adults that have substance abuse on their license or within the “licensed as statements.”; or DBHDS Level C or Mental Health Residential Children that have substance abuse on their license or within the “licensed as statements.”</p> <p>If providers are providing withdrawal management, they will need to also have a DBHDS Medical Detox license.</p>
3.5	Clinically Managed High Intensity Residential Services (Adults)/ Medium Intensity (Adolescents)	<p>DBHDS Substance Abuse Residential Treatment Services (RTS) for Adults or Children; DBHDS Psychiatric Unit that have substance abuse on their license or within the “licensed as statements.”; DBHDS Substance Abuse RTS for Women with Children; DBHDS Substance Abuse and Mental Health Residential Treatment Services (RTS) for Adults that have substance abuse on their license or within the “licensed as statements.”; or DBHDS Level C or Mental Health Residential Children that have substance abuse on their license or within the “licensed as statements.”.</p> <p>If providers are providing withdrawal management, they will need to also have a DBHDS Medical Detox license.</p>

3.7	<p>Medically Monitored Intensive Inpatient Services (Adults)</p> <p>Medically Monitored High-Intensity Inpatient Services (Adolescents)</p>	<p>DBHDS Freestanding Psychiatric Hospital and Inpatient Psychiatric Unit with a DBHDS Medical Detoxification License or Managed Withdrawal License;</p> <p>DBHDS Substance Abuse DBHDS Residential Treatment Services for Adults or Children with a Medical Detox license;</p> <p>Residential Crisis Stabilization Units with DBHDS Medical Detoxification License or Managed Withdrawal License;</p> <p>DBHDS Substance Abuse Residential Treatment Services (RTS) for Women with Children with a DBHDS Managed Withdrawal License;</p> <p>DBHDS Managed Withdrawal-Medical Detox Adult Residential Treatment Service (RTS) License;</p> <p>DBHDS Medical Detox/Chemical Dependency Unit for Adults; or DBHDS Level C or Mental Health Residential Children with a substance abuse residential license and a DBHDS Managed Withdrawal License</p>
4	Medically Managed Intensive Inpatient	Acute care general hospital (12-VAC5-410) licensed by the Virginia Department of Health.
OTP	Opioid Treatment Program	DBHDS licensed for Opioid Treatment Services
OBOT	Office-Based Opioid Treatment	Independent licensed practitioners through the Virginia Department of Health Professions.

74. SUD Case Management. 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.

75. 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 Recovery Support Specialists have supervisory arrangements with licensed clinicians and certification with organization deemed acceptable by the DBHDS. Peers must register with the Virginia Counseling in order to become eligible to provide reimbursable services. Peer Recovery Support Specialists may work under supervision, in a variety of service settings.

76. 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 DMAS FFS contractor or providers for assessment and treatment through the ARTS demonstration.

77. Outpatient Services (ASAM Level 1). Counseling services are provided to recipients with an SUD diagnosis (up to an average of nine (9) hours per week for adults, and less than an average of 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.

78. SUD Intensive Outpatient Services (ASAM Level 2.1). Structured programming services provided to recipients with an SUD diagnosis (an average of nine (9) hours to nineteen (19) hours per week for adults, and an average of six (6) hours to 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 DMAS FFS contractor 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.

79. SUD Partial Hospitalization Services (ASAM Level 2.5). Structured programming services provided to recipients with an SUD diagnosis (an average of 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 director employed by the

MCO or DMAS FFS contractor 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 services plan.
- 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/or 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 (6) 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.

- 80. 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 DMAS FFS contractor 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 DMAS FFS contractor 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 DBHDS-licensed ASAM Level 3.1, 3.3, 3.5 and 3.7 programs will be no more than 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 DMAS FFS contractor as a network provider.

One ASAM Level 3 sublevel of care per managed care region is required for DMAS' approval of an ARTS Network Readiness Plan submitted by an MCO or the DMAS FFS contractor. Each MCO and DMAS FFS contractor network must demonstrate all ASAM Level 3 sublevels of care within three years of implementation. The exception to the residential network requirements being met by year three is if the state can demonstrate a hardship due to lack of licensed residential facilities for the particular sublevel of care.

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/or 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:

Table 9. Residential Services		
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 ARTS Care Coordinator or a physician or medical director and in accordance with an individualized service plan.	DBHDS Mental Health & Substance Abuse Group Home Service for Adults or Children; DBHDS Supervised Living Services
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.	DBHDS Supervised Residential Treatment Services for Adults; DBHDS Substance Abuse Residential Treatment Services (RTS) for Women with Children; Substance Abuse and Mental Health Residential Treatment Services (RTS) for Adults that have substance abuse on their license or within the “licensed as statements.” Or Level C or Mental Health Residential Children that have substance abuse on their license or within the “licensed as statements.” If providers are providing withdrawal management, they will need to also

		have a DBHDS Medical Detox license.
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.	<p>DBHDS Substance Abuse Residential Treatment Services for Adults or Children;</p> <p>DBDHS Psychiatric Unit that have substance abuse on their license or within the “licensed as statements”;</p> <p>DBHDS Substance Abuse RTS for Women with Children;</p> <p>DBHDS Substance Abuse and Mental Health Residential Treatment Services (RTS) for Adults that have substance abuse on their license or within the “licensed as statements.”; or</p> <p>DBHDS Level C or Mental Health Residential Children that have substance abuse on their license or within the “licensed as statements”.</p> <p>If providers are providing withdrawal management, they will need to also have a DBHDS Medical Detox license.</p>
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.	<p>DBHDS Freestanding Psychiatric Hospital and Inpatient Psychiatric Unit with a DBHDS Medical Detoxification License or Managed Withdrawal License;</p> <p>DBHDS Substance Abuse Residential Treatment Services (RTS) for adults/children with a DBHDS Managed Withdrawal License;</p> <p>DBHDS Residential Crisis Stabilization Unit with a DBHDS Medical Detoxification License or Managed Withdrawal License;</p> <p>DBHDS Substance Abuse Residential Treatment Services (RTS) for Women with Children with a DBHDS Managed Withdrawal License;</p> <p>DBHDS Level C or Mental Health Residential Children with a substance abuse residential license and a DBHDS Managed Withdrawal License;</p>

		DBHDS Managed Withdrawal-Medical Detox Adult Residential Treatment Service (RTS) License; or DBHDS Medical Detox/Chemical Dependency Unit for adults.
4	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 biopsychosocial dimensions of addictions.	Acute care general hospital (12-VAC5-410) licensed by the Virginia Department of Health

81. 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 DMAS FFS contractor 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).

82. Opioid Treatment Program (OTP) Services. Physician-supervised daily or several times per week 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 service plan.
- 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.

83. Office-Based Opioid Treatment (OBOT) Services. Physician nurse practitioner or-supervised medication and counseling services provided to maintain multidimensional stability for those with severe opioid use disorder by primary care providers and other physician or nurse practitioner offices in accordance with an individualized service plan determined by a licensed physician or licensed nurse practitioner 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 service plan.
- 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.

84. Incorporation of Industry Standards of Care. Through revisions of its contract requirements for MCOs and the DMAS FFS contractor, Medicaid state plan, state regulations and provider manuals, DMAS will establish and maintain standards of care for ARTS that incorporate industry standard benchmarks from the ASAM Criteria for defining medical necessity criteria, covered services and provider qualifications.

Each provider of ARTS must 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 are 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 has contracted 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 receive site visit reports from the DMAS contractor verifying whether their programs meet ASAM criteria for Level 3.1, 3.3, 3.5, and/or 3.7. Providers will submit this report to the MCOs and the DMAS FFS contractor as a requirement to become credentialed as residential treatment providers.
- d. The MCOs and the DMAS FFS contractor 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 DMAS FFS contractor 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 have been issued to define service structure and provider requirements consistent with the ASAM Criteria. The contracts for the MCO and DMAS FFS contractor have been modified to reference these regulations and reflect the ASAM Criteria within provider credentialing and networking requirements.

The ASAM certification process will transition to DBHDS upon promulgation of licensing regulations to incorporate the ASAM Criteria into regulations.

All Virginia Medicaid recipients referred to or seeking ARTS Levels of Care 2.0 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 3.1 an ARTS service provider will conduct an assessment of the recipient's clinical needs and submit clinical information to either the MCO or the DMAS FFS contractor for review. ARTS Care Coordinators or a licensed clinician 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 DMAS FFS contractor 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 DMAS FFS contractor 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 DMAS FFS contractor must provide prior authorization for residential and inpatient services within one (1) calendar day of the prior authorization request being submitted by the provider.

85. Responsibilities of MCOs and the DMAS FFS Contractor for ARTS Benefits. The responsibilities of the MCOs and the DMAS FFS contractor for the ARTS benefit shall be consistent with the requirements defined in the DMAS Addiction and Recovery Treatment Services Provider Manual, the executed contracts for the MCOs or the DMAS FFS contractor. The ARTS Network Development Plan and ARTS Network Readiness Plan will be implemented as defined in the contracts for the MCO and DMAS FFS contractor with DMAS to include the responsibilities listed below:

86. Responsibilities of MCOs and the DMAS FFS Contractor—Provider Network Development.

- a. The contracts for the MCO and DMAS FFS contractor 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 DMAS FFS contractor will credential and enroll network providers licensed within the scope of practice as defined by Virginia state licensure authorities. The MCOs and the DMAS FFS contractor 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 will perform site visits to Residential Treatment providers will ensure that MCO and DMAS FFS contractor credentialing for the Residential Services (ASAM Levels 3.1 through 3.7) aligns with ASAM Criteria or meeting criteria will be a component of licensing requirements.
- c. Each MCO and the DMAS FFS contractor must submit an ARTS provider network adequacy report to ensure recipient access to timely care through a sufficient network of high quality, credentialed, and knowledgeable providers in each level of care including ASAM Levels 1.0, 2.1, 2.5, 3.1, 3.3, 3.5, 3.7. 4.0 as well as Opioid Treatment Programs and Office-Based Opioid Treatment providers defined in 12VAC130-5000 et.al. DMAS continuously monitors the ARTS network for adequacy and for the ASAM Level of Care each provider meets.
 - i. Access standards and timeliness requirements are specified in the contracts for the MCOs and the DMAS FFS contractor.

The MCOs and the DMAS FFS contractor will deliver monthly network files to DMAS to provide updates on network development progress as required in the contracts for the MCO and DMAS FFS contractor.
- d. The DMAS FFS contractor 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).
- e. 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.

87. Responsibilities of MCOs and the DMAS FFS Contractor—Provider Requirements.

Each MCO and the DMAS FFS Contractor must include the following provider requirements within their contracts with ARTS providers:

- a. Telehealth and in-home assessments: Each MCOs 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 will provide in-home patient assessments and evaluations.
- b. Culturally Competent Services: The MCOs and the DMAS FFS contractor 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 DMAS FFS contractor 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 and nurse practitioner of recipients who are prescribed these medications unless the recipient refuses to consent to sign a 42 CFR part 2-compliant release of information for this purpose.

88. Responsibilities of MCOs and the DMAS FFS Contractor—Care Coordination. Each MCO and the DMAS FFS contractor 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 DMAS FFS contractor 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 DMAS FFS contractor 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 DMAS FFS contractor 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 DMAS FFS contractor 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 DMAS FFS contractor will facilitate the transfer of clinical information between treating practitioners to foster continuity of care and progress towards recovery.
- e. The MCOs and the DMAS FFS contractor will address recipient's mental health needs not specifically related to SUD. MCO and DMAS FFS contractor case management staff will assess recipient needs for psychiatric or psychosocial services and refer as necessary to providers. The MCO and DMAS FFS contractor will ensure communication via medical records and other appropriate means to enable the MCOs to adequately track member progress.
- f. The MCOs and the DMAS FFS contractor 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 DMAS FFS contractor 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 DMAS FFS contractor 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.

89. ARTS Provider Specifications. The following requirements must 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 services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed or Registered Practitioners 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); or "Supervisees in social work" under the supervision of a licensed clinical social worker approved by the Virginia Board of Social Work (18VAC140-20-10). Certified or registered staff include an individual with certification as a substance abuse counselor (CSAC) (18VAC115-30-10), an individual in their Virginia Board of Counseling approved status as a CSAC –

Supervisee, 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.

90. 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 shall collaborate with sister state agencies to 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. Potential strategies may include the following:

- a. Follow the Prescription Monitoring Program requirements as defined in Title 54.1, Chapter 25.2 of the Code of Virginia and in the contracts of the MCOs and the DMAS FFS contractor.
- b. Require hospice settings to notify pharmacies of a patient's death to prevent diversion of prescription opioid pain medication.
- c. Introduce targeted provider education requirements regarding pain management, prescribing, and the diagnosis and management of addiction based on prescribing history data.
- d. Make 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. Disseminate 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. Encourage 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. Require Medicaid MCOs and the DMAS FFS contractor 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. Recommend that all prescribers in the Commonwealth follow the recommendations in the *CDC Guidelines*, and educating prescribers on these guidelines.

- j. Continue 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. Consider claims edits for concurrent opioid and benzodiazepine prescriptions.
- l. Reduce administrative barriers to prescribing MAT products, including removing the service authorization requirement for pharmacotherapy on the most current preferred drug list.
- m. Pursue 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/nurse practitioners and licensed or registered behavioral health providers to develop and monitor individualized and personalized treatment plans that are focused on the best outcomes for the individual.
- n. Develop state guidelines for best practices for buprenorphine providers.
- o. Develop a process for the MCOs and the DMAS FFS contractor to credential preferred OBOT providers that will provide high-quality, evidence-based treatment, including medication and psychosocial supports.
- p. Implementing a comprehensive statewide MAT training curriculum for Preferred OBOT providers, including a buprenorphine waiver training track for physicians, nurse practitioners and physicians assistants, and a psychosocial counseling track for behavioral health providers. This activity is not eligible for FFP.

91. Services for Adolescents and Youth. DMAS must 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 must 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.”

92. 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 DMAS FFS contractor 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 DMAS FFS contractor 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 DMAS FFS contractor to determine if there are challenges that can be addressed with facilitation and technical assistance. If the MCO or the DMAS FFS

contractor remains noncompliant, the MCO or the DMAS FFS contractor must submit a corrective action plan (CAP) to DMAS. The CAP must detail how and when the MCO or the DMAS FFS contractor will remedy the issue(s) as defined in the MCO and DMAS FFS contractor.

- b. Access: The state must ensure that the MCOs and the DMAS FFS contractor comply with network adequacy and access requirements as defined in the contracts for the MCO and the DMAS FFS contractor 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 IX General Reporting Requirements. In addition to the requisite information described in STC 32, the annual report shall include:
 - i. A 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.

- 93. ARTS Monitoring Protocol.** The state must submit a Monitoring Protocol for the ARTS program authorized by this demonstration within 150 calendar days after approval of the demonstration. The Monitoring Protocol Template must be developed in cooperation with CMS and is subject to CMS approval. Once approved, the ARTS Monitoring Protocol will be incorporated into the STCs, as Attachment E. Progress on the performance measures identified in the Monitoring Protocol must be reported via the quarterly and annual monitoring reports. Components of the Monitoring Protocol include:
- a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC section XIII and reporting relevant information to the state's Health IT plan described in STC 95
 - b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section VIII of the demonstration; and
 - c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

- 94. Mid-Point Assessment.** The state must conduct an independent mid-point assessment by June 30, 2022. The assessor must collaborate with key stakeholders, including representatives of MCOs, SUD treatment providers, beneficiaries, and other key partners in the design, planning and conducting of the mid-point assessment. The assessment must include an examination of progress toward meeting each milestone from the State Medicaid Director letter, dated November 1, 2017 (SMD # 17-003 RE: Strategies to Address the Opioid Epidemic), and toward meeting the targets for performance measures as approved in the ARTS Monitoring Protocol. The assessment must also include a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and about the risk of possibly missing those milestones and performance targets. The mid-point assessment must also provide a status update of budget neutrality requirements. For each milestone or measure

target at medium to high risk of not being met, the assessor must provide, for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors that the state can influence that will support improvement. The assessor must provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. A copy of the report must be provided to CMS. CMS must be briefed on the report.

For milestones and measure targets at medium to high risk of not being achieved, the state will submit to CMS modifications to the ARTS Implementation Protocol and ARTS Monitoring Plan Protocols for ameliorating these risks subject to CMS approval.

- 95. ARTS Health Information Technology Plan (Health IT Plan).** The ARTS Health IT plan applies to all states where the Health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #18-011 and #17-003, respectively, states must submit to CMS the applicable Health IT plan, to be included as Attachment F to the STCs, to develop infrastructure and capabilities consistent with the requirements outlined in the SUD demonstration-type.

The ARTS Health IT Plan must detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of SUD health IT ecosystem improvement. The Plan must include implementation milestones and dates for achieving them, and must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) Health IT Plan.

- a. The state must include in its Monitoring Protocol an approach to monitoring its ARTS Health IT Plan which will include performance metrics to be approved in advance by CMS.
- b. The state must monitor progress, each DY, on the implementation of its ARTS Health IT Plan in relationship to its milestones and timelines and report on its progress to CMS in an addendum to its Annual Report.
- c. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing the state's ARTS Health IT policies and in all related applicable state procurements (e.g., including managed care contracts) that are associated with this demonstration.
- d. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.
- e. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.
- f. Components of the Health IT plan include:

- i. The ARTS Health IT Plan must describe the state’s goals, each DY, to enhance the state’s prescription drug monitoring program’s (PDMP).³
- ii. The ARTS Health IT Plan must address how the state’s PDMP will enhance ease of use for prescribers and other state and federal stakeholders.⁴ This will also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the ARTS Health IT Plan must describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients’ history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.
- iii. The ARTS Health IT Plan must, as applicable, describe the state’s capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the ARTS Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state’s ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state must also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.
- iv. The ARTS Health IT Plan must describe how the activities described in (i) through (iii) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.⁵
- v. The ARTS Health IT plan will describe the state’s current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: 1) Referrals; 2) Electronic care plans and medical records; 3) Consent; 4) Interoperability; 5) Telehealth; 6) Alerting/analytics; and 7) Identity Management.
- vi. In developing the Health IT Plan, states should use the following resources:
 1. States may use federal resources available on Health IT.Gov (<https://www.healthit.gov/topic/behavioral-health>) including but not limited to “Behavioral Health and Physical Health Integration” and “Section 34: Opioid Epidemic and Health IT” (<https://www.healthit.gov/playbook/health-information-exchange/>).
 2. States may also use the CMS 1115 Health IT resources available on “Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability” at <https://www.medicare.gov/medicaid/data-and-systems/hie/index.html>. States should review the “1115 Health IT Toolkit” for health IT considerations in conducting an assessment and developing their Health IT Plans.
 3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health

³ Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the “opioid” epidemic and facilitate a nimble and targeted response.

