



**VIRGINIA DEPARTMENT OF
MEDICAL ASSISTANCE SERVICES
1115 DEMONSTRATION
EXTENSION APPLICATION**

***Virginia COMPASS
Creating Opportunities for Medicaid Participants to Achieve
Self- Sufficiency***

**VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES 1115 DEMONSTRATION
EXTENSION APPLICATION**

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Section I – Historical Narrative Summary of the Demonstration

Introduction

On September 22, 2017, the Centers for Medicare and Medicaid Services (CMS) approved an amendment to the State’s demonstration, “Virginia Governor’s Access Plan (GAP) and Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation” (Project No. 11-W-00297/3) to: increase to 100 percent of the federal poverty level (FPL) income eligibility levels for the GAP—a program for childless adults and non-custodial parents ages 21 through 64 who have been diagnosed with a serious mental illness (SMI); offer additional substance use disorder (SUD) services to the GAP benefit package; and provide Medicaid coverage to former foster care youth who receive Medicaid services in a different state. As part of the approved waiver amendment, the Commonwealth continued the ARTS demonstration, which provides an expanded SUD benefit package to all Medicaid recipients.

On June 7, 2018, Governor Northam signed the 2018 Virginia Acts of Assembly Chapter 2 (2018 Appropriations Act) authorizing the Department of Medical Assistance Services (DMAS) to amend Virginia’s Medicaid State Plan to expand coverage to newly eligible non-disabled, non-pregnant adults ages 19 to 64 with income up to 138 percent of the FPL, effective on January 1, 2019. The Commonwealth is in the process of seeking approval for the State Plan Amendments (SPAs) necessary to effectuate its Medicaid expansion on January 1, 2019. Additionally, because it will have an expanded Medicaid program, the Commonwealth no longer requires demonstration authority for the GAP and has begun the process of sunsetting the program consistent with Special Terms and Condition (STC) Number 10 in its current GAP/ARTS waiver. The Commonwealth is ensuring a smooth transition for enrollees from the GAP to the new adult group by complying with federal transition requirements outlined in its demonstration.

The 2018 Appropriations Act also directed DMAS to submit a waiver seeking federal approval for new Medicaid program features “designed to empower individuals to improve their health and well-being and gain employer sponsored coverage or other commercial health insurance coverage, while simultaneously ensuring the program’s long-term fiscal sustainability.”¹ Virginia seeks to extend the Commonwealth’s current demonstration to build upon Medicaid delivery system reforms already in place under Virginia’s State Plan and Medicaid managed care program and to implement the requirements of the 2018 Appropriations Act. Specifically, this demonstration extension, Virginia COMPASS (Creating Opportunities for Medicaid Participants to Achieve Self- Sufficiency) will:

1. Continue to provide essential SUD services to all Medicaid enrollees through ARTS;
2. Maintain authority for coverage of former foster care youth who aged out of foster care in another state;
3. Implement a work and community engagement program for certain adult populations;
4. Effectuate a Health and Wellness program that includes premiums and cost-sharing designed to promote healthy behavior for certain adult populations between 100 and 138 percent of the federal poverty level;
5. Create a new housing and employment supports benefit for high-need populations.

¹ 2018 Virginia Acts of Assembly Chapter 2. Available at <https://budget.lis.virginia.gov/item/2018/2/HB5002/Chapter/1/303/>.

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Through this demonstration extension, Virginia will have the opportunity to test hypotheses to help refine this demonstration and the development of future programs.

Summary of Virginia's New Demonstration Features

New features in this 1115 Demonstration Extension include:

- The Training, Education, Employment and Opportunity Program (TEEOP)
 - Condition Medicaid coverage for adults with income up to 138 percent of the FPL on compliance with a work and community engagement requirement, with certain enumerated exemptions, to improve Medicaid enrolled adults' health, well-being, and financial stability, and provide those subject to the requirement with assistance in finding and maintaining work and community engagement;
- Health and Wellness Program
 - Require Medicaid enrolled adults with income 100 to 138 percent of the FPL to pay a monthly premium to encourage personal responsibility and prepare Medicaid enrollees for employer-sponsored insurance (ESI) or other commercial coverage;
 - Incentivize healthy behavior and appropriate utilization of healthcare services by requiring adults with income 100 to 138 percent of the FPL to pay a co-payment for non-emergent use of the emergency department (ED) and rewarding individuals who regularly pay their premiums and participate in healthy behaviors through the establishment of a health and wellness account (HWA); and
- Housing and Employment Supports Benefit for High Need Enrollees
 - Provide a housing and employment supports benefit for high-needs Medicaid enrolled adults in order to improve quality of life and health outcomes.

Summary of Current Demonstration Features to be continued Under the 1115 Demonstration Extension

The Commonwealth will extend the waiver authority to provide Medicaid coverage for former foster care youth up to age 26 who aged out of foster care in another state and now reside in Virginia. No changes are being requested for this extension. Youth in foster care face a number of issues when they are released from the custodial care of a state, not the least of which is access to healthcare. This expenditure authority provides former foster care youth with the opportunity to continue receiving Medicaid coverage until age 26, allowing them to transition into managing the responsibilities of living independently.

The Commonwealth will also extend the ARTS benefit package to continue one of the most comprehensive Medicaid SUD benefits in the nation. The ARTS benefit package provides the full continuum of treatment needed to address the substance use crisis and reverse the opioid epidemic in Virginia. The goal of the ARTS benefit package is to transform the SUD treatment delivery system for all Medicaid enrollees with a SUD diagnosis including Opioid Use Disorders (OUD) by increasing access to outpatient and community-based settings while decreasing use of high-cost ED and inpatient hospital services. The ARTS benefit package encompasses the full continuum of evidence-based treatment services utilizing the American Society of Addiction Medicine (ASAM) Criteria.

