

THE DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850



July 9, 2020

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

Dear Ms. Kimsey:

Under section 1115 of the Social Security Act (the Act), the Secretary of Health and Human Services may approve any experimental, pilot, or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain Act programs, including Medicaid. Congress enacted section 1115 of the Act to ensure that federal requirements did not “stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients.” S. Rep. No. 87-1589, at 19 (1962), *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961. As relevant here, section 1115(a)(2) of the Act allows the Secretary to provide federal financial participation for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.

For the reasons discussed below, the Centers for Medicare & Medicaid Services (CMS) is approving Virginia’s request, submitted on November 20, 2018, as part of the state’s extension application otherwise approved on December 30, 2019, to add the High Needs Supports benefit to its section 1115 demonstration project entitled, “Building and Transforming Coverage, Services, and Supports for a Healthier Virginia” (formerly Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation) (Project Number 11-W-00297/3), in accordance with section 1115(a) of the Act. This amendment is effective the date of approval for the rest of the current demonstration period through December 31, 2024, upon which unless extended or otherwise amended, all authorities granted to operate this demonstration will expire.

Extent and Scope of Demonstration Extension

High Needs Supports

Housing instability often co-occurs with, and increases the risk of, complex behavioral and physical health problems. Unemployment is correlated to poor physical and mental health

outcomes. As such, the state will provide supports to improve quality of life and health outcomes under this amendment for a subset of Medicaid beneficiaries. CMS is providing expenditure authority to allow the state to implement High Needs Supports, which are home and community-based services (HCBS) targeted to high need Medicaid beneficiaries.

High Needs Supports will be available to all 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 former foster care youth (FFCY) component of this demonstration age 18 up to 26 and enrolled in the managed care delivery system. Eligible beneficiaries will need to meet specific needs-based criteria and a set of required risk factors as outlined in the special terms and conditions (STC) and Attachment G to target the High Needs Support Services to those beneficiaries who are most likely to benefit from these services. The High Needs Supports only include services that would otherwise be allowable under Section 1915(i) of the Act, including individual housing and pre-tenancy sustaining services, community transition services, pre-employment, and employment sustaining services. The state may impose a waitlist at its discretion, limit the benefit geographically by phasing in the benefit by region, and restrict the benefit to the managed care delivery system and limit the providers, such as public and non-profit providers, who are authorized to deliver these services. Effective with this approval, the state is obligated to adhere to HCBS guidelines, policies and reporting procedures, as outlined in these STCs.

Elements of the Demonstration Request CMS is Not Approving at This Time

As part of its original request for High Needs Supports in its extension application, Virginia also requested to offer post-hospitalization housing for a short-term period of six months, and a one-time payment for first month's rent to beneficiaries receiving High Needs Supports, if such funding is not available through any other program. CMS continues to review Virginia's requests for a one-time payment for first month's rent and post-hospitalization housing, but is not approving these services at this time.

Determination that the Demonstration Project is Likely to Assist in Promoting Medicaid's Objectives

Under section 1901 of the Act, the Medicaid program provides federal funding to participating states "[f]or the purpose of enabling each state, as far as practicable under the conditions "in such state, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."

While this statutory text is not necessarily an exhaustive source of Medicaid objectives, it makes clear that at least one objective of Medicaid is to enable states to "furnish... medical assistance" to certain vulnerable populations (i.e., payment for certain healthcare services defined at section 1905 of the Act, the services themselves, or both). This demonstration promotes that Medicaid objective by providing additional benefits available to certain vulnerable beneficiaries. In addition to providing expanded coverage, CMS has also determined that approval of the

amendment to the demonstration is likely to promote the objectives of the Medicaid program by enabling individuals to reside in an independent community setting and obtain employment as an alternative to institutionalization based on medical need.

Consideration of Public Comments

To increase the transparency of demonstration projects, sections 1115(d)(1) and (2) of the Act direct the Secretary to issue regulations providing for two periods of public comment on a state's application for a section 1115 demonstration that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing. The first comment period occurs at the state level before submission of the section 1115 application, and the second comment period occurs at the federal level after the application is received by the Secretary.

The Affordable Care Act (ACA) specified that comment periods should be "sufficient to ensure a meaningful level of public input," section 1115(d)(2)(A) and (C) of the Act, but the statute imposed no additional requirement on the states or the Secretary to address those comments, as might otherwise be required under a general rulemaking. Accordingly, the implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline, but will not provide written responses to public comments. 42 CFR 431.416(d)(2).

CMS received 1,810 comments during the federal comment period on the demonstration extension request. Although CMS is not legally required to provide written responses to comments, CMS is addressing some of the central issues raised by the comments and summarizing CMS's analysis of those issues for the benefit of stakeholders.