⁴ *Ibid.*

⁵ Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration

XIV. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION

Table 10. Schedule of Deliverables		
Date	Deliverable	STC
30 calendar days after approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
150 calendar days after approval date	ARTS Monitoring Protocol	STC 93
180 calendar days after approval date	Evaluation Design	STC 61
30 calendar days after CMS Approval	Approved Evaluation Design published to state’s website	STC 62
December 31, 2023, or with renewal application	Draft Interim Evaluation Report	STC 62
60 days after receipt of CMS comments	Final Interim Evaluation Report	STC 65
Within 18 months after December 31, 2024	Summative Evaluation Report	STC 66
60 calendar days after receipt of CMS comments	Final Summative Evaluation Report	STC 66
Monthly Deliverables	Monitoring Call	STC 35
Quarterly monitoring reports due 60 calendar days after end of each quarter, except 4 th quarter	Quarterly Progress Reports, including implementation updates	STC 32
	Quarterly Expenditure Reports	STC 45
Annual Deliverables - Due 90 calendar days after end of each 4 th quarter	Annual Reports	STC 32

Attachment A: 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 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 need rigorous quantitative and qualitative evidence to inform policy decisions.

Technical assistance resources for constructing comparison groups, identifying causal inferences, and phasing implementation to support evaluation are available on Medicaid.gov:

<https://www.medicaid.gov/medicaid/section-1115-demo/evaluation-reports/evaluation-designs-and-reports/index.html>

Expectations for Evaluation Designs

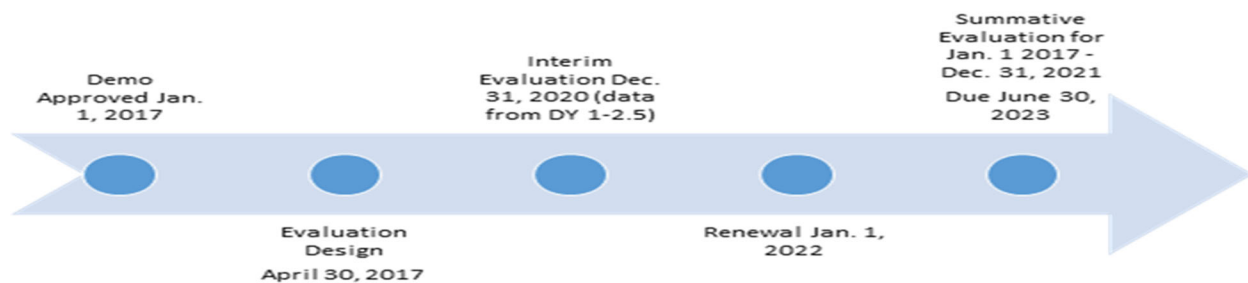
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses,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

The format for the Evaluation Design is as follows:

- A.** General Background Information;
- B.** Evaluation Questions and Hypotheses;
- C.** Methodology;
- D.** Methodological Limitations;
- E.** 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 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.

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

- a. 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).
- b. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
- c. 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;
- d. 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;
- e. Describe the population groups impacted by the demonstration.

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

- a. 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.

- b. 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>
- c. Identify the state’s hypotheses about the outcomes of the demonstration:
 - i. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
 - ii. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

3. 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:

- a. *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?
- b. *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.
- c. *Evaluation Period* – Describe the time periods for which data will be included.
- d. *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:

- i. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
 - ii. Qualitative analysis methods may be used, and must be described in detail.
 - iii. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
 - iv. 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).
 - v. 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).
 - vi. 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.
- e. *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).
- f. *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:
- i. 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.
 - ii. 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.
 - iii. 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).
 - iv. The application of sensitivity analyses, as appropriate, should be considered.
- g. *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.

A. Special Methodological Considerations – CMS recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. Examples of considerations include:

When the demonstration is:

- 1) Long-standing, non-complex, unchanged, or
- 2) Has previously been rigorously evaluated and found to be successful, or
- 3) Could now be considered standard Medicaid policy (CMS published regulations or guidance)

When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:

- 1) Operating smoothly without administrative changes; and
- 2) No or minimal appeals and grievances; and

- 3) No state issues with CMS-64 reporting or budget neutrality; and
- 4) No Corrective Action Plans (CAP) for the demonstration.

E. Attachments

- a. **Independent Evaluator.** This includes a discussion of the state’s process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure 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. The evaluation design should include a “No Conflict of Interest” statement signed by the independent evaluator.
- b. **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.
- c. **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 B: Preparing the Evaluation Report

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 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 need 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. With the following kind of information, states and CMS are best poised to inform and shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. 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. 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 Attachment

Title XIX of 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 Attachment 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.

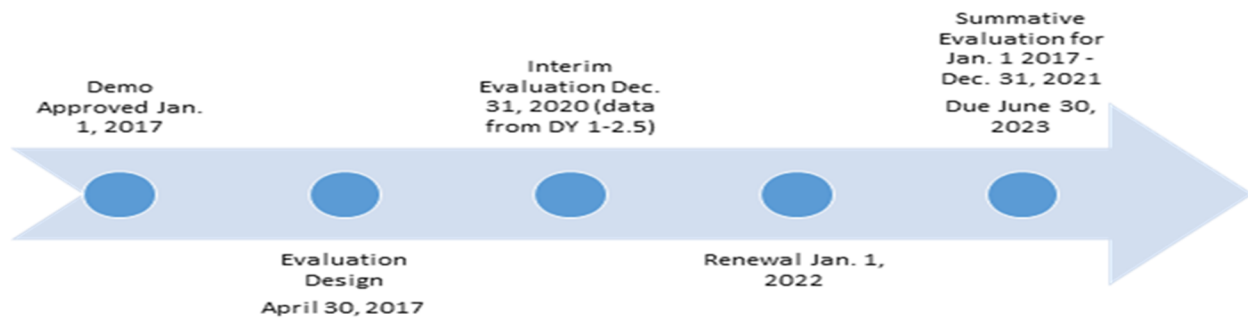
The format for the Interim and Summative Evaluation reports is as follows:

- 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 the evaluation design and reports to the state’s website within 30 days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



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 Attachment) 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.

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

F. 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.

G. 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?

H. 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.

I. 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?

J. Attachment(s)

- 1) Evaluation Design: Provide the CMS-approved Evaluation Design

Building and Transforming Coverage, Services, and Supports for a Healthier Virginia Section 1115 Demonstration Evaluation Design: Substance Use Disorder (SUD) and Former Foster Care Youth (FFCY) Demonstration Components
Demonstration Period: January 1, 2020-December 30, 2024

1.0 General Background Information

1.1 Description and history of demonstration

The number of fatal drug overdoses more than doubled in Virginia between 2007 and 2017, from 721 fatalities in 2007 to 1,526 in 2017.¹ After a small decrease in 2018, fatal drug overdoses resumed their upward trend in 2019. More than 80 percent of fatal drug overdoses in 2018 were due to prescription or illicit opioids, with heroin and fentanyl driving the increase in fatalities in recent years. However, overdoses due to cocaine and methamphetamines have also been rising sharply.

To increase access to substance use treatment services for Virginia Medicaid members, Virginia received approval from the Center for Medicare and Medicaid Services (CMS) in December 2016 for the Addiction and Recovery Treatment Services (ARTS) benefit. Implemented in April 2017, ARTS expanded coverage of treatment services for substance use disorders (SUD) for Medicaid members, including community-based services, short-term residential treatment that meet the definition of an Institution for Mental Diseases (IMD), and inpatient detoxification services.

ARTS was approved as an amendment to an existing Section 1115 demonstration waiver, the Virginia Governors Access Plan (GAP), that had originally been approved in January, 2015. This demonstration provided a limited package of behavioral and physical health services to childless adults and non-custodial parents aged 21 through 64 with household incomes at or below 100 percent of the federal poverty line, and who had been diagnosed with a serious mental illness. After the December 2016 amendment expanded SUD benefits through the ARTS program, there was an additional amendment to the demonstration in September 2017 which added coverage for former foster care youth (FFCY) who aged out of foster care under the responsibility of another state and are now applying for Medicaid in the Commonwealth of Virginia.

CMS approved an extension of Virginia's Section 1115 Demonstration in December 2019, effective January 1, 2020 through December 31, 2024. Under this extension, Virginia will continue to have the authority to provide services to Medicaid members through the ARTS benefit, as well as to provide coverage to FFCY up to age 26 who aged out of foster care in another state and now reside in Virginia. The demonstration will no longer include a separate GAP program (which provided limited benefits to people at or below 100 percent of FPL), as these beneficiaries were transitioned into full Medicaid coverage starting January 1, 2019 through Virginia's Medicaid expansion.

With the end of the GAP program, the name of the demonstration has been changed to Building and Transforming Coverage, Services, and Supports for a Healthier Virginia Section 1115 Demonstration Evaluation Design: Substance Use Disorder (SUD) and Former Foster Care

¹ Virginia Department of Health. Fatal Drug Overdose Quarterly Report: First quarter 2019 (July, 2019). <http://www.vdh.virginia.gov/content/uploads/sites/18/2019/07/Quarterly-Drug-Death-Report-FINAL-Q1-2019.pdf>

Youth (FFCY) Demonstration Components. (Project Number 11-W-0029713). As most of the evaluation plan described below pertains to the ARTS benefit, we will use the term “ARTS” when describing evaluation activities. In section 5.0, we describe the evaluation of Medicaid coverage of FFCY who aged out of foster care in another state.

1.2 Evaluation of ARTS program

In July 2017, the Virginia Department of Medical Assistance Services (DMAS) contracted with Virginia Commonwealth University School of Medicine to conduct an independent evaluation of the ARTS benefit. The evaluation has been conducted by faculty and staff from the Department of Health Behavior and Policy.

The VCU evaluation under the previous demonstration authority focused primarily on how the ARTS benefit affected; (1) the number and type of health care practitioners providing ARTS services; (2) members’ access to and utilization of ARTS services; (3) outcomes and quality of care, including hospital emergency department and inpatient visits; (4) the performance of new models of care delivery, especially Preferred Office-Based Opioid Treatment (OBOT) programs.

A recently published report by the VCU evaluation team found substantial increases in the supply and utilization of addiction treatment services among Virginia Medicaid members in the two years since the ARTS benefit was implemented (through March 2019).² This includes large increases in the number of providers across the continuum of care providing addiction treatment services to Medicaid members, including an almost four-fold increase in the number of outpatient practitioners submitting claims for ARTS services. In addition, the percent of members with SUD who received treatment increased from 24 percent before ARTS to almost 50 percent during the second year of ARTS. The use of medications for opioid use disorder (MOUD) treatment increased from 36 percent of those with opioid use disorder (OUD) before ARTS, to 49 percent during the second year of ARTS. Evidence of improved quality of care and outcomes was shown by significant decreases in emergency department visits and inpatient stays for members with OUD, relative to other Virginia Medicaid members.³

1.3 Goals of the evaluation of ARTS demonstration renewal

CMS guidelines require independent evaluations of approved demonstrations, including for renewals of existing demonstrations. The state must submit a draft evaluation design, for CMS comment and approval, no later than 180 calendar days after approval of the demonstration, which occurred December 30, 2019. To meet this requirement, DMAS requested that the VCU evaluation team prepare an evaluation plan for the ARTS demonstration renewal.

The evaluation design described in this document will build on and continue the evaluation of the ARTS program conducted under the December 2016 amendment that authorized the ARTS program, and will also take advantage of data sources not available at the

² VCU Department of Health Behavior and Policy. *Addiction and Recovery Treatment Services (ARTS): Access and Utilization During the Second Year (April 2018 – March 2019)*.

<https://hbp.vcu.edu/media/hbp/policybriefs/pdfs/FinalARTS2yearreport.Feb2020.pdf>

³ Barnes A, et al., Hospital Use Declines After Implementation of Virginia Medicaid’s Addiction and Recovery Treatment Services Program. *Health Affairs*. 2020(2): 238-246.

<https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00525>

time of the initial evaluation plan, which increase opportunities for identifying suitable comparison groups and including a broader set of measures.

Also, while the renewal includes no changes to benefits and services covered under the ARTS benefit, the number of members eligible for and using ARTS services has increased substantially since January 1, 2019, when the state expanded Medicaid eligibility to all adults with family incomes less than 138 percent of the federal poverty level. In just the first three months of expansion (January through March 2019), there were an additional 12,000 members with SUD who had enrolled through Medicaid expansion. As of April 2020, more than 28,000 members enrolled through Medicaid expansion had received ARTS services.⁴

The evaluation of the ARTS demonstration renewal has three main goals:

- 1) Extend the post-implementation period of the evaluation beyond the first two years of ARTS to include the years 2019-2024. In particular, the evaluation will examine and account for the impact of Virginia's Medicaid expansion in 2019 on SUD prevalence, access to and quality of treatment services, and outcomes among the Medicaid population.
- 2) To strengthen conclusions about the causal impact of ARTS on key measures of access and quality of care by comparing adjusted summary statistics in Virginia to other states using the Medicaid Outcomes Distributed Research Network (MODRN).
- 3) To examine the cumulative impact of ARTS and Medicaid expansion on addiction treatment services for the Virginia population, using national data sources that permit comparisons of treatment before and after expansion in Virginia, and between Virginia, other states, and the overall U.S. on selected measures of SUD treatment access, utilization, quality of treatment, and rates of fatal overdoses.

2.0 EVALUATION QUESTIONS AND HYPOTHESES

The specific evaluation questions and hypotheses for the evaluation are directly informed by the stated goals of the ARTS demonstration, as described on p. 25 of the Special Terms and Conditions: These include:

- Increase rates of identification, initiation, and engagement in treatment;
- Increase adherence to and retention in treatment;
- Reduce overdose deaths, particularly those due to opioids;
- Reduce utilization of emergency departments and inpatient hospital settings through improved access to a continuum of services;
- Reduce preventable admissions to the same or higher level of care; and
- Improve access to care for physical health conditions among beneficiaries.
- Increase IMD SUD costs and outpatient SUD treatment costs and decrease SUD-related emergency room visit and inpatient stay costs.

Figure 1 conceptualizes these goals in terms of the overall purpose (reducing overdose deaths), the primary drivers that will directly lead to fewer overdose deaths (the other six goals

⁴ Estimates from Medicaid Expansion Access and Health Services Dashboard as of April 15, 2020. Virginia Department of Medical Assistance Services. <https://www.dmas.virginia.gov/#/accessdashboard>

of the ARTS demonstration), and secondary drivers that reflect the main mechanisms the ARTS demonstration uses to affect addiction treatment services and, ultimately, overdose deaths.

The ARTS demonstration seeks to achieve its goals primarily through: (1) increasing the supply of addiction treatment providers serving Medicaid members; (2) increasing the capacity of existing treatment providers; (3) expanding services to cover the entire continuum of addiction treatment services, based on the American Society of Addiction Medicine (ASAM) criteria; (4) facilitating transitions between different levels of treatment; and (5) improving the coordination of addiction treatment services with other physical health, mental health, and social service needs.

To increase the supply and capacity of addiction treatment providers, the ARTS program increased reimbursement rates for a number of services, such as residential treatment services, outpatient services, and MOUD treatment. To further increase outpatient capacity, the ARTS demonstration also established a new type of provider, the Preferred Office-Based Opioid Treatment model (P-OBOT). In addition, extensive provider training, outreach, and recruitment efforts by state agencies and managed care organizations are intended to increase provider participation in Medicaid addiction treatment services.