ARTS services are carved in to managed care to promote integration and coordination of a comprehensive health benefit including both physical and behavioral health. The goal is to continue to expand provider capacity to meet the needs of members eligible for Medicaid Expansion. The managed care plans are required by contract to employ ARTS Care Coordinators, who are licensed clinical psychologists, licensed clinical social workers, licensed professional counselors, licensed nurse

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practitioners, or registered nurses with clinical experience in SUD. The ARTS Care Coordinators or licensed physicians make the independent determination of medical necessity, using the multidimensional ASAM assessment, for placement at appropriate levels of care and recommendations for lengths of stay in residential treatment settings.

The ARTS benefit package expanded coverage of inpatient withdrawal and residential treatment to all of Virginia's 1.5 million Medicaid enrollees. In order to receive the ARTS benefit package, an individual must be enrolled in Virginia Medicaid and meet the following medical necessity criteria:

- Must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for substance-related and addictive disorders with the exception of tobacco-related disorders and non-substance-related disorders; OR
- Be assessed to have a current SUD, based on a provisional diagnosis from the DSM to have the presence of a current substance disorder, based on a diagnosis from the DSM substance-related and addictive disorders (with the exception of tobacco-related disorders and non-substance-related disorders) and an assessment which identifies treatment needs consistent with ASAM adult medical necessity criteria or for individuals under 21, ASAM adolescent treatment criteria. Nothing in the ARTS demonstration waives or supersedes any Early Periodic Screening Diagnosis and Treatment (EPSDT) requirements; AND
- Must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.

The ARTS demonstration increased provider reimbursement rates for addiction treatment in intensive outpatient and partial hospitalization settings, and added a new peer recovery support service. Virginia also implemented an innovative payment model to support Opioid Treatment Programs (OTPs) and Preferred Office-Based Opioid Treatment (OBOT) providers with co-located buprenorphine waived practitioners and behavioral health clinicians. This model created financial incentives for high-quality Medication Assisted Treatment (MAT) that includes medication, counseling, and care coordination.

Since ARTS was implemented on April 1, 2017, an independent evaluation by Virginia Commonwealth University demonstrated substantial increases in the number of practitioners providing addiction treatment services to Medicaid enrollees. During the first year of ARTS, the number of outpatient practitioners billing for ARTS services increased by 173 percent, including 848 providers who prescribed buprenorphine for members with OUDs. In addition, nearly 25,000 Medicaid enrollees used addiction-related treatment services, a 57 percent increase from the year before. The full evaluation is attached as Appendix A to this extension request.

Section II – Changes Requested to the Demonstration

A. Implement Work and Community Engagement Requirements

As directed by State legislation, and consistent with CMS's State Medicaid Director Letter (SMDL) encouraging Medicaid programs to test the interaction of community engagement and health and well-being,² the Commonwealth will implement the TEEOP under this 1115 Demonstration Extension. The Commonwealth has designed a Virginia-specific initiative to promote work and community engagement

² Centers for Medicare and Medicaid Services State Medicaid Director Letter, "Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries," January 11, 2018. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>.

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with the goal of promoting health, wellness, and greater financial stability and self-sufficiency for Medicaid enrollees who are subject to TEEOP.

The Commonwealth will mitigate the administrative burden and cost of TEEOP through designing streamlined and automated processes for operationalizing program requirements. At the same time, the Commonwealth will ensure continuity of coverage and minimize confusion and complexity for enrollees by providing clear information on TEEOP requirements and an accessible process for demonstrating compliance with the new requirements, including multiple access points. The Commonwealth will design the TEEOP in a way that takes into account the availability of sustainable jobs and the barriers to employment, in many cases profound, faced by those Medicaid enrollees who are currently unemployed. Virginia will provide essential supports to enable enrollees to meet TEEOP requirements and fulfill the objectives of the program.

Populations Subject to TEEOP

Pursuant to the State legislation, the Commonwealth will make participation in TEEOP a condition of eligibility for all Medicaid enrollees between ages 19 and 64 with incomes up to 138 percent of the FPL who do not otherwise qualify for an exemption, as further defined below.

The Commonwealth estimates that roughly 120,000 enrollees will not be exempt and therefore will be subject to TEEOP when the work and community engagement requirements go into effect.³

Qualifying Activities

Qualifying work and community engagement activities include:

- Employment (unsubsidized or subsidized)
- Job skills/job readiness training or job search activities
- Participation in a state workforce program offered through Virginia Workforce Centers, One-Stops or other approved Virginia state agency (e.g., local departments of social services, Virginia Department of Social Services, Virginia Employment Commission (VEC), Virginia Department of Labor and Industry, Virginia Department for Aging and Rehabilitative Services (DARS), Virginia's Worker's Compensation Commission)
- Participation in a tribal workforce program
- Participation in Virginia's Agriculture and Foreign Labor or other migrant workforce program
- Education related to:
 - Employment
 - General education, including participation in a program of preparation for the General Education Development (GED) certification examination
 - Participation in chronic disease management classes (diabetes, asthma, etc.) or nutrition education classes
 - Participation in financial literacy, health literacy, or insurance literacy education classes
 - Participation in English as a Second Language (ESL) classes
- Vocational education, training, and apprenticeships
- Community work experience programs, community service or public service (excluding political activities) that can reasonably improve work readiness

³ DMAS relied on estimates included in the fiscal impact review conducted by the Joint Legislative Audit and Review Commission. This estimate can be found at <http://lis.virginia.gov/cgi-bin/legp604.exe?181+oth+HB3338JH1110+PDF>

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- Caregiving services for a non-dependent relative or other person with a chronic, disabling health condition
- Any additional qualifying work or community engagement activities the Commonwealth determines will support the health of enrollees and achieve the objectives of the program

It is estimated that almost half (45%) of the estimated 120,000 enrollees subject to the TEEOP requirements are working more than 20 hours per week or enrolled in school and will already be in compliance with the work and community engagement requirements.⁴⁵

Hours Requirement

The work and community engagement hours requirement will begin at 20 hours per month for the first three months during which an enrollee is subject to the TEEOP and will gradually increase from there. After an enrollee is subject to the TEEOP for 12 months, the enrollee will be required to participate in 80 hours per month.