The majority of commenters commented on elements of Virginia's application unrelated to the High Needs Supports benefit. CMS received less than 20 comments on the High Needs Supports benefit, and all commenters spoke positively of Virginia's decision to provide the benefit. Commenters described the High Needs Supports as needed benefits that are currently not widely available, and asserted that the benefit will assist individuals with medical complexities with maintaining stable housing and employment.

After carefully reviewing the public comments submitted during the federal comment period, CMS has concluded that the demonstration is likely to advance the objectives of Medicaid.

Other Information

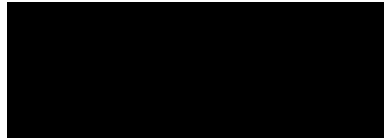
CMS's approval of this demonstration amendment is conditioned upon compliance with the enclosed list of expenditure authorities and the STCs defining the nature, character, and extent of anticipated federal involvement in the demonstration. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as not applicable to expenditures or individuals covered by expenditure authority. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Valisha Andrus. She is available to answer any questions concerning your section 1115 demonstration. Ms. Andrus's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-02-28
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Valisha.Andrus@cms.hhs.gov

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

Sincerely,



Calder Lynch
Deputy Administrator and Director

Enclosures

cc: Margaret Kosherzenko, State Monitoring Lead, 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)

Building and Transforming Coverage, Services and Supports for a Healthier Virginia
Approval Period: January 1, 2020 through December 31, 2024
Amended: July 9, 2020

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)
Attachment F: ARTS Health Information Technology (Health IT) Plan (reserved)
Attachment G: High Needs Supports Eligibility and Services

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 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

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. Building and Transforming Coverage, Services and Supports for a Healthier Virginia Approval Period: January 1, 2020 through December 31, 2024 Amended: July 9, 2020

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:
- i. 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 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

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.

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,	BASE YEAR	TREND	DY 6	DY 7	DY 8	DY 9	DY 10

		or Both							
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

- 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.
- 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
- ARTS Medical Criteria - In order to receive ARTS, the recipient must be enrolled in Virginia Medicaid and meet the following medical necessity criteria.
 - Must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.
 - 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.
 - 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.
- 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	DBHDS Supervised Residential Treatment Services for Adults; DBHDS Substance Abuse Residential Treatment Services (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.” 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 (Adults)/ Medium Intensity (Adolescents)	DBHDS Substance Abuse Residential Treatment Services (RTS) for Adults or Children;

		<p>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>
<p>3.7</p>	<p>Medically Monitored Intensive Inpatient Services (Adults) 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; DBHDS Substance Abuse DBHDS Residential Treatment Services for Adults or Children with a Medical Detox license; Residential Crisis Stabilization Units with DBHDS Medical Detoxification License or Managed Withdrawal License; DBHDS Substance Abuse Residential Treatment Services (RTS) for Women with Children with a DBHDS Managed Withdrawal License; DBHDS Managed Withdrawal-Medical Detox Adult Residential Treatment Service (RTS) License; DBHDS Medical Detox/Chemical Dependency Unit for Adults; or DBHDS Level C or Mental Health Residential Children with a substance abuse residential license</p>

		and a DBHDS Managed Withdrawal License
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

1. 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,	DBHDS Substance Abuse Residential Treatment Services for Adults or Children; DBDHS 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

	physicians/physician extenders, and credentialed mental health professionals.	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”. If providers are providing withdrawal management, they will need to also have a DBHDS Medical Detox license.
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.	DBHDS Freestanding Psychiatric Hospital and Inpatient Psychiatric Unit with a DBHDS Medical Detoxification License or Managed Withdrawal License; DBHDS Substance Abuse Residential Treatment Services (RTS) for adults/children with a DBHDS Managed Withdrawal License; DBHDS Residential Crisis Stabilization Unit with a DBHDS Medical Detoxification License or Managed Withdrawal License; DBHDS Substance Abuse Residential Treatment Services (RTS) for Women with Children with a DBHDS Managed Withdrawal License; DBHDS Level C or Mental Health Residential Children with a substance abuse residential license and a DBHDS Managed Withdrawal License; 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	Acute care general hospital (12-VAC5-410) licensed by the Virginia Department of Health

	interdisciplinary team of credentialed clinical staff knowledgeable of biopsychosocial dimensions of addictions.	
--	--	--

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 3.1an 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/>).

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.