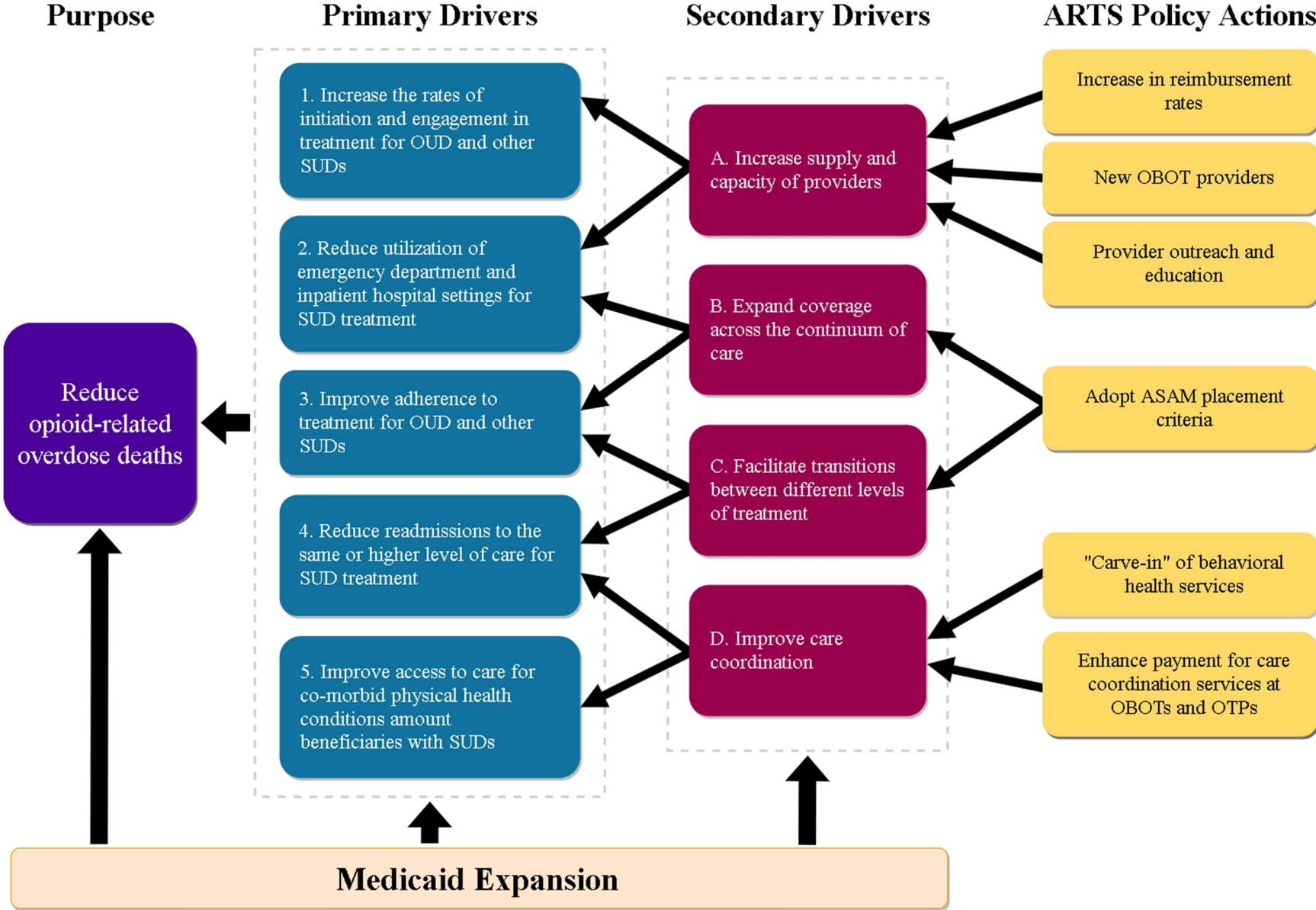
The ARTS demonstration also **expanded Medicaid-covered services along the ASAM continuum of care**, especially residential treatment services and medically managed intensive inpatient services, outpatient, as well as peer recovery services. **Improving transitions across different levels of care, and coordinating addiction treatment services with other physical, mental health, and social needs** are to be accomplished by, (1) shifting behavioral health services to a “carve-in” model so that they are provided by the same managed care organizations (MCOs) that provide other Medicaid services; (2) the use of licensed care coordinators by MCOs for addiction treatment services; and (3) enhanced payment for care coordination services by the new Preferred OBOT providers.

Finally, Medicaid expansion will amplify the effects of the ARTS demonstration by extending access to treatment services to hundreds of thousands of Virginians, most of whom were uninsured prior to January 1, 2019 and did not have access to ARTS benefits. Additional coverage of people with SUD is expected to further decrease the rate of fatal overdoses in the Virginia population. In addition, greater coverage of addiction treatment services through Medicaid expansion is likely to strengthen the addiction treatment system by increasing the number and capacity of addiction treatment providers serving Medicaid patients.

Table 1 describes the specific research questions, hypotheses, and performance metrics that will be used to assess whether the ARTS demonstration has achieved the goals as described above. These research questions and hypotheses are grouped into four over-arching evaluation questions:

- 1) Does the demonstration increase access to and use of SUD treatment services?
- 2) Does the demonstration improve the quality of treatment through improved care coordination of services?
- 3) Does the demonstration reduce the rate of overdose deaths due to substance use disorders?
- 4) How do costs for SUD-related and non-SUD-related services change over the evaluation period?

Figure 1. Driver Diagram for ARTS Demonstration Evaluation



February 3, 2021

Table 1. Research questions and hypotheses

Driver	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question 1: Does the demonstration increase access to and utilization of SUD treatment services?						
Demonstration Goal: Increased rates of initiation and engagement in treatment for OUD and other SUDS						
Evaluation Hypothesis: The demonstration will increase the percentage of beneficiaries who are referred and engage in treatment for OUD and other SUDS						
Primary Driver 1 (Increase rates of IET for OUD and other SUDs)	Initiation and engagement with alcohol and other drug dependence treatment	NQF #0004	Number of members who initiated treatment through inpatient, intensive outpatient, residential, outpatient, telehealth, or MOUD within 14 days of diagnosis	Members who were diagnosed with a new episode of alcohol or drug dependency during the first 10.5 months of the measurement year	MODRN (claims data)	Summary statistics with comparisons to MODRN states
Secondary Driver A (Increase supply and capacity of Medicaid treatment system)	Supply of buprenorphine waived prescribers relative to the state population	None	Number of providers (physicians, nurse practitioners, and physician assistants) who received DATA 2000 waivers from DEA to prescribe buprenorphine	Total population of state	DEA list of waived prescribers	Difference-in-difference approach that controls for Medicaid expansion across states
	Supply of buprenorphine waived prescribers who treat Medicaid patients	None	Number of providers (physicians, nurse practitioners, and physician assistants) who received DATA 2000 waivers from DEA to prescribe buprenorphine, and had at least one claim for Medicaid prescription	Number of Medicaid members	DEA list of waived prescribers linked to Medicaid claims data	Interrupted time-series
	Number of specialty treatment providers who accept Medicaid payment	None	Number of facilities who accept Medicaid payment	Total number of facilities	National Survey of Substance Abuse Treatment Services (N-SSATS)	Difference-in-difference approach that controls for Medicaid expansion across states

Driver	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
	Number of providers who are providing services at each ASAM level of care	None	Number of unique providers billing for ARTS services at different ASAM levels		Medicaid claims data	Interrupted time series
	Number of buprenorphine waived prescribers with patient limits at 75, 100, and 250	None	Number of providers (physicians, nurse practitioners, and physician assistants) who received waivers from DEA to prescribe buprenorphine at patient limits of 75, 100, and 250	Total population of state	DEA list of prescribers linked to Medicaid claims data	Difference-in-difference approach that controls for Medicaid expansion across states
	Median number of Medicaid members receiving prescriptions per prescriber who accepts Medicaid	None	Total number of Medicaid patients receiving buprenorphine prescriptions from waived prescribers	Total number of waived prescribers who had any Medicaid patients	DEA list of prescribers linked to Medicaid claims data	Interrupted time-series

Driver	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Demonstration Goal: Reduce utilization of emergency departments and inpatient hospital settings through improved access to a continuum of services						
Evaluation Hypothesis: The demonstration will decrease the rate of emergency department and acute inpatient stays.						
Primary Driver 2 (Reduced utilization of emergency department and inpatient hospital)	Emergency department visits for SUD and OUD, per 1000 member months	MODRN	The number of ED visits with SUD/ODU in any diagnosis field during the measurement period	Cumulative number of months members enrolled in Medicaid during the measurement period	MODRN (Medicaid claims data)	Summary statistics with comparisons to MODRN states

settings for SUD treatment						
	Inpatient admissions for SUD and OUD, per 1000 member months	MODRN	The number of inpatient admissions with SUD/OD in any diagnosis field during the measurement period	Cumulative number of months members enrolled in Medicaid during the measurement period	MODRN (Medicaid claims data)	Summary statistics with comparisons to MODRN states
	Rate of SUD-related admissions for the population	None	Number of inpatient admissions with SUD/OD in any diagnosis field during the year	Number of people in the state	HCUP Fast Stats	Difference-in-difference approach that controls for Medicaid expansion across states
Secondary Driver B (Expand coverage across continuum of care)	Percent of members with SUD/OD using ARTS services, by type of service	None	Number of members using ARTS services by ASAM level and type of service (based on billing code)	Number of members with OUD	Medicaid claims data	Interrupted time-series
	Percent of members with OUD who receive MOUD treatment	CMS Adult Core Measures	Members with OUD who received MOUD treatment	Members with OUD	MODRN (Medicaid claims data)	Summary statistics with comparisons to MODRN states
Driver	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Demonstration Goal: Increase adherence to and retention in treatment						
Evaluation Hypothesis: The demonstration will increase adherence to and retention in treatment						
Primary Driver 3 (Increase adherence to and retention in treatment)	Continuity of pharmacotherapy for OUD	NQF #3175	Number of members who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than 7 days	Individuals who had a diagnosis of OUD and at least one claim for an OUD medication	MODRN (Medicaid claims data)	Summary statistics with comparisons to MODRN states

	Length of an episode of outpatient treatment	None	Total number of days in treatment for an episode, defined as having at least 2 treatment claims in a month. Start and end of an episode based on not having any treatment claims in 3 months prior to start or 3 months after last claim for an episode	Number of members receiving treatment	Claims data	Interrupted time series
	Average length of stay in treatment, by service setting	None	Number of days in treatment between admission and discharge date	Number of treatment episodes	Treatment Episode Data Set	Difference-in-difference approach that controls for Medicaid expansion across states
	Percent of episodes in which treatment was completed	None	Number of discharges in which the reason for discharge was “treatment completed”	Number of discharges	Treatment Episode Data Set	Difference-in-difference approach that controls for Medicaid expansion across states

Driver	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question 2: Does the demonstration improve quality of treatment through improved care coordination of services						
Demonstration Goal: Reduce readmissions to the same or higher levels of care						
Evaluation Hypothesis: The demonstration will decrease the rate of readmissions to the same or higher level of care						
Primary Driver 4 (Reduce readmissions to the same or higher level care for SUD)	30 day readmission rates to same ASAM level 3 service or higher	None	Number of members admitted to ASAM 3 or 4 level of care within 30 days of discharge from a prior stay at the same level	Members who were discharged from ASAM 3 level of care for SUD	Claims	Interrupted time-series
Secondary Driver C (Improved transitions between	Number of members discharged from ASAM 3 services who receive	None	Number of members who received any lower level of ASAM care or pharmacotherapy within	Members who were discharged from ASAM 3	Claims	Interrupted time-series

Driver	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
different levels of care)	followup care within 30 days of discharge		30 days of discharge from ASAM 3 stay	level of care for SUD		
	Number of members discharged from ASAM level 4 service who receive followup care within 30 days of discharge	None	Number of members who received any lower level of ASAM care or pharmacotherapy within 30 days of discharge from ASAM 4 stay	Members who were discharged from ASAM 4 level of care for SUD		Interrupted time-series
	Number of members with SUD/OD-related emergency department visit who receive followup care within 7 and 30 days	NCQA-FUA-AD	Number of ED visits with a principal diagnosis of SUD/OD that had a followup visit for treatment with a primary diagnosis of SUD/OD with 7 (and 30) days of the visit	Number of ED visits with a principal diagnosis of SUD/OD	MODRN (Medicaid claims)	Summary statistics with comparisons to MODRN states
Demonstration Goal: Improve access to care for physical health conditions among beneficiaries						
Evaluation Hypothesis: The demonstration will increase the percentage of beneficiaries with SUD who receive treatment for co-morbid conditions						
Primary Driver 5 (Improve access to care for co-morbid physical health conditions among beneficiaries with SUD)	Any use of ambulatory or preventive care services	None	Members who had an ambulatory care or preventive care visit without a principal or secondary diagnosis of SUD/OD	Members with a diagnosis of SUD/OD	Claims	Interrupted-time series
	Controlling high blood pressure	NCQA (CMS Core indicators)	Members with OUD/SUD who received treatment for high blood	Members with a diagnosis of SUD/OD	Claims	Interrupted-time series
	Comprehensive diabetes care	NCQA (CMS Core Indicators)	Members with OUD/SUD who received treatment for diabetes	Members with a diagnosis of SUD/OD	Claims	Interrupted-time series
	Diabetes short-term complications admission rate	NCQA (CMS Core Indicators)	Members with OUD/SUD who had inpatient admission related to	Members with a diagnosis of SUD/OD	Claims	Interrupted-time series

Driver	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
			complications from diabetes			
	Members with flu vaccinations	NCQA (CMS Core indicators)	Members with OUD/SUD who received flu vaccination	Members with a diagnosis of SUD/ODU	Claims	Interrupted-time series
	Screening for HIV, HCV, HBV among enrollees with an OUD diagnosis	MODRN	Members with SUD/ODU who have at least one claim for HIV/HBV/HCV screening during the measurement year	Members with a diagnosis of SUD/ODU	MODRN (Medicaid claims)	Summary statistics with comparisons to MODRN states
	Received counseling or psychotherapy for mental health condition	None	Members with SUD/ODU with visit for counseling/psychotherapy for mental health condition other than SUD/ODU	Members with a diagnosis of SUD/ODU	Claims	Interrupted-time series
Secondary Driver D (Greater use of care coordination services among treatment providers)	Number of members with claim for care coordination or case management service related to SUD	None	Number of members with SUD/ODU who had a claim for care coordination or case management	Number of members with SUD/ODU	Claims	Interrupted-time series analysis
	Members who received help with other health and social needs	None	Members who reported receiving help with other medical problem, mental health problem, or assistance with food or housing at their SUD treatment provider	Members with SUD who are receiving treatment	ARTS member survey	Cross-sectional analysis

Driver	Measure description	Measure steward, endorsement	Numerator	Denominator	Data source	Analytic approach
Evaluation Question 3: Are rates of opioid-related overdose deaths impacted by the demonstration?						
Demonstration Goal: Reduction in overdose deaths, particularly those due to opioids.						
Evaluation Hypothesis: The demonstration will decrease the rate of overdose deaths due to opioids.						
Purpose (Reduce overdose fatalities related to SUD)	Rate of opioid-related overdose deaths, among people with Medicaid coverage in past year	None	Number of fatal drug overdoses due to opioids among people enrolled in Medicaid	Number of Medicaid members	Cause of death data linked to claims	Difference-in-difference analysis comparing within state Medicaid overdose rate to non-Medicaid overdose rate
	Rate of overdose deaths due to other substances among people with Medicaid coverage in past year	None	Number of fatal overdoses due to substances other than opioids	Number of Medicaid members	Cause of death data linked to claims	Difference-in-difference analysis comparing within state Medicaid overdose rate to non-Medicaid overdose rate
	Rate of drug overdoses in the Virginia population	None	Number of fatal overdoses due to drugs and alcohol	State population	Vital Statistics from the Center for Disease Control	Difference-in-difference approach that controls for Medicaid expansion across states

Evaluation Question 4: How do costs for SUD-related and non-SUD-related services change over the evaluation period?						
Evaluation Hypothesis: The demonstration will increase IMD SUD costs and outpatient SUD treatment costs and decrease SUD-related emergency room visit and inpatient stay costs						
	Total costs per-member per month (PMPM). Total and federal costs will be calculated	CMS SUD Evaluation Design Guidance, Appendix C	Total costs for members from claims data (inpatient, outpatient, pharmacy, long-term care, and capitated payments to managed care organizations); costs from Institutions for Mental Diseases (IMD); and administrative costs.	Total member months in quarter	Claims	Interrupted-time series analysis
	Total costs PMPM related to diagnosis and treatment for SUD	CMS SUD Evaluation Design Guidance, Appendix C	Total payments summed across all diagnosis and treatment-related claims in quarter. Total costs will be the sum of SUD-IMD costs, other SUD costs, and non-SUD costs.	Total member months in quarter	Claims	Interrupted-time series analysis
	Total costs PMPM for residential SUD treatment (IMD)	CMS SUD Evaluation Design Guidance, Appendix C	IMD costs reported by states with SUD diagnosis and/or procedure codes	Total member months in quarter	Claims	Interrupted-time series analysis
	Total costs PMPM for non-IMD SUD treatment	CMS SUD Evaluation Design Guidance, Appendix C	Costs with SUD diagnosis and/or procedure codes relating to	Total member months in quarter	Claims	Interrupted-time series analysis

Evaluation Question 4: How do costs for SUD-related and non-SUD-related services change over the evaluation period?						
Evaluation Hypothesis: The demonstration will increase IMD SUD costs and outpatient SUD treatment costs and decrease SUD-related emergency room visit and inpatient stay costs						
			outpatient treatment, inpatient treatment, pharmacy, and long-term care			
	Total non-SUD costs PMPM	CMS SUD Evaluation Design Guidance, Appendix C	Costs without SUD diagnosis and/or procedure codes relating to outpatient treatment, inpatient treatment, pharmacy, and long-term care	Total member months in quarter	Claims	Interrupted-time series analysis
	Source of treatment cost drivers – Total PMPM	CMS SUD Evaluation Design Guidance, Appendix C	Total source of treatment costs drivers include the sum of: non-ED outpatient costs, ED outpatient costs, inpatient costs, pharmacy costs, and long-term care costs.	Total member months in quarter	Claims	Interrupted-time series analysis
	Source of treatment cost drivers – <i>Non-ED outpatient</i> costs PMPM	CMS SUD Evaluation Design Guidance, Appendix C	Costs with or without SUD diagnosis and/or procedure codes relating to non-ED outpatient treatment	Total member months in quarter	Claims	Interrupted-time series analysis
	Source of treatment cost drivers – <i>ED outpatient</i> costs PMPM	CMS SUD Evaluation Design Guidance, Appendix C	Costs with or without SUD diagnosis and/or procedure codes relating to ED outpatient treatment	Total member months in quarter	Claims	Interrupted-time series analysis

Evaluation Question 4: How do costs for SUD-related and non-SUD-related services change over the evaluation period?						
Evaluation Hypothesis: The demonstration will increase IMD SUD costs and outpatient SUD treatment costs and decrease SUD-related emergency room visit and inpatient stay costs						
	Source of treatment cost drivers – <i>Inpatient</i> costs PMPM	CMS SUD Evaluation Design Guidance, Appendix C	Costs with or without SUD diagnosis and/or procedure codes relating to inpatient treatment	Total member months in quarter	Claims	Interrupted-time series analysis
	Source of treatment cost drivers – <i>Pharmacy</i> costs PMPM	CMS SUD Evaluation Design Guidance, Appendix C	Costs with or without SUD diagnosis and/or procedure codes relating to pharmacy utilization	Total member months in quarter	Claims	Interrupted-time series analysis
	Source of treatment cost drivers – <i>Long-term care</i> costs PMPM	CMS SUD Evaluation Design Guidance, Appendix C	Costs with or without SUD diagnosis and/or procedure codes relating to long-term care utilization	Total member months in quarter	Claims	Interrupted-time series analysis
	Total costs PMPM for SUD-related treatment services, by ASAM level of care	None	Total payments summed across claims stratified by ASAM level of care	Total member months in quarter	Claims	Interrupted-time series analysis
	Total costs PMPM for MOUD treatment	None	Total payments summed across claims for MOUD treatment services	Total member months in quarter	Claims	Interrupted-time series analysis
	Total costs PMPM for SUD-related acute inpatient and ED services	None	Total payments across claims for acute inpatient and ED services with a diagnosis of SUD	Total member months in quarter	Claims	Interrupted-time series analysis

3.0 METHODOLOGY

3.1 Overview of Design and Data Sources

As stated above, the evaluation of the ARTS demonstration renewal has three main goals: 1) to extend the evaluation of the ARTS demonstration beyond the first two years after implementation (April 2017 through March 2019) to include the years 2019-2024; 2) to strengthen conclusions about the impact of ARTS by comparing the trends before and after ARTS implementation to those of other states that did not implement similar programs; and 3) to examine the cumulative impact of ARTS and Medicaid expansion on addiction treatment services in Virginia. Below we summarize the approach to each of these goals and how they relate to the hypotheses and research questions described in Section 2.0. Section 3.2 describes in greater detail the analytical approaches that will be used to address each of the goals described below.