Table 1: TEEOP Required Participation Hours

Number of Months after Enrollment in TEEOP	Required Participation Hours
3 months after enrollment	20 hours per month
6 months after enrollment	40 hours per month
9 months after enrollment	60 hours per month
12 months after enrollment	80 hours per month

Participating in a designated state agency TEEOP education and training program through Virginia Workforce Centers, One-Stops, or other approved state agency programs shall be considered meeting the 80 hours per month requirement.

Standard Exemptions

Individuals who qualify for a standard exemption include enrollees who are:

- Children who are under age 19
- Full time, three-quarter time, and part-time students in post-secondary education, including community college courses leading to industry certifications or a STEM-H related degree or credential
- Individuals age 65 and older
- Individuals dually enrolled in Medicaid and Medicare
- Individuals who have blindness or who have a disability, including individuals who are:
 - Enrolled in a 1915(c) Waiver;
 - Defined under the Americans with Disability Act, Section 504 or Section 1557, who are unable to comply with the requirements due to disability-related reasons;
 - Supplemental Security Income (SSI) recipients;
 - Social Security Disability Insurance (SSDI) recipients; or
 - State-based disability program recipients

⁴ DMAS relied on estimates included in the fiscal impact review conducted by the Joint Legislative Audit and Review Commission. This estimate can be found at <http://lis.virginia.gov/cgi-bin/legp604.exe?181+oth+HB3338JH1110+PDF>

⁵ Others will likely also already meet the requirements of the TEEOP program but DMAS does not have the appropriate data to estimate these additional enrollees.

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- Pregnant women and postpartum women up to six months after delivery
- Former foster care children under age 26
- Primary caregiver for a dependent child under age 19
- Primary caregiver for an adult dependent with a disability or a non-dependent relative
- Medically frail individuals
 - An individual who is medically frail or has special medical needs. Individuals with medical frailty or special medical needs include but are not limited to: individuals with disabling mental disorders, individuals with chronic SUD, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living, individuals with a disability determination based on Social Security Criteria
 - Individuals found to be medically complex and enrolled in a Commonwealth Coordinated Care (CCC) Plus Medicaid managed care plan
 - Individuals participating in a SUD treatment program (receiving ARTS services) or a state-certified drug court program
 - Individuals with a SUD diagnosis
 - Individuals who are physically or mentally unable to work
 - Individuals with HIV/AIDS
 - Individuals who are chronically homeless (residing in a place not meant for human habitation, a shelter for homeless persons, a safe haven, or the streets)
 - Individuals who were incarcerated within the past 12 months
 - Other individuals whom DMAS has determined to be medically frail due to serious and complex medical conditions or special medical needs
 - Individuals receiving long-term services and supports
- Individuals fulfilling Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) work program requirements
- Individuals with acute medical conditions that a medical professional validates would prevent compliance with work and community engagement requirements
- Individuals residing in institutions
- Individuals with a serious mental illness or disabling mental disorder
- Victims of domestic violence
- Any additional exemptions as the Commonwealth deems necessary to support the health of enrollees and achieve the objectives of the program

Hardship/Good Cause Exemptions

To address life circumstances that affect an individual's ability to engage in work and community engagement, the Commonwealth will exempt the following Medicaid enrollees. The duration of the exemption will be dependent on the individual's circumstances:

- Individuals who experience a hospitalization or serious illness or who reside with an immediate family member who experiences a hospitalization or serious illness
- Individuals who are temporarily incapacitated
- Birth or death of a household member
- Severe inclement weather
- Family emergency
- Change in family living circumstances (e.g., separation, divorce)
- Individuals living in geographic areas with high unemployment rates, as defined by the Commonwealth

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- Individuals residing in geographic areas where Commonwealth workforce programs are unavailable or at full capacity
- Provider attestation of inability to engage in work and community engagement on a short-term basis
- Individuals displaced or significantly impacted by a natural or man-made disaster or catastrophic event

Determining Standard and Good Cause/Hardship Exemptions and Compliance with Work and Community Engagement Hours

The Commonwealth will use a variety of methods to identify standard and good cause/hardship exemptions as well as compliance with work and community engagement hours for those who are not exempt, using a multi-pronged process including but not limited to:

- Leveraging the Medicaid eligibility application process by adding voluntary questions as a supplement to the single streamlined application to help identify possible exemptions (e.g., whether the individual is currently enrolled in full or part-time education);
- Using available data (within DMAS and other state agencies) to identify individuals who should be exempt from or are already complying with work hours (e.g., exemption from or compliance with SNAP requirements, employment-based income that equates to required work hours assuming Virginia minimum wage, claims experience indicating medical frailty);
- Utilizing a screening tool to be administered by managed care plans, Commonwealth eligibility workers, and healthcare providers to identify individuals who are medically frail; and
- Accepting enrollee attestation and conducting integrity audits of attested exemptions through a sampling method.

Notices

A description of the TEEOP and its work and community engagement requirements will be outlined in supplemental information provided to enrollees in the Medicaid application, redetermination, and change reporting processes. All Medicaid enrollees subject to the TEEOP will receive consumer notices at application and renewal that describe the program, qualifying work and community engagement activities, standard and good cause exemptions, required hours, compliance reporting processes, and who they can contact to have their questions answered. This information will also be available at county eligibility offices, online, and through the call center.

Assessment Process

For individuals who have not been identified as exempt or already meeting qualifying activities, the Commonwealth will provide information regarding TEEOP requirements including a notice that the individual must participate in an assessment to assist with meeting the requirements. The assessment, which will not require a face-to-face interview, will include a process to identify enrollees who need employment supports and connect them to needed services.

Penalties for Non-Compliance

Non-exempt enrollees who fail to comply with their work and community engagement requirements for three consecutive or non-consecutive months within a 12-month period will have their coverage suspended. Notices will be sent to enrollees providing information that their coverage will be suspended if they do not demonstrate compliance within 30 days of the date of notice. The notice will also include information on how to “cure” their non-compliance.