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.medicaid.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 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

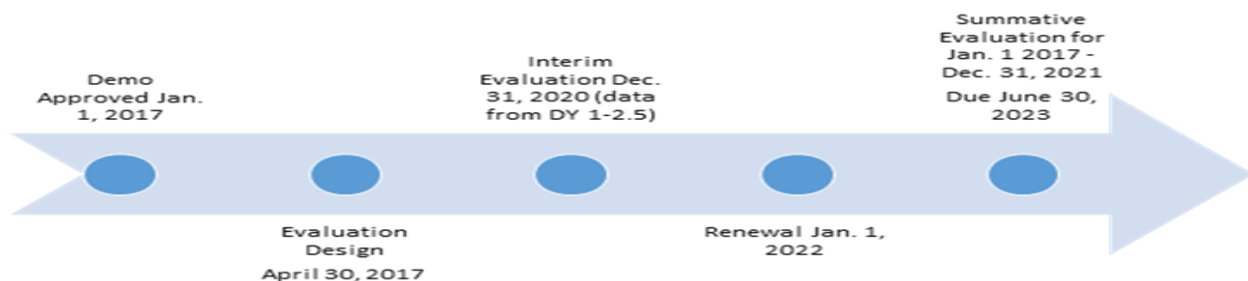
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, 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.

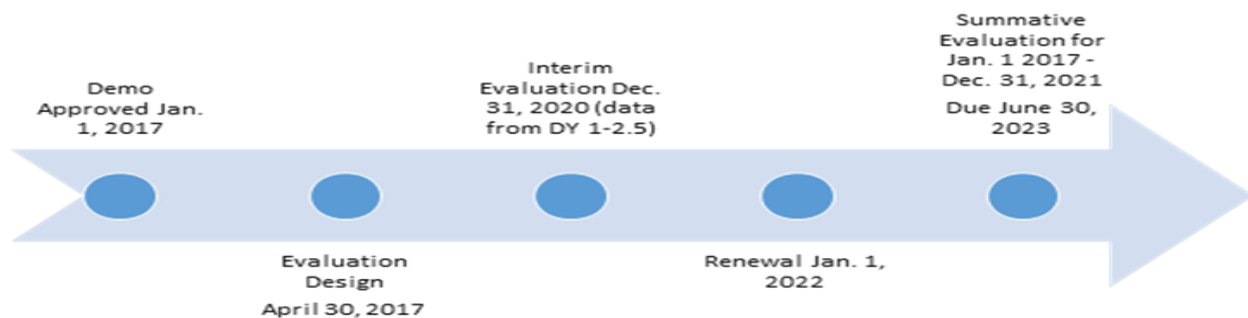
The format for the Interim and Summative Evaluation reports is as follows:

- 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:

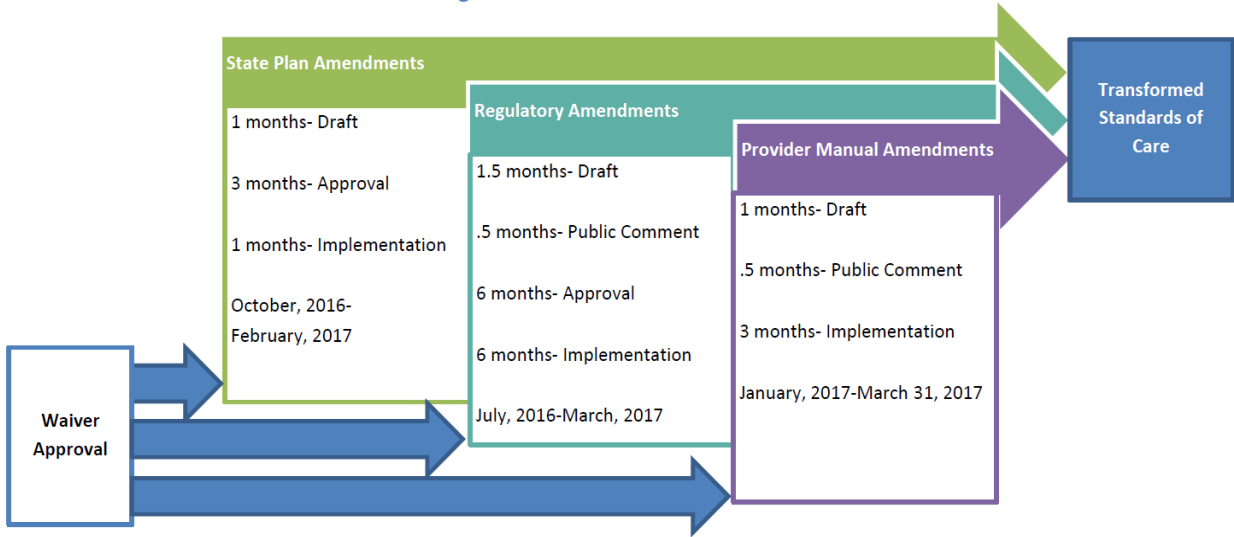
- 1) What lessons were learned as a result of the demonstration?
- 2) What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment(s)

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

**Attachment C:
Evaluation Design (reserved)**

**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</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</i> <i>Adult – with modifier HB</i> <i>Adolescent – with modifier HA</i></p>

<p><i>with 16 beds or greater. The 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</i></p>		

<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).		
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</i>		

<i>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).		
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.