Goal 1: Examine the impact of ARTS beyond the first two years of the demonstration.

Under the original ARTS demonstration, our evaluation examined changes in measures of SUD treatment access, utilization, provider supply, and outcomes between the year prior to ARTS implementation (April 1, 2016 to March 30, 2017) and the two years following implementation of ARTS (April 1, 2017 through March 30, 2019). We will extend the post-implementation period of the evaluation to include the years 2019 through 2024 for selected measures. To simplify the analysis, and to also ensure consistency across measures and with other aspects of the evaluation described below, we will examine change based on a calendar year (that is, annual, semi-annual, or quarterly measures of utilization based on a calendar year) rather than based on the “ARTS year”, which overlapped with two calendar years.

Most analyses during the first two years of the demonstration were based on an analysis of Virginia Medicaid claims data to observe trends in SUD treatment access, utilization, and outcomes. For measures in which it is difficult or infeasible to obtain within-state or cross-state comparison groups, we will use interrupted time-series analyses (described below) to examine changes between the ARTS pre-implementation period (2015 and 2016) and the post implementation period (2018 to 2023). This approach will be used primarily to assess the following components of the evaluation:

- Secondary Driver B (Expand coverage across the entire continuum of care): Number of providers billing for ARTS services at each ASAM level; member utilization by ASAM level of care.
- Primary Driver 4 (Reduce readmissions to the same or higher level of care): 30 day readmission rates to same ASAM level 3 or higher
- Secondary Driver C (Facilitate transitions between different levels of treatment): Number of members discharged from ASAM 3 or ASAM 4 services who receive follow-up care within 30 days of discharge).
- Primary Driver 5 (Improve access to co-morbid physical health conditions): Use of primary or preventive for selected chronic conditions.

- Secondary Driver D (Improve care coordination): Number of members with a claim for care coordination or case management services.

As Virginia expanded eligibility for Medicaid coverage on January 1, 2019 to include adults with family incomes at 138 percent of poverty or less, our analysis will also account for the fact that the Virginia Medicaid population changed substantially in both size and composition in 2019. Our evaluation will track changes in the overall increase in the number of Medicaid members with a SUD diagnosis and the number utilizing various ARTS services resulting from Medicaid expansion in 2019.

More importantly, the evaluation will also account for the fact that members enrolled in Medicaid expansion could differ from other Medicaid members in ways that could affect estimates of the rate of Medicaid members receiving SUD treatment as well as other measures in Table 1. For example, analysis based on the first three months of Medicaid expansion in Virginia shows that Medicaid expansion members with SUD are more likely to be male, somewhat younger in age, and less likely to have physical or mental health co-morbidities compared to adult Medicaid members with SUD from other eligibility groups. Interrupted time-series analyses of the impact of ARTS on rates of access, utilization, and outcomes for the Medicaid population will account for potential changes in the characteristics of the Medicaid population resulting from expanded eligibility in 2019.

The current evaluation builds upon prior evaluation work by also incorporating cost information to understand whether the ARTS benefit increased SUD-related outpatient treatment costs and reduced SUD-related emergency room visit and inpatient stay costs. Following CMS SUD Evaluation Design, Appendix C, total costs, costs related to SUD diagnosis and treatment, and sources of treatment cost drivers for members in the target population will be analyzed. Generally, managed care organization paid amounts from Medicaid claims data will be used as the measure of costs for each type of service (e.g., inpatient, long-term care). For each of these services costs will include total payments for all claims related to the service.

Goal 2 – Strengthen conclusions about the causal impact of ARTS by comparing Medicaid members in Virginia to Medicaid members in other states.

Although prior evaluation results showed large increases in access to and utilization of addiction treatment services in the two years following implementation of ARTS, most of the analysis did not include the use of comparison groups – that is, individuals either within or outside of the state that are similar to Virginia Medicaid members with SUD, but who are unaffected by the ARTS reforms. The inclusion of such comparison groups can greatly strengthen conclusions about the impact of ARTS because they permit an estimate of the counterfactual, or how SUD treatment and access would have changed for Virginia Medicaid had ARTS not been implemented. Such comparisons are difficult because: 1) ARTS was implemented statewide and for all Medicaid members on April 1, 2017, thereby greatly limiting the use of within-state comparisons; 2) lack of available data on Medicaid members in other states with which to make comparisons on measures of SUD treatment access and utilization during the same time period; and 3) difficulty in identifying states that are similar to Virginia prior to ARTS implementation, but who remained static in terms of SUD policy throughout the ARTS evaluation period.

One exception was an analysis of the impact of ARTS on acute hospital emergency department and inpatient utilization, which utilized Virginia Medicaid members who did not

have SUD as a comparison group.⁵ While our analysis showed that this was a reasonable comparison for this particular analysis, the non-SUD Medicaid population in Virginia is a limited comparison group that is unlikely to be useful for other analyses described in this evaluation plan.

Since the initial evaluation plan was developed in 2016, other data sources have become available that permit more informative comparisons with other states. For this evaluation, we will leverage Virginia's participation in the Medicaid Outcomes Distributed Research Network (MODRN) to compare changes on key measures of SUD treatment access, utilization, and quality of care for Virginia with Medicaid members in other states. MODRN is a multi-state collaborative effort consisting of 13 Medicaid state agencies and university partners to facilitate standardized measures based on state Medicaid claims data for facilitating cross-state comparisons of opioid-related research. In addition to Virginia, MODRN states include: Delaware, Kentucky, Maine, Maryland, Massachusetts, Michigan, North Carolina, Ohio, Pennsylvania, Tennessee, West Virginia, and Wisconsin. With the exception of Tennessee and North Carolina, all MODRN states have expanded Medicaid, with Virginia, expanding in 2019, the most recent to expand. Approximately one-in-four Medicaid members in the United States are enrolled in Medicaid programs participating in the MODRN collaborative with the 11 initial MODRN states accounting for 16.3 million (22%) Medicaid enrollees. MODRN states are largely contiguous and include 6/10 states ranking highest in overdose deaths in the country (e.g., Ohio, West Virginia). Moreover, most of states in the MODRN collaborative have SUD waivers approved or pending.

MODRN includes a number of common quality and performance metrics developed by the National Quality Forum and other sources that are being constructed for each year starting with 2014. The following measures being proposed for this evaluation will be based on MODRN:

- Initiation and engagement with treatment for alcohol, opioid, and other drug use dependence (Primary Driver #1).
- Utilization of emergency department and inpatient hospital settings for SUD (Primary Driver #2).
- Rates of Medications for Opioid Use Disorder (MOUD) use for members with OUD (Primary Driver #3).
- Continuity of pharmacotherapy (Primary Driver #3)
- Screening for HIV, HCV, HBV among members with OUD diagnosis (Primary Driver #5)
- Follow-up care within 7 and 30 days of an emergency department visit related to SUD (Secondary Driver C).

MODRN facilitates cross-state comparisons of these measures through a common data model that standardizes the definition and construction of these measures across states. Thus, MODRN permits comparisons of changes in these measures in Virginia before and after implementation of the ARTS demonstration with changes on the same measures in other states. These comparisons will allow for stronger conclusions about the impact of ARTS on SUD treatment access and quality. A more detailed discussion of the analysis conducted through the MODRN is provided below.

⁵ Barnes et al., *op cit*

Goal 3. Examine the cumulative impact of ARTS and Medicaid expansion on addiction treatment services in Virginia.

Virginia is unique among state Medicaid programs in that a comprehensive reform of addiction treatment services in 2017 was followed by expanded eligibility for Medicaid in 2019. The combination of expanded Medicaid coverage of addiction treatment services and expanded eligibility for Medicaid is expected to have substantial effects on population-level estimates of SUD treatment access, utilization, and outcomes for Virginia. Using Medicaid-only data sources (such as claims data) does not permit a complete assessment of the impact of Medicaid expansion on the Virginia population, since these data only reflect people enrolled in Medicaid before and after expansion. Data sources that are representative of the entire population – including uninsured people -- are necessary to assess the impact on SUD treatment when uninsured people gain coverage. Therefore, we will utilize national data sources to examine the combined impact of ARTS and Medicaid expansion on population-level estimates of supply of SUD providers, access to treatment, quality of treatment, and outcomes by comparing the changes in these measures for Virginia relative to other states and the overall U.S.

We will assess the combined impact of ARTS and Medicaid expansion on supply and capacity of buprenorphine prescribers (Secondary Driver A) through the Drug Enforcement Administration (DEA) database on providers who received waivers to prescribe buprenorphine through the 2000 Drug Addiction Treatment Act (DATA); we have obtained the complete DEA list of all providers that had waivers from 2002 (the beginning of the program) through 2020. These data include counts of waived prescribers at different patient limits (30, 100, 275), license type (including nurse practitioners and physician assistants since 2017), and location. To assess changes in supply and capacity of waived prescribers, we will construct state and county-level measures of the number of waived prescribers relative to the population, as well as total patient capacity of waived prescribers.

Secondary driver A will also be addressed with the National Survey of Substance Use Treatment Services (N-SSATS), an annual census of treatment providers conducted by the Substance Abuse and Mental Health Services Association (SAMHSA). Information is collected on the location, organization, structure, services, payers (including Medicaid) and utilization of substance abuse treatment facilities in the United States. State identifiers are included on public use files, permitting a comparison of trends in Virginia with other states and the overall U.S. We have already acquired data for 2015 through 2019, and will acquire data for 2020 when it becomes available (likely in Fall, 2021). To assess changes in the supply of treatment facilities we will construct state-level measures of the number of SUD treatment facilities of different types (e.g, residential, IOP, outpatient), the number of treatment facilities offering MOUD treatment, and the number of treatment facilities accepting Medicaid payment. NSSATS data in the odd years (2015, 2017, 2019) provide more detail on number of beds and use rates (number of patients in treatment / number of beds) which we will use to assess changes in treatment capacity.

The Treatment Episode Data Set (TEDS) will be used to examine the combined impact of ARTS and Medicaid expansion on quality of treatment services. Compiled by SAMHSA, TEDS summarizes information about the characteristics and outcomes of treatment for alcohol and/or drug use among clients aged 12 years and older in facilities that report to individual state administrative data systems. To address Primary Driver 3 (improve adherence to treatment for OUD and other SUDs), we will use the TEDS to assess the combined impact of ARTS and Medicaid expansion on changes in the length of treatment episodes and the rate at which

treatment is completed. Using data from the TEDS discharge file, we will construct state-level measures of the average length of stay, as well as the percent of discharges where the reason for treatment was “treatment completed”, and a second indicator for “dropped out of treatment.” The analysis will control for changes in other characteristics of treatment episodes using information from the TEDS admission and discharge files, such as patient characteristics, treatment setting, and other characteristics of treatment. Due to the lag in the availability of the TEDS data, it is anticipated that this analysis will be completed in 2023, when 2019 data become publicly available.

The combined impact of ARTS and Medicaid expansion on OUD-related inpatient use (Primary Driver 2) will be assessed using the “Fast Stats” online data tool from the Health Care Cost and Utilization Project (HCUP). This tool provides state-level estimates of the rates of inpatient utilization (per 100,000 people) since 2010 by quarter. Estimates include all inpatient stays (for all payers) as well as for specific types of inpatient stays, including those related to an OUD diagnosis. Using this tool, we will construct a database of state and quarter specific estimates of the rate of OUD-related inpatient stays between 2016-2019. We will also link state-level information from the American Community Survey (to control for changes in population characteristics), and state-level estimates of self-reported OUD prevalence from the National Survey of Drug Use and Health (to control for changes in prevalence) that are publicly available. Availability of state-level inpatient admissions data through the HCUP Fast Stats varies by state. As of this writing, data through the first quarter of 2019 are available for Virginia. We will begin analysis when Virginia and at least 10-15 other states (non-expansion as well as selected others) have data available through 2019, likely in late 2022 or early 2023.

Finally, we will assess the combined impact of ARTS and Medicaid expansion on rates of fatal drug overdoses in Virginia by obtaining data from National Vital Statistics System maintained by the Center for Disease Control and Prevention on numbers and rates of fatal drug overdoses by state and year. As geographic identifiers are not available on public use files, we will apply to the National Center for Health Statistics to the restricted use files for the multiple cause of death (MCOB) micro-data files. These will permit a comparison of quarterly changes in the rate of fatal drug overdoses for Virginia (and Virginia counties) with other comparison states. Data are currently available for 2016 through 2019. We will apply to obtain the restricted use files in 2021.

3.2 Analytic Approaches**

Goal 1: Interrupted Time Series Analyses. As described above, measures for which we have data only on Virginia Medicaid members, including claims-based measures of utilization and costs that are specific to Virginia Medicaid, will rely primarily on a summary-level interrupted time series analyses (ITS) with the unit of time measured in quarters to allow for sufficient variation in outcomes prior to ARTS implementation (~8 quarters) and post (~30 quarters). For these analyses, the unit of analysis is the summary measure (e.g. a ratio or percentage) at a given time period rather than individual’s outcome at the given time period. Assume an outcome of interest Y , across $t = 0 \dots, m$ time periods. Let Y_t represent the outcome at time t , T represents the time elapsed, and W_t represent an indicator variable specifying whether or not time T is part of the post-ARTS intervention period in Virginia. The interrupted time series model is given by:

$$Y_t = \beta_0 + \beta_1 T + \beta_2 W_t + \beta_3 W_t * T + \varepsilon_t$$

where β_0 and β_1 represent the pre-ARTS intercept and slope respectively, and β_2 and β_3 represent the change in the intercept and slope respectively during the post-intervention period.

The parameter ε_t represents random error in the time series at time t . The estimates β_2 and β_3 are the causal parameters of the interest in the model.

As discussed above, Medicaid expansion (beginning in January 1, 2019) will likely affect rates of SUD treatment access and quality because expansion enrollees differ in important ways from members enrolled through traditional eligibility criteria. To account for this, the framework will be extended to examine changes in three time periods in Virginia to consider post-expansion effects (i.e., pre-ARTS, post-ARTS but pre-expansion, and post-ARTS and post-expansion). In this case, additional parameters for the change in intercept and slope in the third time period would also be estimated giving the model the following form:

$$Y_t = \beta_0 + \beta_1 T + \beta_2 W_{1t} + \beta_3 W_{1t} * T + \beta_4 W_{2t} + \beta_5 W_{2t} * T + \varepsilon_t$$

Where W_{1t} and W_{2t} are indicators of the second (post-ARTS but pre-expansion) and third (post-ARTS and post-expansion) time periods. The coefficients β_2 and β_3 represent the changes in the second time period relative to the first (post-ARTS but pre-expansion versus pre-ARTS) and β_4 and β_5 represent the changes in the third time period relative to the first (post-ARTS and post-expansion versus pre-ARTS). To account for autocorrelation, Newey-West standard errors will be used in ITS models [ref].⁶

Goal 1: Cross-sectional analyses of ARTS member survey data. An example of the cross-sectional analyses the evaluators will conduct from ARTS member survey data follows. To assess whether members receiving ARTS services report receiving care coordination, specifically help with other health and other social needs as the ARTS intervention progresses (Secondary Driver E, Table 1), responses from multiple waves of the ARTS member survey will be pooled (see below for more detailed description of ARTS member survey). To date, two survey periods have already been fielded (Wave 1 – January – March 2020; Wave 2 October 2020 – March 2021), and subsequent waves are expected to be fielded in 2022 and 2023. Each wave is a cross-section of members receiving ARTS services who are randomly sampled and then sent mail surveys. As there is no pre-intervention survey data, descriptive (non-experimental) analyses will be required. Examples of cross-sectional analyses that will be leveraged from these data include linear probability models/logistic regressions estimating the adjusted probability/likelihood of whether or not members receiving ARTS services also report receiving assistance with other health and social needs (outcomes; Y_{it}).

$$Y_{it} = \beta_1 X_{it} + YEAR_t + \varepsilon_{it}$$

These analyses will be adjusted for covariates (X_{it}) including member characteristics (sex, race/ethnicity, eligibility group, age), education, psychological distress, polysubstance use, employment, housing and food insecurity, and survey time period ($YEAR_t$). Importantly, the first wave of the ARTS member survey was fielded immediately prior to the outbreak of the COVID-19 pandemic, with the second wave fielded during the pandemic allowing for comparisons in care coordination for non-substance use services before and during the pandemic.

⁶ Newey, W. K., & West, K. D. (1986). A simple, positive semi-definite, heteroskedasticity and autocorrelation consistent covariance matrix.

Goal 1: Difference-in-difference analysis comparing within state Medicaid overdose rate to non-Medicaid overdose rates. To evaluate whether the ARTS intervention shifted rates of opioid and non-opioid overdose deaths in Virginia, a difference-in-difference design will be used. Medicaid claims will be linked to Virginia Department of Health cause of death data to identify overdose deaths among members covered by Medicaid in the previous year creating a binary Medicaid coverage variable (covered by Medicaid in the past year; not covered by Medicaid in the past year). Data will be aggregated at the quarter level and differences in overdose deaths across Medicaid coverage vs. no Medicaid coverage, pre vs. post ARTs intervention period, and the interaction of the two will be estimated separately for opioid and non-opioid related overdose deaths. Control variables available on death certificates in Virginia include sex, age, race/ethnicity, and marital status. These and other potential confounders that can be included in the analyses will be adjusted for.