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Prior to suspending an enrollee's coverage, the Commonwealth will determine whether the enrollee is eligible for another Medicaid eligibility group or entitled to an exemption. The Commonwealth will notify individuals of their full appeal rights in accordance with 42 CFR Part 431 Subpart E upon suspension. The Commonwealth will maintain eligibility for enrollees who submit an appeal request or report a good cause exemption prior to disenrollment.

Reactivation of Coverage

Enrollees whose coverage is suspended as a result of non-compliance with work and community engagement requirements may have their coverage re-instated upon:

- Demonstrating compliance with work and community engagement requirements for one month;
- Qualifying for another Medicaid eligibility category not subject to work and community engagement requirements;
- Qualifying for a standard or hardship/good cause exemption; or
- Turning age 65.

Employment Supports for TEEOP Participants

Recognizing that Virginia's Medicaid population faces unique employment, poverty, housing, and other important circumstances that interact with an individual's health and well-being, the Commonwealth proposes a multi-pronged, comprehensive approach to meaningfully connect TEEOP participants to the supports necessary to be successful in meeting the new program requirements.

To implement TEEOP, the Commonwealth will seek administrative efficiencies across its successful systems administering employment and community engagement programs as part of SNAP, TANF, and the Workforce Innovation and Opportunity Act. The TEEOP will also build on Virginia's existing workforce programs and will work with Virginia Workforce Centers and the VEC to extend available employment supports services to TEEOP participants.

In order to ensure TEEOP enrollees have appropriate access to education, skill-building, and effective workforce services that will help them improve their success in the labor market and earn a living wage, the Commonwealth will submit to CMS for approval a targeted ABP State Plan Amendment (SPA) that will include employment supports to address barriers to meaningful community engagement and employment. Specifically, the Commonwealth will define habilitation benefits under Essential Health Benefits to encompass Section 1915(c) and (i) authorized supports.⁶ Such supports will be modified to address the needs of the TEEOP population and shall include:

- Education supports (e.g., subsidies for industry certification and licensure)
- Pre-vocational supports (e.g., activities targeted to preparing an individual for work, tickets to public transportation, gas cards for rural activities, and emergency funds for one-time incidences)
- Individual and small group employment supports (e.g., vocation and job training, financial literacy training, interview coaching, resume preparation, and career fairs)

To access these habilitative services, enrollees must complete a case management screening and assessment to determine the type and level of services they require. Individuals subject to work and community engagement requirements will be automatically referred to the screening and assessment

⁶ 42 CFR § 440.335; 78 Fed Reg. 42214-42215.

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process; those who are exempt from work and community engagement requirements will be counseled that they may “opt-in” and self-refer to the screening and assessment process.

These new employment supports will serve to meet the unique needs of the TEEOP population not covered under current state or federal programs due to eligibility, funding, or benefit limitations. Submission, to be pursued outside this waiver application, of the ABP SPA to provide these supports may be contingent on the appropriation of additional State funding by the State Legislature to the extent the Commonwealth’s coverage assessment does not cover spending for the previously-eligible adult population.

In addition, the Commonwealth will design a targeted case management benefit package for the TEEOP population under its Targeted Case Management State Plan authority. Under this Targeted Case Management State Plan, which is also to be pursued outside this waiver application, the Commonwealth will provide coordination, assessment, and referrals for employment and other supports to address social determinants of health.

B. Implement a Health and Wellness Program

The Commonwealth will implement a Health and Wellness Program to encourage certain newly eligible adults to take greater responsibility for their personal health and well-being while preparing for the financial requirements of ESI or other private health insurance coverage.

Premiums for Individuals with Income 100 to 138 percent of the FPL

The Commonwealth will require individuals, who are not otherwise exempt, to pay monthly premiums. Per the State Legislation, the Commonwealth will establish monthly premiums based on a sliding income scale.

Table 2: Sliding Scale Premium Amount for Enrollees with Incomes at or above 100 percent FPL

Monthly Income	Premium Amount
100-125 percent FPL	\$5 per month
126-138 percent FPL	\$10 per month

Virginia will make Medicaid coverage effective on the first day of the month following receipt of the premium payment. Premiums may be paid directly by an enrollee or on behalf of an enrollee by a third party. In recognition of individuals who may be “un-banked,” the Commonwealth will accept payment through a variety of payment mechanisms (e.g., acceptance of a pre-payment option or money order).

Healthy Behavior Incentives

Individuals who are subject to premiums and who complete at least one healthy behavior during the coverage year will have their premiums reduced by 50 percent in the following coverage year. Examples of healthy behaviors may include, but are not limited to: an annual wellness exam (may include immunizations and screening during visit), mammograms, pap smears/cervical cancer screenings, colon cancer screenings, flu vaccinations, nutrition counseling, tobacco cessation counseling or medications, and SUD treatment.

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Premium Exemptions

The same categories of individuals that qualify for a TEEOP exemption will be exempt from a premium obligation. The Commonwealth estimates 42,000 enrollees will not be exempt and will therefore be subject to premium requirements.⁷

Consequences for Unpaid Premiums

Enrollees will have their coverage suspended if they fail to pay their premiums after a three-month grace period. Coverage will be reactivated at any time after making one premium payment, meeting an exemption, or reporting a change in circumstances that reduces family income to less than 100 percent of the FPL.

The Commonwealth will recover owed premium payments through debt set-off collections. Individuals are not required to pay the full amount of premiums owed prior to having their coverage reactivated.

Co-Payments for Non-Emergent Use of the ED

To promote accountability related to the utilization of healthcare services, individuals with income 100 to 138 percent of the FPL will be required to pay a \$5 co-payment for each non-emergent or avoidable ED visit. Because this co-payment amount meets federal statutory requirements, the Commonwealth does not require demonstration authority. The same categories of individuals who qualify for a TEEOP exemption will be exempt from a co-payment for non-emergent use of the ED.

Co-payments for non-emergent use of the ED will not be charged at the point of service but rather will be deducted from the individual's HWA as described in further detail below.

Premium and Co-Payment Cap

Per federal requirements, individuals shall not be required to pay more than 5 percent of their aggregate household income in premiums and co-payments.

HWAs and Health Rewards

The Commonwealth will develop HWAs, funded through enrollee contributions and State funds, to the extent that the State Legislature appropriates State funds for this purpose, to incentivize healthy behaviors and promote personal responsibility. Enrollees will be required to pay monthly contributions (in the form of premiums) to a HWA. These payments will constitute a fulfillment of the HWA deductible obligation.⁸ Enrollees with incomes between 100 and 125 percent of the FPL are required to meet a \$50 deductible obligation while enrollees with income between 126 and 138 percent of the FPL must meet a \$100 deductible obligation.

Enrollees who meet their deductible obligation *and* engage in at least one healthy behavior (discussed above) will receive a rebate from their HWA. Specifically, enrollees who meet their deductible and healthy behavior obligation will be eligible to withdraw funds from their HWA up to the full balance (i.e. at least \$50 for an enrollee with income between 100 and 125 percent of the FPL or at least \$100 for an

⁷ DMAS relied on estimates that 35% of Medicaid expansion enrollees will be between 100 and 138 percent of the federal poverty level as well estimates included in the fiscal impact review conducted by the Joint Legislative Audit and Review Commission. This estimate can be found at <http://lis.virginia.gov/cgi-bin/legp604.exe?181+oth+HB3338JH1110+PDF>.

⁸ Note: This differs from commercial insurance where deductibles are met through payment of medical costs after payment of the premium.

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enrollee with income between 126 and 138 percent of the FPL based on their respective \$5 and \$10 monthly premiums). The withdrawal will be distributed in the form of a limited-use Health Rewards gift card distributed at the start of the following coverage year. Individuals may use the Health Rewards gift card to pay for non-covered medical or other health-related services (e.g. eyeglasses or vitamins).

Enrollees who meet their deductible obligation but do not engage in a healthy behavior will not be eligible for a Health Reward; however, their HWA accrued funds will roll over to the next coverage year, at which time the enrollee will be eligible for a Health Reward (provided they meet deductible and healthy behavior obligation.)

Enrollees who do not meet their deductible obligation and do not participate in a healthy behavior will forfeit any accrued HWA funds (i.e. they are not eligible for Health Rewards or HWA fund rollover).

Co-payments for non-emergent use of the ED will not be charged at the point of service. Instead, any incurred co-payments for non-emergency use of the ED will be deducted from the enrollees' HWA funds.⁹

Individuals are entitled to receive a full rebate of their HWA balance if their income falls below 100 percent FPL or they become ineligible for Medicaid (e.g., income increases above 138 percent FPL, individual moves out of state, or doesn't renew coverage).

Individuals will receive quarterly statements regarding their HWA.

C. Provide Housing and Employment Supports Benefit for High-Need Enrollees

The Commonwealth will offer a housing and employment supports benefit to a targeted group of high-need Medicaid enrollees. Housing instability often co-occurs with, and increases risk of, complex behavioral and physical health problems. Homeless individuals are less likely than others to have a usual source of care and are more likely to delay needed medical care and use the ED.¹⁰ Unemployment is also linked to poor physical and mental health outcomes.¹¹ As such, the Commonwealth will provide certain eligible, high-need Medicaid enrollees the supports necessary to obtain and maintain employment and stable housing, thereby improving enrollees' quality of life and health outcomes.

To implement the housing supports benefit, the Commonwealth will build on the existing supportive housing programs established by the Virginia Department of Behavioral Health and Developmental Services (DBHDS), the Virginia Department of Housing and Community Development, and the Virginia Housing Development Authority. Similarly, to implement the employment supports benefit, the

⁹ The amount of the Health Rewards gift card will reflect a deduction of any incurred co-payments for non-emergent use of the ED based on ICD-10 codes billed for non-emergent conditions that do not require treatment in the ED.

¹⁰ Schanzer, B., Dominguez, B., Shrout, P. E., & Caton, C. L. M. (2007). Homelessness, Health Status, and Health Care Use. *American Journal of Public Health*, 97(3), 464–469. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1805022/>.

¹¹ Olesen, S., Butterworth, P., Leach, L., Kelaheer, M., & Prikis, J. (2013) Mental Health Affects Future Employment as Job Loss Affects Mental Health: Findings from a Longitudinal Population Study. *BMC Psychiatry*, 13. Available at <https://bmcp psychiatry.biomedcentral.com/articles/10.1186/1471-244X-13-144>.

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Commonwealth will build on the existing supportive employment programs established by the Virginia Workforce Centers, the VEC, and the DARS.

The housing and employment supports benefit includes Home and Community-Based Services (HCBS) that would otherwise be allowable under Section 1915(i) SPA authority. Through this 1115 Waiver Extension, the Commonwealth is seeking 1115 Demonstration authority to impose an enrollment cap that will be based on available state funding which has not yet been appropriated¹², limit the benefit geographically by phasing in the benefit by region, 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.

The Commonwealth developed needs-based criteria and a set of required risk factors, specified below, to target the housing and employment supports benefit to Medicaid enrollees who are most likely to benefit from these services.