Our difference-in-difference approach to estimate reductions in overdose rates (Y_{it}) in the pre vs. post ARTS benefit period ($ARTS_t$) were higher among those with Medicaid coverage ($Medicaid_{it}$) than those without will take the following form where i denotes the individual and t denotes year:

$$Y_{it} = \beta_1 ARTS_t + \beta_2 Medicaid_{it} + \beta_3 ARTS_t * Medicaid_{it} + \beta_4 X_{it} + YEAR_t + \varepsilon_{it}$$

The coefficient β_3 is the difference-in-difference estimate of the mean difference in overdoses between those in Virginia Medicaid and those not covered by Medicaid in the post-ARTS period compared to the pre-ARTS period and X_{ist} denotes individual-level demographic characteristics described above.

Goal 2: Summary statistics using MODRN to compare Virginia with other states

Although a difference-in-differences analysis is the conventional approach to examining the impact of a state policy or program relative to that of a comparison group, this approach requires linkages of person-level data for both the intervention and comparison groups. The sharing of person-level data is not permitted in the MODRN collaborative as data use agreements among the states in MODRN permit only aggregate level comparisons across the participating states. Additionally, as noted above, 11 of the 13 MODRN states have expanded Medicaid and most of states in the MODRN collaborative have SUD waivers approved or pending, adding additional challenges beyond the inability to obtain person-level data, to using MODRN states as a counterfactual in a traditional difference-in-difference approach. Therefore, a summary statistics will be used to compare SUD/ODU service utilization and quality measures between Virginia and other MODRN states. These summary statistics can be adjusted in each MODRN state for treatment group, age group, gender, race ethnicity, rural, and eligibility category, among other covariates. A table detailing hypothetical state adjusted averages in the pre- vs. post-ARTS period in Virginia and two other states (State A, State B) in quarterly rates of OUD-related emergency department use is presented below. Rather than be used to generate causal estimates per se, the proposed analytic approach using MODRN data will help strengthen other causal models proposed in this evaluation (e.g., difference-in-difference approach controlling for Medicaid expansion) by allowing the evaluators to descriptively compare performance pre- and post-ARTS in Virginia to the average performance in these periods across all other MODRN states.

Table 1. Example of hypothetical results of pre- vs post-ARTS adjusted summary statistics.

State	Treatment	Quarterly rate of OUD-related ED Use	SE	p
Virginia	Pre-ARTS	Ref		
	Post-ARTS	-1.2900	-0.0561	0.0001
MODRN State A	Pre-ARTS	Ref		
	Post-ARTS	-0.1131	-0.0476	0.0051
MODRN State B	Pre-ARTS	Ref		
	Post-ARTS	-0.8519	-0.0435	0.0001

Goal 3. Using a difference-in-difference approach that controls for Medicaid expansion across states to estimate the combined impact of ARTS and Medicaid expansion on SUD treatment access and outcomes for the Virginia population.

We will use a difference-in-difference approach that controls for Medicaid expansion across states to assess the combined impact of ARTS and Medicaid expansion on access to addiction treatment services in Virginia. As described above, these analyses will be based on national data sources that include the entire population, and not just the population enrolled in Medicaid. Our primary empirical model will take the following form:

$$Y_{ist} = \beta_1 ARTS_{st} + \beta_2 Expansion_{st} + \beta_3 Expansion_{st} * ARTS_{st} + \beta_4 X_{ist} + STATE_s + YEAR_t + \varepsilon_{ist}$$

where i denotes the individual, s denotes the state, and t denotes year. In this model, $ARTS_{st}$ is an interaction represented as a binary variable equal to 1 if the individual lives in Virginia, the only state with the ARTS policy, and was observed in the data in 2017, when the policy was implemented, or later. Similarly, $Expansion_{st}$ is an interaction equal 1 if the individual was observed in state s that adopted the ACA's Medicaid expansion in year t . The variable $Expansion_{st} * ARTS_{st}$ indicates whether an individual lives in Virginia in 2019 or after. X_{ist} denotes individual-level demographic characteristics. State and year fixed effects are denoted by the terms $STATE_s$ and $YEAR_t$.

The estimated coefficient for β_1 represents the mean difference in outcomes between Virginia and other states in the post ARTS period compared to the pre ARTS period, adjusted for individual-level covariates and state and year fixed effects. The coefficients for β_2 provides the mean difference in outcomes between expansion and non-expansion states during the post-expansion period, as compared with the period before expansion. Finally, β_3 is a difference-in-difference coefficient that controls for Medicaid expansion across states and is an estimate of the mean difference in outcomes between Virginia in the post-ARTS, post-expansion period compared to the post-ARTS, pre-expansion period.

We will use linear regression models to facilitate a direct interpretation of the coefficients and estimated Huber–White robust standard errors clustered according to state. Based on these models, we will derive adjusted estimates for Virginia and other comparison groups. For example, an analysis treatment length and completion rates using the TEDS may result in the following table (Table 2) where average length of treatment increases 1.3 days in Virginia ($p < 0.05$) after ARTS, relative to the pre ARTS period and compared to changes in other states during the same time. The difference-in-difference approach that controls for Medicaid expansion across states will also be able to test for differences in ARTS effects before versus after Medicaid expansion in Virginia. In the example table below, average length of treatment increases 0.5 days ($p < 0.05$) after Virginia’s expansion compared to the post ARTS, pre expansion period in Virginia. Across all states, Medicaid expansion, in this example, increases average length of treatment by 1.2 days ($p < 0.05$), relative to non-expansion states. Examples using other outcomes (Average MOUD length of treatment, percent completed a treatment episode) available in TEDS are also presented in the table below.

Table 2. Example of estimates to be generated from the difference-in-difference approach that controls for Medicaid expansion across states of the combined impact of ARTS and Medicaid expansion on SUD quality of treatment.

	Average length of treatment (days)	Average length of MOUD treatment (days)	Percent completed an episode of treatment
<i>ARTS</i>	1.3*	2.0*	31%*
<i>Expansion</i>	1.2*	1.3*	23%*
<i>ARTS*Expansion</i>	0.5*	0.9*	8%*

* $p < 0.05$. Source: Treatment Episode Data Set, 2015-2020

3.3. Primary Data Collection

Patient experience survey. We will complement the analysis of Medicaid claims and other secondary data with a survey of Medicaid members who use ARTS services. Such a survey is currently being conducted for 2020 and 2021 and includes a stratified random sample of Medicaid members who had a diagnosis for OUD. The main objectives of the ARTS member survey are to: (1) assess patient experiences with the treatment they are receiving, and to understand how these experiences differ by treatment setting (e.g. OBOT, OTP, other outpatient providers); (2) to understand how patient experience with treatment differs by patient factors, such as race/ethnicity, co-morbid mental health problems, and social factors such as food and housing insecurity, social support, and experience with the criminal justice system, and; (3) to better understand the reasons why some members receive a diagnosis of OUD, but do not utilize Medicaid-covered OUD treatment services. An additional goal of the survey that has emerged recently is to assess the impact of the COVID-19 pandemic on members’ access to treatment services, and their experience with treatment services.

The current member survey is being fielded in two waves: (1) From January to March, 2020; and; (2) From October 2020 to March 2021. Each wave includes an initial sample of about 5,000 members, with an expected 1,000 completed interviews in each wave (about a 20 percent response rate). A stratified random sample was performed in order to obtain representative samples of members ages 21 and over with diagnosed OUD based on four types of

ARTS service utilization in the previous six months, as identified in the Medicaid claims data: (1) Members diagnosed with an OUD who had at least two claims related to the use of OBOT providers; (2) Members diagnosed with an OUD who did not use OBOT providers, but had at least two claims at OTP providers; (3) Members diagnosed with an OUD who did not use OBOT or OTP providers, but used other outpatient providers for ASAM 1 services; (4) Members who had any diagnosis for OUD in the previous year, but had no claims for any ARTS or other OUD treatment services in the past year. The sample is roughly equally split between the four sampling strata.

The survey questionnaire includes questions from the CAHPS Experience of Care and Health Outcomes (ECHO), which was developed specifically to identify experiences with behavioral health services provided by managed care organizations, as well as other questions designed to understand barriers to treatment, reasons for discontinuing treatment, and the benefits of treatment to member's personal, family, and employment circumstances. We also adapted questions from a survey conducted in Pennsylvania to assess Centers of Excellence providers. These questions assess how the treatment they received affected their ability to stay off drugs or alcohol, their ability to work, relationships with family and friends, social activities, and their ability to find stable housing. Other survey questions assessed their current level of psychiatric distress (using the Kessler 6 index), food and housing security, levels of social support, and experience with the criminal justice system in the previous 12 months.

In addition, since the second wave of the survey began after the onset of the COVID-19 pandemic, we included questions in the second wave that are designed to explicitly assess how the pandemic has affected their ability to get treatment services, including their utilization and access to telehealth services.

Postal addresses are the most consistently reported and accurate contact information in the enrollment data, while telephone numbers are either missing or considered inaccurate for the majority of members. Therefore, the survey is being conducted by mail. Respondents are provided with a \$5 incentive in the survey packet that is mailed to them, as well as a stamped envelope with which to return the completed survey. Survey responses are entered into a REDcap database, and converted to SAS datafiles for the purpose of analysis.

The first wave of the survey achieved a response rate of slightly over 20 percent. Differences between survey respondents and nonrespondents on a range of member demographic and claims-based service utilization measures will be assessed to identify potential nonresponse bias. To at least partially correct for any nonresponse bias, survey weights will be constructed using the propensity cell weighting method.

A similar design will be used to field a third wave of the member survey in late 2022 and early 2023, approximately two years after the second wave of the survey is completed. The primary purpose of the third wave of the survey is to assess changes in patient experiences with treatment services since 2020-21, at the height of the COVID-19 pandemic. Of particular interest is whether any changes in member-reported problems with access to care, dissatisfaction with providers and treatment, psychological distress, and food and housing security experienced during the COVID-19 pandemic have been restored to their pre-pandemic levels (the first wave in early 2020). We will also assess whether disparities in patient experience by treatment setting, race/ethnicity, and other patient factors have narrowed or increased since the first and second waves. We will also consider additional questions on pandemic-related changes to treatment services that are maintained after the end of the pandemic, such as the use of telehealth.

To maximize the ability to assess changes in patient experiences with previous waves, we will use similar sampling and data collection methods as described above, including a mail-based survey with at least 1,000 completed interviews among members with an OUD diagnosis. Although we will allow for some changes to the survey questionnaire to address new areas of interest, the overall structure and length of the questionnaire will be similar to the first two waves in order to minimize the potential that changes in survey responses from previous waves are due to changes in survey design.

Semi-structured interviews with MCO care coordinators. As mentioned above, the ARTS demonstration included a change from a “carve-out” to a “carve-in” model of care for behavioral health services in order to increase coordination between behavioral and physical health services. To facilitate this coordination, the six MCOs employ licensed care coordinators to assist members with identifying addiction treatment services, encouraging follow-up after discharge from acute hospital and residential treatment facilities, and coordinating other physical and social needs of members. To understand the processes and mechanisms by which MCOs managing and coordinating SUD treatment services for Medicaid members, we will conduct a series of semi-structured interviews with licensed care coordinators who are employed by the MCOs. We will interview the care coordinators who are tasked specifically with connecting members to SUD treatment services and facilitating transitions between different levels of treatment. The interviews will focus on four areas: (1) transitions between different levels of ASAM treatment, (2) retaining members in treatment once initiated; (3) coordination of SUD with other behavioral, physical health, and social needs; (4) how care coordination from the MCOs complements, conflicts with, or overlaps with care coordination services provided by many treatment providers, such as Preferred OBOTs.

Semi-structured interviews will be conducted due to the relatively small number of MCO care coordinators that have been identified by DMAS (n=23). We will interview a minimum of 3-4 care coordinators from each of the six MCOs, for a total of 18-20 interviews. Contact information for the care coordinators will be provided by DMAS. In addition, we will interview about 10-12 treatment providers to understand their perspectives on the role of MCO care coordinators in the treatment process, as well as their views on the effectiveness of these roles. We will identify providers likely to have had substantial interactions with MCO care coordinators, such as high volume OBOTs and residential treatment facilities.

All interviews will be recorded and transcribed. Using qualitative research software, transcriptions will be coded by topic, question, MCO, respondent type, geographic area, and other information important for the analysis, and entered into a database. The coding of responses will facilitate analysis by allowing us to query the database to identify responses based on question, topic, and stratified by key respondent characteristics.

3.3 Target and Comparison Populations.

The use of comparison states is being proposed for Goals 2 and 3 of the evaluation. Identifying “ideal” comparison states is difficult because most states have been active throughout the evaluation period in using Medicaid programs to address the opioid epidemic, including changes in benefits and covered services, increasing the supply and capacity of treatment providers, and modifying regulations regarding MOUD treatment. In addition, an increasing number of states have used Section 1115 demonstration waivers for SUD to allow federal Medicaid payments for residential treatment centers that have 16 or more beds, which otherwise

is prohibited under the Institution for Mental Disease (IMD) exclusion. The activity of state Medicaid programs in this area makes it difficult to select an ideal comparison group to represent the “counterfactual”, that is, what would have happened in Virginia if the ARTS demonstration had not been implemented.

At the same time, Virginia’s ARTS program is unique in that a comprehensive reform and expansion of addiction treatment services for Medicaid members was combined with a Section 1115 waiver, making all Medicaid members eligible April 1, 2017. While other states have implemented similar reforms, they have generally done so over much longer time periods, or prior to the evaluation period for this project. We are not aware of any other states that have combined a Section 1115 Demonstration Waiver for SUD with a comprehensive reform of services that was implemented simultaneously and that covered the entire Medicaid population throughout the state.

Use of the MODRN allows us to compare Virginia with other states who differ from Virginia on a number of domains, such as the timing of Section 1115 waiver adoption and implementation, changes made to covered SUD benefits, regulation of MOUD treatment (e.g. use of prior authorization for buprenorphine), as well as changes to other policies related to SUD.

As part of the MODRN project, a detailed inventory of Medicaid policies relating to SUD treatment and outcomes has been conducted for each of the participating states, which will facilitate identification of states in MODRN that are most optimal as comparison groups. For example, while most states in MODRN have adopted SUD demonstration waivers, Virginia was one of the early adopters (implemented in April, 2017), while most other states did not implement their waivers until late 2018 or early 2019. In sum, instead of using a single state that would likely be an imperfect comparison to Virginia, we will use a number of states in MODRN that did not implement reforms on the same timing and scale of ARTS, but may have implemented a number of smaller scale reforms over a longer time period or prior to the evaluation period.

The expansion of Medicaid eligibility less than 2 years after ARTS implementation further distinguishes Virginia from all other states. For the analysis of the combined impact of ARTS and Medicaid expansion, we will have a broader group of states with which to select comparison groups, as the data for this analysis is based on national data sources. As with the analysis of MODRN, we will try to limit comparison states to those that have not implemented large-scale reforms of their Medicaid addiction treatment systems during the evaluation period.

3.4. Assessing the impact of COVID-19

The COVID-19 pandemic has likely had major impacts on Medicaid enrollment, the number of Medicaid members with diagnosed SUD, and utilization of treatment services and outcomes. It is important to assess COVID-19 effects, not only to understand how the pandemic has affected Medicaid members with SUD, but also to understand how COVID-19 affected the demonstration and the ability of this evaluation to assess the impact of the demonstration and Medicaid expansion. We will assess the impact of COVID-19 in several ways/

First, we will split the post-Medicaid expansion period into roughly three periods: (1) 2019, the first year of Medicaid expansion and before the start of the pandemic; (2) 2020-2021, the years of the COVID-19 pandemic at its height, and; (3) 2022-2024, the expected post-pandemic time period. These time periods will be adjusted based on further evidence of when COVID-19 began to affect utilization (e.g. the first quarter of 2020), and when the pandemic is

considered to have largely ended. To assess the cumulative impact of ARTS and Medicaid expansion as described in Section 3.2 above, we will initially limit the post-expansion period to 2019 (and possibly the first quarter of 2020) in order to avoid the confounding effects of COVID-19.

To understand how COVID-19 affected Medicaid members and the demonstration, we will assess changes in the number of Medicaid members, the diagnosed prevalence of SUD and OUD, characteristics of Medicaid members with SUD and OUD, indicators of treatment utilization, quality, and outcomes between the pre-pandemic period (2019), the COVID-19 period (2020-2021), and the post-COVID-19 period (2022-2024). While these analyses will mostly be cross-sectional in nature, we will also examine a cohort of Medicaid members who initiated treatment in late 2019 or early 2020 (prior to the start of the pandemic) to examine the impact of the COVID-19 pandemic on their treatment utilization and outcomes, relative to a cohort of Medicaid members who initiated treatment in 2018 and completed at least one year of treatment prior to the start of COVID-19. Comparing cohorts that received treatment before and during COVID-19 should allow for strong conclusions about how access to and treatment for SUD changed during the pandemic. We

As described above, the three waves of the ARTS member survey are timed (coincidentally) to assess changes in the patient experience with treatment, specifically the pre-pandemic period (January – March 2020), the pandemic period (October 2020 – March 2021) and post-pandemic period (likely late 2022 and early 2023). In addition to changes in measures of patient satisfaction, social and personal outcomes of treatment, and access to services, the survey will also allow us to assess changes in (and control for) indicators of mental health, food and housing insecurity, social support, experience with the criminal justice system, and other patient characteristics among members who use ARTS services.

3.5 Evaluation Period

Our analysis will be organized around three key dates: April 1, 2017 when the ARTS demonstration was first implemented, January 1, 2019 when Medicaid eligibility was expanded to include adults up to ages 138% of the federal poverty level, and December 31, 2024 when the evaluation period ends under the current waiver. Our evaluation will cover roughly two time periods:

- 2015-2016 (pre-ARTS period) to 2017-18 (the post-ARTS period but before Medicaid expansion)
- 2017-2018 (the post-ARTS period prior to expansion) to 2019-2024 (the post-ARTS, post-Medicaid expansion period).
- As described above, the 2019-2024 period will be subdivided into 2019, 2020-2021, and 2022-2024 to address the potential effects of COVID-19.