High-Needs Target Criteria for Housing Supports Benefit

Eligibility for housing supports services is available to Medicaid enrollees ages 18 or older who meet the following needs-based criteria and risk factors:

Needs-Based Criteria

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

1. Individual has a behavioral health need, which is defined as one or more of the following criteria:
 - a. SMI, as defined by at least one of the following ICD-10 diagnosis codes:
 - i. Schizophrenia (F20)
 - ii. Delusional Disorder (F22)
 - iii. Brief Psychotic Disorder (F23)
 - iv. Schizoaffective disorders (F28)
 - v. Unspecified psychosis not due to a substance or known physiological condition (F29)
 - vi. Manic episode (F30.1-.4)
 - vii. Bipolar disorder (F31)
 - viii. Major depressive disorder, single episode (F32.0-.5, .9)
 - ix. Major depressive disorder, recurrent (F33.0-.4, .9)
 - x. Agoraphobia with and without panic disorder (F40.01-.02);
 - xi. Panic disorder (F41.0)
 - xii. Obsessive-compulsive disorder (F42.2, .8, .9)
 - xiii. Post-traumatic stress disorder (F43.1)
 - xiv. Eating disorder (F50.0-.02)
 - b. SUD, which means a substance-related addictive disorder, as defined in the DSM-V, (with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders) marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use, is seeking treatment for the use of, or is in active recovery from use of alcohol or other drugs despite significant related problems

¹² While the majority program costs are likely covered to the coverage assessment, appropriation of state funds may be necessary to coverage the benefits for the previously-eligible adult population.

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OR

2. Individual has a serious and complex medical condition

AND

Risk Factors

Individual has at least one or more of the following risk factors:

1. Chronic homelessness (residing in a place not meant for human habitation, a shelter for homeless persons, a safe haven, or the streets)
2. History of frequent or lengthy stays in an institutional setting, institution-like setting, assisted living facility, or residential setting
3. Frequent ED visits or hospitalizations
4. History of involvement with the criminal justice system
5. Frequent turnover or loss of housing as a result of behavioral health symptoms

Housing Supports Services

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 Transition Services, inclusive of Community Transition Services

1. Conducting a functional needs assessment identifying the individual's preferences related to housing
2. Assisting in budgeting for housing/living expenses
3. Assisting with completion of applications for housing
4. Assisting individuals with finding and applying for housing necessary to support the individual in meeting their medical or behavioral healthcare needs
5. Developing an individualized community integration plan addressing goals and barriers-and an individualized housing support plan
6. Identifying and establishing short and long-term measurable goal(s), and establishing how goals will be achieved and how barriers will be addressed
7. Providing supports and interventions per the individualized services plan
8. Assisting with identifying resources to secure housing
9. Ensuring the living environment is safe and accessible for move-in
10. Assisting in arranging for and supporting the details and activities of the move-in
11. Providing community transition services for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses; services/expense necessary to establish a basic household

Individual Housing and Tenancy Sustaining Services

1. Coordination with the tenant to review, update and modify their individualized housing support plan on a regular basis to reflect current needs and preferences and address existing or recurring housing retention barriers
2. Support in planning, participating in, and updating the individualized services plan at redetermination and/or revision plan meetings
3. Coordinating with and linking the recipient to services

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4. Monitoring and follow-up to ensure that linkages are established and services are addressing community integration needs
5. Entitlement assistance
6. Assistance with securing supports to preserve the most independent living
7. Providing supports to assist the individual in the development of independent living skills
8. Providing supports to assist the individual in communicating with the landlord and/or property manager
9. Education and training on the role, rights, and responsibilities of the tenant and landlord
10. Connecting the individual to training and resources and continued training that will assist the individual in being a good tenant and lease compliant
11. Advocating on behalf of and linking the tenant to community resources to prevent eviction
12. Providing early identification and intervention for actions or behaviors that may jeopardize housing

Services not Included in the Housing Supports 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)

High-Needs Target Criteria for Employment Supports Benefit

Eligibility for employment supports services is available to Medicaid enrollees ages 18 or older who meet the following needs-based criteria and risk factors:

Needs-Based Criteria

DMAS will apply the same needs-based criteria for the employment supports benefit as required for the housing supports benefit, as described above.

AND

Risk Factors

Individual has at least one or more of the following risk factors:

1. Unable to be gainfully employed for at least 90 consecutive days due to a mental or physical impairment
2. An inability to obtain or maintain employment resulting from age, physical/sensory disability, or moderate to severe brain injury
3. More than one instance of inpatient or outpatient SUD in the past two years
4. At risk of deterioration of mental illness and/or SUD, including one or more of the following:
 - a. Persistent or chronic risk factors such as social isolation due to a lack of family or social supports, poverty, criminal justice involvement, or homelessness
 - b. Care for mental illness and/or SUD requires multiple provider types, including behavioral health, primary care, long-term services and supports, and/or other supportive services
 - c. Past psychiatric history, with no significant functional improvement that can be maintained without treatment and/or supports

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- d. Dysfunction in role performance, including one or more of the following:
 - i. Behaviors that disrupt employment or schooling, or put employment at risk of termination or schooling suspension
 - ii. A history of multiple terminations from work or suspensions/expulsions from school
 - iii. Cannot succeed in a structured work or school setting without additional support or accommodations
 - iv. Performance significantly below expectation for cognitive/developmental level

Employment Supports Services

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

Educational Services

- 1. Subsidies for industry certification
- 2. Subsidies for industry licensure

Pre-Employment Services

- 1. Pre-vocational/job-related discovery or assessment
- 2. Person-centered employment planning
- 3. Individualized job development and placement
- 4. Job carving
- 5. Benefits education and planning
- 6. Transportation (only in conjunction with the delivery of an authorized pre-employment supports service)

Employment Sustaining Services

- 1. Career advancement services
- 2. Negotiation with employers
- 3. Job analysis
- 4. Job coaching
- 5. Benefits education and planning
- 6. Transportation (only in conjunction with the delivery of an authorized employment supports service)
- 7. Asset development
- 8. Follow-along supports

Services not Included in the Employment Supports 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

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Section III. Implementation of Extension

Specific implementation target dates depend on policy negotiations with and waiver approval by CMS. It is the intention of the Commonwealth that implementation of TEEOP and the Health and Wellness Program will begin in demonstration year 1 with enforcement in demonstration year 2 and that implementation of the housing and employment supports program for high-need enrollees will begin in demonstration year 2.