3.6 Subgroup Analyses

We will conduct analysis of subgroups that are high priority to the Commonwealth of Virginia, including differences by region, urban/rural residence, racial and ethnic disparities, pregnant women, and different age groups. We will also explore how results differ by measures of community well-being using Virginia's Health Opportunity Index, a novel method that

quantifies community well-being and social determinants of health at the census tract level along dimensions of access to care, economic, educational, and environmental factors.⁷

4.0 METHODOLOGICAL LIMITATIONS

There are two major methodological limitations to this evaluation. First, the ARTS demonstration waiver along with the entire package of reforms contained within the program was implemented statewide on April 1, 2017, including expanded coverage of services, increases in reimbursement rates, and the switch to a “carve-in” model for behavioral health services. It will be difficult to test the impact of these specific components on outcomes, such as SUD-related hospital use and fatal drug overdoses. Although the evaluation will assess changes in the supply of providers, access to and utilization of services, and coordination with physical and mental health services that are addressed by specific provisions of ARTS, major conclusions will be based on the overall impact of the ARTS demonstration, rather than specific provisions.

As mentioned above, we do not believe it is possible to identify ideal comparison groups or states with which to serve as a true counterfactual to Virginia Medicaid during the evaluation period, especially an evaluation period that extends from 2015 through 2023. However, because the ARTS demonstration combined with Medicaid expansion is unique among states, we can restrict comparison states to those that did not implement reforms on the same scale and timeframe as the ARTS demonstration. While not ideal, using MODRN and national data sources to identify comparison groups greatly strengthens the evaluation design (relative to using only Virginia data), and will permit stronger conclusions about the impact of ARTS.

⁷ Virginia Department of Health. *Virginia Health Opportunity Index*. Available at: <https://apps.vdh.virginia.gov/omhhe/hoi/>.

5.0 EVALUATION OF FORMER FOSTER CARE YOUTH WHO AGED OUT OF FOSTER CARE IN ANOTHER STATE

5.1 Background.

As mentioned above, a September 2017 amendment to the demonstration added coverage for former foster care youth (FFCY) who aged out of foster care under the responsibility of another state and are now applying for Medicaid in the Commonwealth of Virginia. The Affordable Care Act included provisions to allow youth to maintain coverage under their parents' or guardian's health insurance plan until age 26, as well as for youth in foster care who have Medicaid coverage to continue with Medicaid coverage up to age 26.

A final rule published by CMS on November 21, 2016 allows Medicaid coverage of former foster care youth only in the state for which they received Medicaid coverage while in foster care. However, section 1115 demonstration authority allows states the option of providing coverage to youth who were in foster care and Medicaid in a different state. The September, 2017 amendment to the demonstration – now called the “Building and Transforming Coverage, Services, and Supports for a Healthier Virginia” – is intended for this purpose. As required by the section 1115 demonstration authority, the state must conduct a separate evaluation of the FFCY provision, and provide regular and annual monitoring reports to CMS to inform policy decisions.

5.2 Demonstration goals regarding former foster care youth age aged out of foster care in another state.

- 1) Ensure access to Medicaid services for former foster care youth between the ages of 18 and 26, who previously resided in another state and are now covered through Virginia Medicaid through the former foster care youth eligibility group.
- 2) Improve or maintain health outcomes for the demonstration population.

5.3 Evaluation Questions and Hypotheses.

A summary of the demonstration's core evaluation questions, hypotheses, data sources, and analytical approaches are provided in the table below. CMS guidance on the evaluation design for the FFCY demonstration suggests including both “process” and “outcome” measures. Process measures include enrollment and basic measures of utilization that will allow us to track and monitor the number of members who are benefitting from the demonstration.

Outcome measures would allow for a more comprehensive assessment of the impact of the demonstration. However, because the number of members expected to be affected by the demonstration is small (less than 100, see below), we do not think it is possible to assess outcomes or draw any meaningful conclusions about outcomes based on the measures suggested by CMS. Therefore, the evaluation will be limited to an assessment of process measures.

Summary of Key Evaluation Questions, Hypotheses, Data Sources, and Analytic Approaches

Demonstration Goal 1: Expand access to Medicaid for former foster care youth who were in foster care and Medicaid in another state and are now applying for Medicaid in the state in which they live.					
Evaluation Component	Evaluation Question	Evaluation Hypotheses	Measure [Reported for each Demonstration Year]	Recommended Data Source	Analytic Approach
Process	Does the demonstration provide continuous health insurance coverage?	Beneficiaries will be continuously enrolled for 12 months.	Number of beneficiaries continuously enrolled/ total number of enrollees	Administrative data – enrollment data	Descriptive statistics (frequency and percentage)
	How did beneficiaries utilize health services?	Beneficiaries will access health services.	Number of beneficiaries who had an ambulatory care visit/ Total number of beneficiaries	Administrative data – Medicaid claims	Descriptive statistics (frequencies and percentages)
			Number of beneficiaries who had an emergency department visit/ Total number of beneficiaries		
			Number of beneficiaries who had an inpatient visit/ Total number of beneficiaries		
			Number of beneficiaries who had a behavioral health encounter /Total number of beneficiaries		

5.4 Methodology

- a) Evaluation design: The evaluation will use a post-only assessment, as it is expected that less than 500 members will be enrolled in Medicaid through the demonstration (see below). The timeframe for the post-only period will begin when the demonstration begins, and ends when the demonstration ends.
- b) Data collection and sources: The former foster care youth demonstration population will be identified through Medicaid enrollment files. Monthly enrollment by eligibility group is tracked for all Medicaid members, and there are specific eligibility codes for those enrolled through the former foster care youth program. The enrollment files do not specifically identify whether enrollees were in foster care and Medicaid in a different state before they enrolled in Virginia Medicaid. To identify the demonstration population, we will identify those enrolled in Medicaid through the former foster care youth program who were not continuously enrolled in Medicaid in the year prior to their 18th birthday. The evaluation team will extract enrollment and claims data for the demonstration population annually. All data will be collected retrospectively through administrative data.
- c) Data Analysis Strategy. Quantitative methods based on descriptive analyses will be used to analyze the data.

5.5 Justification for Excluding Comparison Groups and Baseline Data

In 2019, there were an estimated 65 Medicaid enrollees covered under the demonstration. This falls well short of the criteria for having at least 500 potential enrollees needed to include a comparison group in the evaluation, based on CMS' Modified Evaluation Design for the Section 1115 Demonstration on Former Foster Care Youth Who Were in Foster Care and Medicaid in a Different State.

Also, the state does not have information on Medicaid enrollment of the demonstration population before they enrolled in Virginia Medicaid, and therefore is lacking baseline data on the demonstration population (that is, Medicaid enrollment before the demonstration began). However, the evaluators will be able to track Medicaid enrollment and utilization on a monthly basis since their enrollment began, beginning with the start of the demonstration in September, 2017.

ATTACHMENTS

A. Independent Evaluator

This demonstration waiver will be evaluated by an independent party. The Department of Health Behavior of Policy (HBP) is part of the Virginia Commonwealth University School of Medicine and is a separate entity from DMAS. The HBP department is comprised of 16 faculty from multiple disciplines including health economics, social epidemiology, sociology, and health psychology. HBP addresses the behavioral, social, organizational, and policy factors affecting the health of individuals and populations using rigorous quantitative and qualitative methods. The department includes two doctoral programs – one in Health Care Policy and Research, and a second Ph.D. program in Social and Behavioral Sciences.

Along with the Department of Biostatistics and Division of Epidemiology in the Department of Family Medicine, HBP is one of the core public health departments within the VCU School of Medicine. HBP faculty actively collaborate with faculty in other departments and centers within both the School of Medicine and other VCU departments, including the Department of Health Administration, the Department of Family Medicine and Population Health, the Massey Cancer Center, the Wright Center for Clinical and Translational Research, the Institute for Drug and Alcohol Studies, and the Center for the Study of Tobacco Products.

Drs. Peter Cunningham and Andrew Barnes (Principal Investigator and Co-Principal Investigators for this project, respectively) have been leading the evaluation of the ARTS demonstration since it began in 2017, which is part of a broader partnership they have established with DMAS. In addition to the evaluation of ARTS, Drs. Barnes and Cunningham are the university partners for Virginia for the Medicaid Outcomes Distributed Research Network. They have also partnered with DMAS on a needs assessment for Virginia's SUPPORT Act grant, and are leading two other state-funded evaluations of Medicaid programs. Through their partnership with DMAS, they have access to Medicaid enrollment and claims data that are necessary to complete the evaluation work. As part of the VCU School of Medicine, they are able to draw on the clinical and research expertise related to substance use disorders of other faculty and researchers within VCU. Dr. Cunningham has over 30 years of experience in health services and health policy research, including 19 years at Mathematica Policy Research, Inc., 7 years at the Agency for Healthcare Research and Quality, and 7 years at VCU. Dr. Barnes is a health policy researcher and health economist with 10 years of experience on faculty at VCU. He also serves on advisory roles with AcademyHealth's State Research and Policy Interest Group and AcademyHealth's State-University Partnership Learning Network.

B. Conflict of interest statement

HBP agrees that no agency, employment, joint venture, or partnership has been or will be created between DMAS and HBP. HBP further agrees that as an independent entity, it assumes all responsibility for any federal, state, municipal or other tax liabilities along with workers compensation, unemployment compensation, and insurance premiums that may accrue as a result of funds received pursuant to this work. HBP agrees that it is an independent entity for all purposes including, but not limited to, the application of the Fair Labor Standards Act, the Social Security Act, the Federal Unemployment Tax Act, the Federal Insurance Contribution Act, provisions of the Internal Revenue Code, Virginia tax law, Workers Compensation law, and Unemployment Insurance law.

HBP will maintain communication with DMAS staff throughout the evaluation period to better understand policy and program implementation, and to obtain DMAS' assistance with access to administrative data. HBP will make independent decisions about the evaluation itself, including methodology, analytical strategy, analysis of evaluation data, and presentation of results.

C. Timeline and Major Milestones

Milestone	Date
Completion of first interim report under demonstration renewal, submitted to DMAS	12/2020
Revised evaluation plan submitted to CMS	2/2021
Completion of ARTS member survey, wave 2	4/2021
Ongoing analysis of claims and survey data	1/2021 to 12/2021
Analysis of cumulative impact of ARTS and Medicaid expansion on provider supply using DEA waived prescriber data and N-SSATS	5/2021 to 12/2021
Completion of second interim report under demonstration renewal, including separate report on FFCY who aged out of foster care in another state	12/2021
Ongoing analysis of claims and survey data	1/2022 to 12/2022
Semi-structured interviews with MCO care coordinators	3/2022 to 9/2022
ARTS member survey, wave 3	10/2022 to 3/2023
Analysis of cumulative impact of ARTS and Medicaid expansion on SUD-related hospital inpatient admissions	5/2022 to 12/2022
Completion of third interim report under demonstration renewal, including separate report on FFCY who aged out of foster care in another state.	12/2022
Ongoing analysis of claims and survey data	1/2023 to 12/2023
Analysis of cumulative impact of ARTS and Medicaid expansion on access to and quality of treatment services for the Virginia population (based on analysis of TEDS)	7/2023 to 6/2024
Completion of fourth interim report under demonstration renewal, including separate report on FFCY who aged out of foster care in another state	12/2023
Ongoing analysis of claims, completion of all analytical tasks	1/2024 to 12/2024
Completion of final report	12/2024

Total

Total Budget for Addiction and Recovery Treatment Services Evaluation

PROJECT YEAR	PROJECT COST
Year 1: FY2020	
Total Direct Costs	\$154,545
F&A 10%	\$15,455
Total Costs - Year 1	\$170,000
Year 2: FY2021	
Total Direct Costs	\$154,482
F&A 10%	\$15,448
Total Costs - Year 2	\$169,930
Year 3: FY2022	
Total Direct Costs	\$154,482
F&A 10%	\$15,448
Total Costs - Year 3	\$169,930
Year 4: FY2023	
Total Direct Costs	\$154,482
F&A 10%	\$15,448
Total Costs - Year 4	\$169,930
Year 5: FY2024	
Total Direct Costs	\$154,482
F&A 10%	\$15,448
Total Costs - Year 5	\$169,930
TOTAL FOR ARTS	\$849,720

FY2020 Budget for Addiction and Recovery Treatment Services Evaluation

PERSONNEL	TITLE	Responsibilities	% EFFORT	PROJECT SALARY	PROJECT COST
Task 1: ARTS Year 2 Report					
Dr. Peter Cunningham	Principal Investigator	Oversee analysis and production of 2 year report	5%	\$12,112	\$12,112
Dr. Andrew Barnes	Co-Investigator	Assist with production and quality control of report	3%	\$4,755	\$4,755
Megan Mueller	Data Analyst	Statistical programming of Medicaid claims data, preparation of report tables	10%	\$5,500	\$5,500
Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$8,969
Production of reports and copy editing					\$950
Total Direct Costs					\$32,286
F&A 10%					\$3,229
Total Costs - Task 1					\$35,515
Task 2: ARTS Member Experience Survey					
Dr. Peter Cunningham	Principal Investigator	Oversee design, fielding, and analysis of member survey	5%	\$12,112	\$12,112
Lauren Guerra	Research Assistant	Manage data collection, including preparation and mailing of surveys, and data entry	25%	\$8,445	\$8,445
Huyen Pham	Research Assistant	Lead the analysis of the member survey	25%	\$7,500	\$7,500
Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$8,243
Incentives		3000x\$2.00			\$6,000
Paper and postage		4000x\$3.50			\$14,000
Total Direct Costs					\$56,300
F&A 10%					\$5,630
Total Costs - Task 2					\$61,930
Task 3: Effectiveness of ARTS Treatment Options					
Dr. Peter Cunningham	Principal Investigator	Oversee analysis and preparation of reports	8.5%	\$20,590	\$20,590
Dr. Andrew Barnes	Co-Investigator	Develop economic modeling, assist in report preparation	2%	\$3,170	\$3,170
Megan Mueller	Data Analyst	Statistical programming, preparation of tables for reports, and assistance with report production	15%	\$8,240	\$8,240
Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$12,836
Total Direct Costs					\$44,836
F&A 10%					\$4,484
Total Costs - Task 3					\$49,320
Task 4: Qualitative Analysis of Member Experiences in ARTS Sub-Populations					
Dr. Marshall Brooks	Principal Investigator	Oversee and lead qualitative data collection, production of report	10%	\$11,330	\$11,330
Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$4,543
Incentives		50x\$5.00			\$250
Transcription		50x\$100			\$5,000
Total Direct Costs					\$21,123
F&A 10%					\$2,112
Total Costs - Task 4					\$23,235
TOTAL FOR ARTS					\$170,000

FY2021 Budget for Addiction and Recovery Treatment Services Evaluation

PERSONNEL	TITLE	Responsibilities	% EFFORT	PROJECT SALARY	PROJECT COST
Task 1: Analysis of ARTS Member Survey					
Dr. Andrew Barnes	Co-Principal Investigator	Oversee analysis	5%	\$7,925	\$7,925
Megan Mueller	Data Analyst	Statistical programming, preparation of tables for reports	10%	\$5,500	\$5,500
Lauren Guerra	Research Assistant	Assistance with tables and report preparation	20%	\$8,200	\$8,200
Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$8,672
Total Direct Costs					\$30,297
F&A 10%					\$3,030
Total Costs - Task 1					\$33,327
Task 2: Analysis of episodes of care at OBOTs					
Dr. Peter Cunningham	Principal Investigator	Leads and oversees analysis	5%	\$12,112	\$12,112
Erin Britton	Data Analyst	Statistical analysis and programming of Medicaid claims data	25%	\$7,500	\$7,500
Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$4,857
Total Direct Costs					\$24,469
F&A 10%					\$2,447
Total Costs - Task 2					\$26,916
Task 3: Update analysis of claims data for trends in SUD prevalence and utilization					
Dr. Peter Cunningham	Principal Investigator	Oversee analysis and preparation of reports	5%	\$12,112	\$12,112
Megan Mueller	Data Analyst	Statistical programming, preparation of tables for reports, and assistance with report preparation	25%	\$13,750	\$13,750
Erin Britton	Data Analyst	Assistance with statistical programming of Medicaid claims data	25%	\$7,500	\$7,500
Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$10,371
Total Direct Costs					\$43,733
F&A 10%					\$4,373
Total Costs - Task 3					\$48,106
Task 4: Using MODRN to compare SUD access and treatment in Virginia to other states					
Dr. Andrew Barnes	Co-Principal Investigator	Oversee and lead qualitative data collection, production of report	5%	\$7,925	\$7,925
Megan Mueller	Data Analyst	Statistical programming, preparation of tables for reports	15%	\$8,250	\$8,250
Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$6,486
Total Direct Costs					\$22,661
F&A 10%					\$2,266
Total Costs - Task 4					\$24,927
Task 5: Assess combined impact of ARTS and Medicaid expansion on supply of treatment providers					
Dr. Peter Cunningham	Principal Investigator	Oversees project design and analysis	4.4%	\$10,658	\$10,658
Heather Saunders	Research Assistant	Leads the statistical programming for the analysis	30%	\$9,000	\$9,000
Lauren Guerra	Research Assistant	Assists with the analysis and preparation of tables for reports	15%	\$6,150	\$6,150
Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$7,514
Total Direct Costs					\$33,322
F&A 10%					\$3,332
Total Costs - Task 5					\$36,654
TOTAL FOR ARTS					\$169,930