New programs included under this wavier application require large and complex business processes development, infrastructure planning and deployment, and systems acquisitions and builds. The Commonwealth is also concerned with reporting from states with similar requirements that suggests loss of coverage may result from inadequate systems or a lack of information regarding work/community engagement and/or premium requirements rather than a failure to comply. The Commonwealth is committed to meaningfully connect the Medicaid population to the supports necessary to be successful in meeting the new program requirements.

As such, the Commonwealth proposes to implement program components as business processes and systems builds come on line rather than waiting for all components to be ready. Such an implementation approach will promote continuity of coverage, minimize confusion and complexity for enrollees, and ensure the supports necessary to achieve the goals of the Demonstration are in place.

Section IV. Requested Waivers and Expenditure Authorities

A list and programmatic description of the waivers and expenditure authorities that are being requested for the extension period, or a statement that the State is requesting the same waiver and expenditure authorities as those approved in the current demonstration.

Table 3: Virginia Waiver and Expenditure Authority Requests

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver Request?
§1902(a)(8) and §1902(a)(10) Provision of Medical Assistance and Eligibility	To suspend eligibility for enrollees who fail to comply with work and community engagement requirements unless the enrollee is exempt; and to limit the state plan group coverage to former foster care youth who were in Medicaid and foster care in a different state	No
§1902(a)(17) Comparability	To apply premiums, require participation in HWAs, and apply non-emergent use of the ED co-payments only for individuals with income between 100-138 percent FPL	No
§1902(a)(14) Premiums	To impose monthly premiums on individuals with income 100-138 percent of the FPL	No

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Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver Request?
§1902(a)(8) Reasonable Promptness	To waive the reasonable promptness requirement and suspend coverage for non-payment of premiums and limit the number of high-needs individuals who receive employment and housing supports	No
§1902(a)(23)(A) Freedom of Choice	To restrict the housing and employment support benefit to the managed care delivery system and to limit the providers who are authorized to deliver the benefits	No
§1902(a)(1) Statewideness	To restrict the provision of housing and employment supports to high-risk enrollees to certain geographic regions	No
Expenditures related to ARTS	Expenditures not otherwise eligible for federal financial participation may be claimed for otherwise covered services furnished to otherwise eligible individuals (eligible under the State Plan or Former Foster Care Youth components of this demonstration), including services for individuals who are short-term residents in facilities that meet the definition of an IMD for the treatment of SUD and withdrawal management	Yes

Section V. Summaries of External Quality Review Organization (EQRO) Reports, Managed Care Organization (MCO) and State Quality Assurance Monitoring

Summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and State quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration, such as the CMS Form 416 EPSDT/CHIP report.

Please see “The Virginia Governor’s Access Plan (GAP), Addiction, and Recovery Treatment Services (ARTS) and Former Foster Care Youth (FFCY) Delivery System Transformation Section 1115 Annual Report 2017¹³” attached to this application. The EQRO reports for the MCOs are not specific to ARTS.

Section VI. Financial Data

CMS requires that all 1115 Demonstration applications demonstrate budget neutrality. With the

¹³ Virginia Department of Medical Assistance Services, “The Virginia Governor’s Access Plan (GAP), Addiction, and Recovery Treatment Services (ARTS) and Former Foster Care Youth (FFCY) Delivery System Transformation: Section 1115 Annual Report 2017” (2017). Available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/va/Governors-Access-Plan-GAP/va-gov-access-plan-annl-rpt-2017.pdf>.

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exception of an extension of the ARTS delivery system transformation, the Commonwealth is not seeking expenditure authority for this demonstration extension's new programs.¹⁴

This application presents information on projected expenditures and enrollment as required by CMS.

Table 4: Historical Enrollment and Expenditures for Former Foster Care Youth (FFCY) from Another State

	CY2017	CY2018
Member Months	813	*
Total Expenditures	\$393,551	*
Per Member Per Month (PMPM)	\$484	*

Table 5: Projected Enrollment and Expenditures of FFCY from Another State in the 1115 Demonstration Extension

	DY 1	DY2	DY3	DY4	DY5
Member Months	812	820	828	836	844
Total Expenditures	\$522,222	\$553,738	\$587,093	\$622,404	\$659,778
Per Member Per Month (PMPM)	\$643	\$675	\$709	\$745	\$782

Table 6: ARTS Program Without Waiver Estimates

Non-Expansion Adults					
	DY 01	DY 02	DY 03	DY 04	DY 05
Member Months	4,246	4,611	5,008	5,439	5,907
Per Member Per Month (PMPM)	\$4,606.35	\$4,836.67	\$5,078.50	\$5,332.43	\$5,599.05
Total Expenditures	\$19,558,562	\$22,301,885	\$25,433,128	\$29,003,087	\$33,073,588
Expansion Adults					
	DY 01	DY 02	DY 03	DY 04	DY 05
Member Months	5,748	6,392	7,108	7,904	8,789
PMPM	\$4,606.35	\$4,836.67	\$5,078.50	\$5,332.43	\$5,599.05
Total Expenditures	\$26,477,300	\$30,915,995	\$36,097,978	\$42,147,527	\$49,210,050

¹⁴ DMAS notes that because the Commonwealth will expand eligibility to the new adult group beginning January 1, 2019, a budget neutrality test is no longer needed for the demonstration authority to provide coverage for former foster care youth who were in foster care under the responsibility of other states and have income higher than 133 percent of the FPL. See: CMCS Informational Bulletin. Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib112116.pdf>.

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Table 7: ARTS Program With Waiver Estimates

Non-Expansion Adults					
	DY 01	DY 02	DY 03	DY 04	DY 05
Member Months	4,246	4,611	5,008	5,439	5,907
PMPM	\$4,606.35	\$4,836.67	\$5,078.50	\$5,332.43	\$5,599.05
Total Expenditures	\$19,558,562	\$22,301,885	\$25,433,128	\$29,003,087	\$33,073,588
Expansion Adults					
	DY 01	DY 02	DY 03	DY 04	DY 05
Member Months	5,748	6,392	7,108	7,904	8,789
PMPM	\$4,606.35	\$4,836.67	\$5,078.50	\$5,332.43	\$5,599.05
Total Expenditures	\$26,477,300	\$30,915,995	\$36,097,978	\$42,147,527	\$49,210,050

Tables 8 and 9 present Medicaid cost and coverage estimates for non-expansion and expansion adults with and without the new features of the waiver. To do so, DMAS estimated the impact of key features of the waiver for each eligibility group. It is important to note that benefit spending discussed in this waiver (e.g., housing and employment support benefits) are not included in these budget neutrality estimates because this waiver does not seek a waiver of expenditure authority to pursue these benefits.