FY2022 Budget for Addiction and Recovery Treatment Services Evaluation

PERSONNEL	TITLE	Responsibilities	% EFFORT	PROJECT SALARY	PROJECT COST
Task 1: Analysis of ARTS Member Survey					
Dr. Andrew Barnes	Co-Principal Investigator	Oversee analysis	5%	\$7,925	\$7,925
Megan Mueller	Data Analyst	Statistical programming, preparation of tables for reports	10%	\$5,500	\$5,500
Lauren Guerra	Research Assistant	Assistance with tables and report preparation	20%	\$8,200	\$8,200
Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$8,672
Total Direct Costs					\$30,297
F&A 10%					\$3,030
Total Costs - Task 1					\$33,327
Task 2: Analysis of episodes of care at OBOTs					
Dr. Peter Cunningham	Principal Investigator	Leads and oversees analysis	5%	\$12,112	\$12,112
Erin Britton	Data Analyst	Statistical analysis and programming of Medicaid claims data	25%	\$7,500	\$7,500
Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$4,857
Total Direct Costs					\$24,469
F&A 10%					\$2,447
Total Costs - Task 2					\$26,916
Task 3: Update analysis of claims data for trends in SUD prevalence and utilization					
Dr. Peter Cunningham	Principal Investigator	Oversee analysis and preparation of reports	5%	\$12,112	\$12,112
Megan Mueller	Data Analyst	Statistical programming, preparation of tables for reports, and assistance with report preparation	25%	\$13,750	\$13,750
Erin Britton	Data Analyst	Assistance with statistical programming of Medicaid claims data	25%	\$7,500	\$7,500
Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$10,371
Total Direct Costs					\$43,733
F&A 10%					\$4,373
Total Costs - Task 3					\$48,106
Task 4: Using MODRN to compare SUD access and treatment in Virginia to other states					
Dr. Andrew Barnes	Co-Principal Investigator	Oversee and lead qualitative data collection, production of report	5%	\$7,925	\$7,925
Megan Mueller	Data Analyst	Statistical programming, preparation of tables for reports	15%	\$8,250	\$8,250
Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$6,486
Total Direct Costs					\$22,661
F&A 10%					\$2,266
Total Costs - Task 4					\$24,927
Task 5: Assess combined impact of ARTS and Medicaid expansion on supply of treatment providers					
Dr. Peter Cunningham	Principal Investigator	Oversees project design and analysis	4.4%	\$10,658	\$10,658
Heather Saunders	Research Assistant	Leads the statistical programming for the analysis	30%	\$9,000	\$9,000
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Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$7,514
Total Direct Costs					\$33,322
F&A 10%					\$3,332
Total Costs - Task 5					\$36,654
TOTAL FOR ARTS					\$169,930

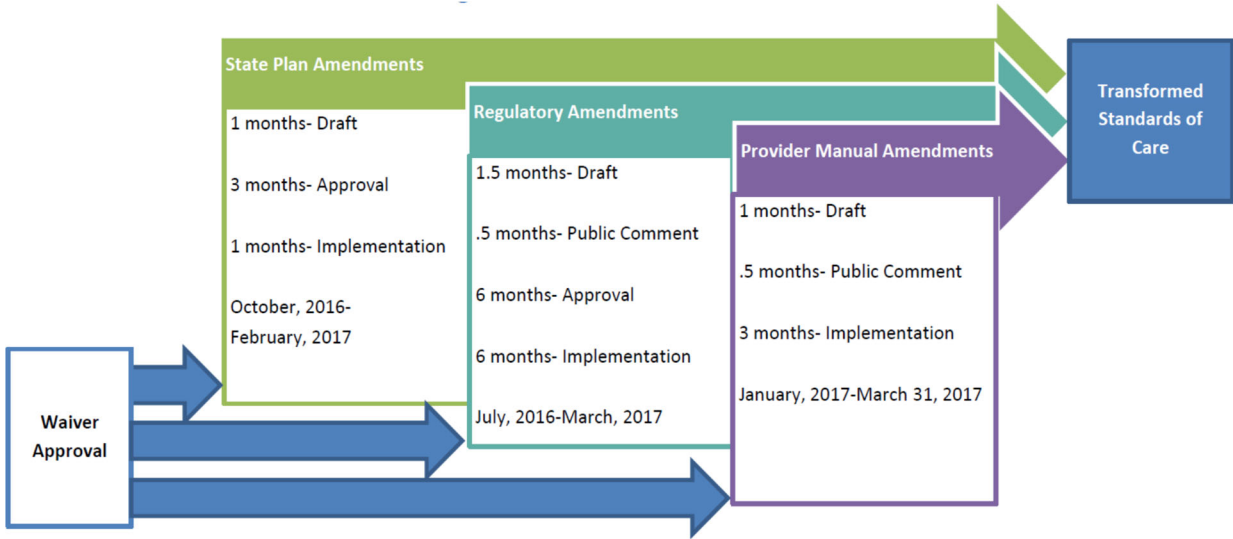
FY2023 Budget for Addiction and Recovery Treatment Services Evaluation

PERSONNEL	TITLE	Responsibilities	% EFFORT	PROJECT SALARY	PROJECT COST
Task 1: Analysis of ARTS Member Survey					
Dr. Andrew Barnes	Co-Principal Investigator	Oversee analysis	5%	\$7,925	\$7,925
Megan Mueller	Data Analyst	Statistical programming, preparation of tables for reports	10%	\$5,500	\$5,500
Lauren Guerra	Research Assistant	Assistance with tables and report preparation	20%	\$8,200	\$8,200
Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$8,672
Total Direct Costs					\$30,297
F&A 10%					\$3,030
Total Costs - Task 1					\$33,327
Task 2: Analysis of episodes of care at OBOTs					
Dr. Peter Cunningham	Principal Investigator	Leads and oversees analysis	5%	\$12,112	\$12,112
Erin Britton	Data Analyst	Statistical analysis and programming of Medicaid claims data	25%	\$7,500	\$7,500
Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$4,857
Total Direct Costs					\$24,469
F&A 10%					\$2,447
Total Costs - Task 2					\$26,916
Task 3: Update analysis of claims data for trends in SUD prevalence and utilization					
Dr. Peter Cunningham	Principal Investigator	Oversee analysis and preparation of reports	5%	\$12,112	\$12,112
Megan Mueller	Data Analyst	Statistical programming, preparation of tables for reports, and assistance with report preparation	25%	\$13,750	\$13,750
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Total Direct Costs					\$43,733
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Total Costs - Task 3					\$48,106
Task 4: Using MODRN to compare SUD access and treatment in Virginia to other states					
Dr. Andrew Barnes	Co-Principal Investigator	Oversee and lead qualitative data collection, production of report	5%	\$7,925	\$7,925
Megan Mueller	Data Analyst	Statistical programming, preparation of tables for reports	15%	\$8,250	\$8,250
Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$6,486
Total Direct Costs					\$22,661
F&A 10%					\$2,266
Total Costs - Task 4					\$24,927
Task 5: Assess combined impact of ARTS and Medicaid expansion on supply of treatment providers					
Dr. Peter Cunningham	Principal Investigator	Oversees project design and analysis	4.4%	\$10,658	\$10,658
Heather Saunders	Research Assistant	Leads the statistical programming for the analysis	30%	\$9,000	\$9,000
Lauren Guerra	Research Assistant	Assists with the analysis and preparation of tables for reports	15%	\$6,150	\$6,150
Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$7,514
Total Direct Costs					\$33,322
F&A 10%					\$3,332
Total Costs - Task 5					\$36,654
TOTAL FOR ARTS					\$169,930

FY2024 Budget for Addiction and Recovery Treatment Services Evaluation

PERSONNEL	TITLE	Responsibilities	% EFFORT	PROJECT SALARY	PROJECT COST
Task 1: Analysis of ARTS Member Survey					
Dr. Andrew Barnes	Co-Principal Investigator	Oversee analysis	5%	\$7,925	\$7,925
Megan Mueller	Data Analyst	Statistical programming, preparation of tables for reports	10%	\$5,500	\$5,500
Lauren Guerra	Research Assistant	Assistance with tables and report preparation	20%	\$8,200	\$8,200
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Total Direct Costs					\$30,297
F&A 10%					\$3,030
Total Costs - Task 1					\$33,327
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Total Costs - Task 2					\$26,916
Task 3: Update analysis of claims data for trends in SUD prevalence and utilization					
Dr. Peter Cunningham	Principal Investigator	Oversee analysis and preparation of reports	5%	\$12,112	\$12,112
Megan Mueller	Data Analyst	Statistical programming, preparation of tables for reports, and assistance with report preparation	25%	\$13,750	\$13,750
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Total Direct Costs					\$43,733
F&A 10%					\$4,373
Total Costs - Task 3					\$48,106
Task 4: Using MODRN to compare SUD access and treatment in Virginia to other states					
Dr. Andrew Barnes	Co-Principal Investigator	Oversee and lead qualitative data collection, production of report	5%	\$7,925	\$7,925
Megan Mueller	Data Analyst	Statistical programming, preparation of tables for reports	15%	\$8,250	\$8,250
Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$6,486
Total Direct Costs					\$22,661
F&A 10%					\$2,266
Total Costs - Task 4					\$24,927
Task 5: Assess combined impact of ARTS and Medicaid expansion on supply of treatment providers					
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Heather Saunders	Research Assistant	Leads the statistical programming for the analysis	30%	\$9,000	\$9,000
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Fringe Benefits		40.1% for FT faculty and staff; 8.6% for PT			\$7,514
Total Direct Costs					\$33,322
F&A 10%					\$3,332
Total Costs - Task 5					\$36,654
TOTAL FOR ARTS					\$169,930

**ATTACHMENT D:
Timeline for Establishing Standards of Care for ARTS System**



ATTACHMENT E:
ARTS Monitoring Protocol

The state should complete this Transmittal Title Page as part of its SUD Monitoring Protocol. This form should be submitted as the title page of all Monitoring Reports. The content of this transmittal table should stay consistent over time.

State	<i>Virginia</i>
Demonstration Name	<i>Virginia ARTS</i>
Approval Date	<i>December 15, 2016</i>
Approval Period	<i>January 1, 2020 through December 31, 2024.</i>
SUD (or if broader demonstration, then SUD Related) Demonstration Goals and Objectives	<ul style="list-style-type: none"> •<i>Promote strategies to ID Medicaid individuals with SUD</i> <ul style="list-style-type: none"> •<i>Enhance clinical practices and promote guidelines and decision making tools for serving youth and adults with SUD</i> •<i>Build after care and recover supports (like recovery coaching)</i> •<i>Coordinate SUD treatment with Primary care and Long Term Care</i> •<i>Coordinate with other sources of local, state and federal funds for an efficient use of resources consistent with program objectives</i> •<i>Encourage increased use of quality and outcome measures to inform benefit design and payment models</i> •<i>Identify strategies to address prescription and illicit opioid addiction, consistent with efforts to curb epidemic.</i>

2. Proposed Modifications to SUD Narrative Information on Implementation, by Reporting Topic

Summary of proposed modification	Related metric (if any)	Justification for modification
1. Assessment of Need and Qualification for SUD Services		
<p><i>Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)</i></p> <p><i>EXAMPLE</i> <i>Additional topic of interest</i></p> <p><i>[Add rows as needed]</i></p>		<p><i>Summarize how the proposed modification will alter reporting relative to the SUD Monitoring Report Template and provide reasoning why this modification is needed</i></p> <p><i>EXAMPLE</i> <i>In addition to reporting on the requested information, the state plans to report on progress on X implementation activity not currently listed in the report template. The state will add this activity as a new row to the “Narrative Information on Implementation” table in Part A of its Monitoring Reports.</i></p>
<p><input type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.</p>		
<p><input checked="" type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).</p>		
2. Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)		
<p><i>The department will use the recommendation from NPR to identify separate residential stays as a break in stay of one day as long as the provider NPI is the same. The department will use the required CMS procedure codes along with the Virginia specific codes to identify IMDs from a list of providers with specific NPIs who are licensed in the state as a residential provider with 16 beds or greater. The</i></p>	<p><i>10- Residential and Inpatient Services</i></p>	<p><i>The state request to modify current requirements as the state utilizes additional procedure codes for its residential substance use disorder services. Those procedure codes and breakdown by level of care are listed below.</i></p> <p><i>ASAM Level 3.3 - Clinically managed population-specific high intensity residential services H0010 Rev 1002 with modifier TG</i></p> <p><i>ASAM Level 3.5 Clinically managed high-intensity residential services (Adult) and Clinically managed medium-intensity residential services (Adolescent) H0010 Rev 1002 Adult – with modifier HB Adolescent – with modifier HA</i></p>

<p><i>department will utilize the codes below to identify IMD claims for lengths of stay.</i></p>		<p><i>ASAM Level 3.7 Medically monitored intensive inpatient services (Adult) and Medically monitored high intensity inpatient services (Adolescent) H2036 Rev 1002 Adult - with modifier HB Adolescent -with modifier HA</i></p>
<p><i>The department will utilize the required CMS codes, but will also include the Virginia specific codes below to identify IMD claims for lengths of stay.</i></p>	<p><i>36- Average Length of Stay in IMDs</i></p>	<p><i>The state request to modify current requirements as the state utilizes additional procedure codes for its residential substance use disorder services. Those procedure codes and breakdown by level of care are listed below.</i></p> <p><i>ASAM Level 3.3 - Clinically managed population-specific high intensity residential services H0010 Rev 1002 with modifier TG</i></p> <p><i>ASAM Level 3.5 Clinically managed high-intensity residential services (Adult) and Clinically managed medium-intensity residential services (Adolescent) H0010 Rev 1002 Adult – with modifier HB Adolescent – with modifier HA</i></p> <p><i>ASAM Level 3.7 Medically monitored intensive inpatient services (Adult) and Medically monitored high intensity inpatient services (Adolescent) H2036 Rev 1002 Adult - with modifier HB Adolescent -with modifier HA</i></p>
<p><input checked="" type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.</p>		
<p><input type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).</p>		
<p>3. Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)</p>		
<p><i>Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)</i></p>		

<i>[Add rows as needed]</i>		
<input type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input checked="" type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
4. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)		
<i>Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)</i>		
<i>[Add rows as needed]</i>		
<input type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input checked="" type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
5. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)		
<i>Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)</i>		
<i>[Add rows as needed]</i>		
<input type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input checked="" type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
6. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)		

<i>Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)</i>		
<i>[Add rows as needed]</i>		
<input type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input checked="" type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
7. Improved Care Coordination and Transitions between Levels of Care (Milestone 6)		
<i>Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)</i>		
<i>[Add rows as needed]</i>		
<input type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input checked="" type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
8. SUD Health Information Technology (Health IT)		
Opioid Prescriptions	S.1	"Use of Opioid Utilization-Members and Opioid Utilization-Providers report (dashboard reports from OTAAS Project) -Number of members, utilization rates, total #of prescriptions (member and provider), opioid days supply, total opioid cost (\$) -Opioid measures stratified by cities and counties and by age groups"

Access to ARTS Provider/Resource directory - connecting providers and members to additional SUD services.	S.2	Monthly updates of the ARTS provider network submitted by the MCOs are deduplicated and uploaded in a google map dedicated to show providers by the American Society of Addiction Medicine (ASAM) Level of Care.
Peer Recovery Supports	S.3	Use of OTAAS data to measure Peer Recovery Support Services utilization. -Number of members and claims for Peer Recovery Support Services using relevant procedure codes (T1012 and S9445). -Analyze the use of Peer Recovery Support Services and utilization in conjunction with other services.
<input checked="" type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
9. Other SUD-Related Metrics		
<i>Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)</i>		
<i>[Add rows as needed]</i>		
<input type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input checked="" type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
10. Budget Neutrality		
<i>Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template</i>		

<i>(Narrative Information on Implementation)</i>		
<i>[Add rows as needed]</i>		
<input type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input checked="" type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
11. SUD-Related Demonstration Operations and Policy		
<i>Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)</i>		
<i>[Add rows as needed]</i>		
<input type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input checked="" type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
12. SUD Demonstration Evaluation Update		
<i>Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)</i>		
<i>[Add rows as needed]</i>		
<input type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input checked="" type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		

13. Other Demonstration Reporting		
<i>Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)</i>		
<i>[Add rows as needed]</i>		
<input type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input checked="" type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
14. Notable State Achievements and/or Innovations		
<i>Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)</i>		
<i>[Add rows as needed]</i>		
<input type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input checked="" type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		

3. Acknowledgement of Budget Neutrality Reporting-

The state has reviewed the Budget Neutrality workbook provided by the project officer and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (no modifications).

4. SUD Demonstration Monitoring Reporting Schedule

Reporting schedule for VA monitoring information for third and fourth SUD demonstration years (DYs)

Dates of reporting quarter	VA's broader 1115 DY	VA's SUD DY	Report due (per STCs schedule)	SUD metrics included in report
April 1, 2019 – June 30, 2019	DY5 Q2	DY3 Q1	8/29/2019	<ul style="list-style-type: none"> • Narrative information for SUD DY3 Q1 • Grievances and appeals for SUD DY3 Q1 • Monthly and quarterly metrics for SUD DY2 Q4 • Annual CMS-constructed and state-identified metrics (calculated for SUD DY2)
July 1, 2019 – September 30, 2019	DY5 Q3	DY3 Q2	11/29/2019	<ul style="list-style-type: none"> • Narrative information for SUD DY3 Q2 • Grievances and appeals for SUD DY3 Q2 • Monthly and quarterly metrics for SUD DY3 Q1
October 1, 2019 – December 31, 2019	DY5 Q4	DY3 Q3	2/28/2020	<ul style="list-style-type: none"> • Narrative information for SUD DY3 Q3 • Grievances and appeals for SUD DY3 Q3 • Monthly and quarterly metrics for SUD DY3 Q2
January 1, 2020 – March 31, 2020*	DY6 Q1	DY3 Q4	6/30/2020	<ul style="list-style-type: none"> • Narrative information for SUD DY3 Q4 • Grievances and appeals for SUD DY3 Q4 • Monthly and quarterly metrics for SUD DY3 Q3 • Annual metrics that are established quality measures (calculated for CY 2019)
April 1, 2020 – June 30, 2020*	DY6 Q2	DY4 Q1	8/29/2020	<ul style="list-style-type: none"> • Narrative information for SUD DY4 Q1 • Grievances and appeals for SUD DY4 Q1 • Monthly and quarterly metrics for SUD DY3 Q4

- Annual CMS-constructed and state-identified metrics (calculated for SUD DY3)

*The state's demonstration approval period ends December 31, 2019. These rows are included to illustrate a year of reporting for all metrics and narrative information.

5. Reporting in quarterly and annual monitoring reports

Report name:	DY1 Q1 report	DY1 Q2 report	DY1 Q3 report	DY1 Q4 (annual) report	DY2 Q1 report
Report due date:	Due 60 days after quarter ends	Due 60 days after quarter ends	Due 60 days after quarter ends	Due 90 days after quarter ends	Due 60 days after quarter ends
Measurement periods, by reporting category					
Narrative information on implementation	DY1 Q1	DY1 Q2	DY1 Q3	DY1 Q4	DY2 Q1
Grievances and appeals	DY1 Q1	DY1 Q2	DY1 Q3	DY1 Q4	DY2 Q1
Other monthly and quarterly metrics	NA	DY1 Q1	DY1 Q2	DY1 Q3	DY1 Q4
Annual metrics that are established quality measures*	NA	NA	NA	All states except those with DY ending 12/31: DY1 (Q1-Q4)	States with DY ending on 12/31: DY2 Q1
Other annual metrics	NA	NA	NA	NA	DY1

DY = Demonstration year

NA = not applicable (information not expected to be included in report)

* Metrics that are established quality measures should be calculated for the calendar year. All other metrics should be calculated for the SUD demonstration year.

**ATTACHMENT F:
ARTS Health Information Technology (Health IT) Plan (reserved)**

**ATTACHMENT G:
High Needs Supports Eligibility and Services**

Target Group: Housing and employment supports eligibility is targeted to Medicaid beneficiaries age 18 or older who are enrolled under the Medicaid State Plan and is also targeted to those in the Medicaid 1115 waiver former foster care youth (FFCY) eligibility group age 18 up to 26 who aged out of foster care in another state.

DMAS will limit the High Needs Supports benefit to individuals who are not receiving housing or employment support services through an existing 1915(c) developmental disability (DD) waiver. Being on a 1915(c) DD waiver waitlist will not preclude eligible individuals from receiving the High Needs Supports benefit.

Needs-Based Criteria and Risk Factors: The Department of Medical Assistance Services (DMAS) assures there are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria below for receipt of High Needs Supports home and community-based services (HCBS).

Individual meets at least one of the following health needs-based criteria and is expected to benefit from housing or employment supports:

1. Individual has a behavioral health need, which is defined as one or more of the following criteria:
 - a. Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support), resulting from the presence of a serious mental illness or developmental or cognitive disability.
 - b. Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria (or equivalent assessment) would indicate that the individual would meet at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder (SUD) treatment.
2. Individual assessed to have a need for assistance, demonstrated by the need for assistance with two or more activities of daily living (ADLs); or hands-on assistance with one or more ADLs, defined in Virginia's Administrative Code (VAC) as "personal care tasks such as bathing, dressing, toileting, transferring, and eating or feeding."
3. Individual assessed to have a complex physical health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support), resulting from the presence of a continuing, progressive, or indefinite physical condition, developmental or cognitive disability, or an emotional medical condition.

AND The individual meets at least one of the following sets of risk factors:

1. **The individual has at least one or more of the following risk factors and is expected to benefit from housing support services:**
 - a. At risk of homelessness.

- i. At risk of homelessness is defined as an individual who will lose their primary nighttime residence.
- b. Homelessness.
 - i. Homelessness is defined as lacking a fixed, regular, and adequate nighttime residence, meaning:
 - 1) Has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (e.g., a car, park, abandoned building, bus or train station, airport, or camping ground).
 - 2) Living in a place not meant for human habitation, in an emergency shelter, in transitional housing (including congregate shelters, transitional housing, and hotels and motels) or exiting an institution where they temporarily resided in one of the aforementioned situations.
 - 3) Fleeing domestic violence or another dangerous situation related to violence.
Or
 - 4) An individual living with children or unaccompanied youth unstably housed. Unstably housed is defined as an individual living with children or unaccompanied youth who have not had a lease or ownership interest in a housing unit in the last 60 or more days, who have had two or more moves in the last 60 days, and who are likely to continue in such a state.
 - c. History of frequent or lengthy stays in an institutional setting (as defined in 42 CFR 435.1010), assisted living facility (as defined in 22VAC30-80-10), or residential setting (consistent with those settings noted in 12VAC35-105-20 for residential services and residential treatment settings).
 - i. Frequent is defined as more than one time in the past 12 months.
 - ii. Lengthy is defined as at least 28 or more consecutive days within an institutional setting, assisted living facility, or residential setting.
 - d. History of frequent emergency department (ED) visits and/or hospitalizations.
 - i. Frequent is defined as more than four ED visits and/or hospitalizations in the past 12 months.
 - e. History of involvement with the criminal justice system.
 - i. History of involvement with the criminal justice system is defined as an individual who has been confined to a prison, jail, halfway house, boot camp, weekend program, and other justice-involved facilities in which individuals are locked up overnight, for at least 24 hours over the past 12 months.
 - f. History of frequent moves or loss of housing as a result of behavioral health symptoms (e.g., lapsed rent payments due to psychiatric hospitalization).
 - i. Frequent is defined as more than once in the past six months.

OR

- 2. The individual has at least one or more of the following risk factors and is expected to benefit from employment support services:**
 - a. Unable to be gainfully employed for at least 90 consecutive days in the past 12 months due to a mental or physical impairment.

- b. Unable to obtain or maintain employment resulting from age, physical/sensory disability, or moderate to severe brain injury.
- c. More than one instance of inpatient or outpatient SUD service in the past two years.
- d. At risk of deterioration of mental illness and/or SUD, including one or more of the following:
 - i. Persistent or chronic risk factors such as social isolation due to a lack of family or social supports, poverty, criminal justice involvement, or homelessness.
 - 1) DMAS will apply the same definition of homelessness as required for the housing supports risk factors, as described above.
 - ii. Care for mental illness or SUD requires multiple provider types, including behavioral health, primary care, long-term services and supports, or other supportive services.
 - iii. Past psychiatric history, with ongoing treatment and supports necessary to ensure functional improvement.
 - iv. Dysfunction in role performance, including one or more of the following:
 - 1) Behaviors that disrupt employment or schooling, or put employment at risk of termination or schooling suspension.
 - 2) A history of multiple terminations from work or suspensions/expulsions from school.
 - 3) Cannot succeed in a structured work or school setting without additional support or accommodations.
 - 4) Performance significantly below expectation for cognitive/developmental level.

Housing and Employment Supports Services

Housing Supports: Housing supports services are determined to be necessary for an individual to obtain and reside in an independent community setting and are tailored to the goal of maintaining an individual’s personal health and welfare in a home and community-based setting. Housing supports services may include one or more of the following components:

Individual Housing and Pre-Tenancy Services:

1. Conducting an assessment to identify the individual’s needs and preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other preferences).
2. Assisting in budgeting for housing/living expenses, including financial literacy education on budget basics.
3. Assisting individuals with finding and applying for housing, including filling out housing, utility, and rental assistance applications and obtaining and submitting appropriate documentation.
4. Assisting individuals with completing reasonable accommodation requests as needed to obtain housing.
5. Developing an individualized housing support plan that identifies short and long-term measurable goals, how goals will be achieved and how barriers to achieving goals will be addressed.
6. Assisting with identifying and securing resources to obtain housing.

7. Ensuring the living environment is safe (including the assessment of health risks to ensure the living environment is not adversely affecting the occupants' health) and accessible for move-in.
8. Assisting in arranging for and supporting the details and activities of the move-in.

Individual Housing and Tenancy Sustaining Services:

1. Coordination with the individual to plan, participate in, review, update and modify their individualized housing support plan on a regular basis, including at redetermination and/or revision plan meetings, to reflect current needs and preferences and address existing or recurring housing retention barriers.
2. Providing assistance with securing and maintaining entitlements and benefits (including rental assistance) necessary to maintain community integration and housing stability (e.g., assisting individuals in obtaining documentation, assistance with completing documentation, navigating the process to secure and maintain benefits, and coordinating with the entitlement/benefit assistance agency).
3. Assistance with securing supports to preserve the most independent living.
4. Monitoring and follow-up to ensure that linkages are established and services are addressing community integration needs.
5. Providing supports to assist the individual in the development of independent living skills to remain in the most integrated setting (e.g., skills coaching to maintain a healthy living environment, develop and manage a household budget, interact appropriately with neighbors or roommates, reduce social isolation, utilize local transportation).
6. Providing supports to assist the individual in communicating with the landlord and/or property manager.
7. Education and training on the role, rights, and responsibilities of the tenant and landlord.
8. Providing training and resources to assist the individual with complying with his/her lease.
9. Assisting in reducing the risk of eviction by providing services to prevent eviction (e.g., to improve conflict resolution skills; coaching; role-playing and communication strategies targeted towards resolving disputes with landlords and neighbors; communicating with landlords and neighbors to reduce the risk of eviction; addressing biopsychosocial behaviors that put housing at risk; providing ongoing support with activities related to household management; and linking the tenant to community resources to prevent eviction).
10. Providing early identification and intervention for actions or behaviors that may jeopardize housing.
11. Providing a pest eradication treatment no more than one time per year that is necessary for the individual's health and safety as documented by a health care professional. This service is not intended for monthly, routine or ongoing treatments. This service is coverable when the individual is living in their own home, when not already included in a lease, and when the pest eradication is for the management of health and safety as identified in the person-centered service plan. The service is not otherwise provided under this waiver (except as part of Community Transition Services for individuals transitioning out of institutional settings and provider-owned and operated congregate living arrangements) and the Medicaid state plan, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

12. Modifications to improve accessibility of housing (e.g., ramps, rails) and safety (e.g., grip bars in bathtubs) when necessary to ensure occupant's health, and when modification is not covered by another entity as required by law.
13. Assistance with connecting the enrollee to expert community resources to address legal issues impacting housing and thereby adversely impacting health, such as assistance with breaking a lease due to unhealthy living conditions.
14. Shared living support services that provide for the payment for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the individual. Payment will not be made when the individual lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

Community Transition Services:

1. Supports designed to assist individuals transitioning out of institutional settings and provider-owned and operated congregate living arrangements, not to exceed \$5,000 per member per lifetime, regardless of the number of services. Supports cover expenses necessary to enable individuals to obtain an independent, community-based living setting. Specifically, allowable expenses may include: security deposits required to obtain a lease on an apartment or home; essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; moving expenses; necessary home accessibility adaptations; and activities to assess need, arrange for, and procure needed resources.

Services Not Included in the High Needs Supports Housing Benefit:

1. Payment of rent or other room and board costs.
2. Capital costs related to the development or modification of housing.
3. Expenses for utilities or other regular occurring bills.
4. Goods or services intended for leisure or recreation.
5. Duplicative services from other state or federal programs.
6. Services to individuals in a correctional institution or an Institution of Mental Disease (IMD) (other than services that meet the exception to the IMD exclusion).
7. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and only when the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes.

Employment Supports: Employment supports services are determined to be necessary for an individual to obtain and maintain employment in the community. Employment supports services will be individualized and may include one or more of the following components:

Pre-Employment Services (individual and small group):

1. Pre-vocational/job-related discovery or assessment.
2. Assessment of workplace readiness (e.g., people skills, technology knowledge).
3. Person-centered employment planning.
4. Individualized job development and placement (e.g., job fairs, interviews).
5. Mentoring (e.g., on how to change cultural behavior, re-entry from incarceration).
6. Career coaching (e.g., resume coaching, interview coaching).
7. Job carving.
8. Benefits education, planning, and training.
9. Transportation (provided either as a separate transportation service to employment services or to the individual's job, or services included in the rate paid to the provider of employment services).
10. Soft skill training (e.g., interpersonal skills, customer service, answering the phone, workplace culture).
11. Volunteer work and paid internships.
12. Job preparation training (e.g., coaching on appropriate personal hygiene and attire, timeliness, workplace behavior and communication, reliability).
13. Training to improve executive functioning skills (e.g., sustaining attention, organizing, and task prioritization).
14. Behavioral modification (e.g., to increase emotional maturity, to developed alternative coping mechanisms for adverse behaviors such as alcohol/drug use).
15. Coordination with other care providers to address behavioral health needs that impact an individual's ability to secure and maintain employment.

Employment Sustaining Services (individual and small group):

1. Job coaching (including situational assessments).
2. Career advancement services.
3. Negotiation with employers.
4. Job analysis.
5. Training and systemic instruction
6. Benefits education and planning.
7. Financial and health literacy.
8. Transportation (provided either as a separate transportation service to employment services or to the individual's job, or included in the rate paid to the provider of employment services).
9. Payment for public transportation (e.g., bus passes, mass transit vouchers) to support the enrollee's ability to participate in work/community engagement and to gain access to community services, activities, and resources.
10. Account credits for cost-effective private forms of transportation (e.g., taxi, ridesharing) in areas without access to public transit in order to enable individuals to participate in work/community engagement and to gain access to community services, activities, and resources.
11. Transportation education assistance in gaining access to public or mass transit, including access locations, pilot services available via public transportation, and how to purchase transportation passes.

12. Assistance with linking to high quality child care and after-school programs and programs that increase adults' capacity to participate in work/community engagement activities.
13. Asset development.
14. Follow-along supports.
15. Peer supports for employment provided by a co-worker or other job site personnel, provided that the services furnished (e.g., emotional support, connections to resources) are not part of the normal duties of the co-worker, supervisor or other personnel and these individuals meet the pertinent qualifications for the provider of service.

Services Not Included in the High Needs Supports Employment Benefit:

1. Generalized employer contacts that are not connected to a specific enrolled individual or an authorized service.
2. Employment support for individuals in sub-minimum wage, or sheltered workshop settings.
3. Facility-based habilitation or personal care services.
4. Wage or wage enhancements for individuals.
5. Duplicative services from other state or federal programs.
6. Medicaid funds to defray the expenses associated with starting up or operating a business.

Provider Qualifications: Contracted High Needs Supports providers must assure staff providing housing and employment supports services maintain appropriate qualifications in order to effectively serve enrollees. Staff providing High Needs Supports services must receive DMAS-approved housing and employment supports trainings in accordance with evidence-based principles and practices, as well as other applicable trainings in accordance with the Commonwealth Coordinated Care (CCC) Plus contract. Below are the minimum provider staff qualifications. DMAS and the managed care organizations (MCOs) (contingent upon DMAS review and approval) may also impose licensure/certification/accreditation requirements beyond the minimum provider qualifications outlined below.

Provider Type	Education and Experience	Skills	Services
Housing Supports	<ul style="list-style-type: none"> • Education (e.g., Bachelor's degree, Associate's degree, certificate) in a human/social services field or a relevant field; and/or • At least one year of relevant professional experience and/or training in the field of service. 	Knowledge of principles, methods, and procedures of services included under housing supports services, or comparable services meant to support an individual's ability to obtain and maintain stable housing.	<ul style="list-style-type: none"> • Individual Housing and Pre-Tenancy Services. • Individual Housing and Tenancy Sustaining Services. • Community Transition Services.

Provider Type	Education and Experience	Skills	Services
Employment Supports	<ul style="list-style-type: none"> • Education (e.g., Bachelor’s degree, Associate’s degree, certificate) in a human/social services field or a relevant field; and/or • At least one year of relevant professional experience and/or training in the field of service. 	Knowledge of principles, methods, and procedures of services included under employment supports services, or comparable services meant to support an individual’s ability to obtain and maintain stable employment.	<ul style="list-style-type: none"> • Pre-Employment Services (individual and small group). • Employment Sustaining Services (individual and small group).

Administrative Approach: The state will provide a set of housing and employment supports to certain high need Medicaid beneficiaries enrolled in the managed care delivery system by contracting with Commonwealth Coordinated Care Plus (CCC Plus) MCOs to provide the approved High Needs Supports services and related activities. The state will maintain authority, accountability, oversight, and evaluation of the High Needs Supports program, including oversight of delegated activities to CCC Plus MCOs and any other contracted entities, as well as oversight of the High Needs Supports quality strategy described in STCs 23 – 26.

The state will leverage multiple pathways to ensure a “no wrong door” approach to identifying enrollees who may be eligible for High Needs Supports. Multiple entities, including MCOs, state agencies, community organizations, and providers, will play a critical role in identifying individuals for the High Needs Supports benefit. The state will send information it receives regarding potentially eligible enrollees to the MCOs to determine eligibility for the benefit. The state will develop standardized High Needs Supports screening questions that MCOs will use to determine High Needs Supports eligibility. The state will validate the eligibility determination provided by the MCOs.

The state will develop standardized elements for a High Needs Supports assessment to be performed by MCO care coordinators, and review/approve any changes to the assessment proposed by the MCOs. The state will require the MCOs to ensure their care coordinators develop the High Needs Supports person-centered care plan that reflects enrollees’ housing and employment-related needs, goals, and preferences, and to connect enrollees to providers and services authorized by the MCO. The state will require that MCOs, in collaboration with providers, track and report the services provided to High Needs Supports enrollees, ensuring accountability for service delivery and payment. The state will conduct periodic audits of payments to verify accurate reporting and spending.

The following activities will be delegated to MCOs; the state will monitor and ensure MCO compliance and performance with respect to these functions:

- Develop, manage, and contract with a network of High Needs Supports providers to deliver and pay claims for High Needs Supports services.

- Screen members to identify those potentially eligible for High Needs Supports.
- Conduct the High Needs Supports eligibility screening to determine High Needs Supports eligibility based on the eligibility criteria set forth above.
- Perform ongoing data surveillance/identification of members to monitor any changes to the member's High Needs Supports status.
- Oversee the provision of the standardized High Needs Supports assessment and the development/maintenance of the High Needs Supports person-centered care plan by the MCO care coordinators.
- Authorize High Needs Supports services and care plan modifications.
- Work with MCO care coordinators to ensure care management and monitor/track enrollees' access to services and progress against their goals.

Payment Methodology: The state will demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the High Needs Supports program. Working closely with the state's contracted actuary, the state will establish a payment floor for the federally-approved High Needs Supports services. The services will be priced based on factors such as the intensity of services, duration of services, geography, contracted provider per unit cost, and comparable fee-for-service (FFS) service costs. The state will allow MCOs to negotiate High Needs Supports payment rates above the payment floor. Once the High Needs Supports program is fully implemented in a manner envisioned by the state, DMAS may consider revising the payment methodology approach to remove the payment floor and allow MCOs to negotiate provider payment rates. The state will require MCOs to reimburse network providers authorized to deliver High Needs Supports services based on the standards and requirements set forth by the state. The state will conduct periodic audits of payments to verify accurate reporting and spending. The state will demonstrate actuarial soundness on an annual basis pursuant to 42 CFR Part 438.