The Commonwealth notes that these estimates are highly dependent on the assumptions utilized in this analysis for three main reasons. First, as discussed above, the 2018 Appropriations Act authorized DMAS to amend Virginia’s Medicaid State Plan to expand coverage to newly eligible non-disabled, non-pregnant adults ages 19 to 64 with income up to 138 percent of the FPL, effective on January 1, 2019. As such, the Commonwealth does not yet have historical experience with the vast majority of the populations for which the new features of the demonstration will apply. Any estimates of the new demonstration features on the new adult population represent a hypothetical population.¹⁵

Second, DMAS does not have experience with the policies set forth in the Health and Wellness Program or the TEEOP. To produce the projected expenditures and enrollment, DMAS relied on the limited experiences from other states with respect to provisions of the Health and Wellness Program¹⁶ and the Commonwealth’s budgetary fiscal impact statements with respect to the TEEOP.¹⁷ In both cases, the implementation of this demonstration will differ in important ways that are likely to affect actual experience under this demonstration. Differences between the projections and actual amounts depend on the extent to which future experience conforms to the assumptions made in this analysis.

Third, DMAS is limited in its current access to information regarding some of the eligibility criteria for new programs and exemptions that will be allowed under the demonstration.

The Commonwealth will work with all individuals who are not otherwise determined to be exempt or already meeting the work and community engagement and/or Health and Wellness Program

¹⁵ DMAS relied on the budgetary estimates included in HB 5002.

¹⁶ The Indiana Family and Social Services Administration. (2016). Healthy Indiana Plan Demonstration. Section 1115 Quarterly Report. Available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-qtrly-rpt-aug-oct-12302016.pdf>.

¹⁷ Virginia General Assembly. (2018). HB 338 Medicaid; Training, Education, Employment, and Opportunity Program for Able-Bodied Adult Recipients. Available at <http://lis.virginia.gov/cgi-bin/legp604.exe?181+oth+HB338IMP>.

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requirements to ensure they have the education, notifications, tools, and supports they need to meet the requirements. We do, however, estimate a decrease in Medicaid coverage for the populations subject to the new requirements. Such coverage loss could occur for a number of reasons including that an individual does not comply with the requirements or gains alternative coverage (e.g., employer coverage or other private coverage).¹⁸

Table 8: New Demonstration Features Without Waiver Estimates

Non-Expansion					
Adults	DY 01	DY 02	DY 03	DY 04	DY 05
Member Months	1,412,075	1,426,196	1,440,458	1,454,863	1,469,412
PMPM	\$672.00	\$705.60	\$740.88	\$777.92	\$816.82
Total Expenditures	\$948,914,400	\$1,006,323,898	\$1,067,206,523	\$1,131,772,844	\$1,200,245,404

Expansion Adults					
	DY 01	DY 02	DY 03	DY 04	DY 05
Member Months	2,588,230	3,628,410	3,654,127	3,672,440	3,690,844
PMPM	\$630.26	\$649.17	\$668.64	\$688.70	\$709.36
Total Expenditures	\$1,631,257,871	\$2,355,447,105	\$2,443,305,983	\$2,529,217,064	\$2,618,148,935

Table 9: New Demonstration Features With Waiver Estimates

Non-Expansion					
Adults	DY 01	DY 02	DY 03	DY 04	DY 05
Member Months	1,412,075	1,412,414	1,426,538	1,440,804	1,455,212
PMPM	\$672.00	\$705.60	\$740.88	\$777.92	\$816.82
Total Expenditures	\$948,914,400	\$996,599,318	\$1,056,839,473	\$1,120,836,011	\$1,188,646,557

Expansion Adults					
	DY 01	DY 02	DY 03	DY 04	DY 05
Member Months	2,588,230	3,320,412	3,343,946	3,360,704	3,377,546
PMPM	\$630.26	\$649.17	\$668.64	\$688.70	\$709.36
Total Expenditures	\$1,631,257,871	\$2,155,504,386	\$2,235,905,341	\$2,314,523,839	\$2,395,906,706

Section VII. Evaluation

A summary of evaluation activities and findings to date for the GAP and ARTS demonstrations is attached to this application as “The Virginia Governor’s Access Plan (GAP), Addiction, and Recovery Treatment Services (ARTS) and Former Foster Care Youth (FFCY) Delivery System Transformation Section 1115 Annual Report 2017.”¹⁹ The one-year evaluation of the ARTS program conducted by the

¹⁸ The Commonwealth estimates that roughly 120,000 enrollees will not be exempt and therefore subject to TEEOP when Medicaid eligibility is conditioned upon the fulfillment of work and community engagement requirements. It is estimated that almost half of these 120,000 enrollees are working more than 20 hours per week or enrolled in school and will already be in compliance with the work and community engagement requirements. Roughly 18 percent of individuals subject to TEEOP are estimated to lose Medicaid coverage. Available at <http://lis.virginia.gov/cgi-bin/legp604.exe?181+oth+HB338IMP>.

¹⁹ Virginia Department of Medical Assistance Services, “The Virginia Governor’s Access Plan (GAP), Addiction, and Recovery Treatment Services (ARTS) and Former Foster Care Youth (FFCY) Delivery System Transformation: Section

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independent evaluator, Virginia Commonwealth University, is attached to this application as “Addiction and Recovery Treatment Services: Access and Utilization during the First Year (April 2017 – March 2018).²⁰

The Commonwealth intends to continue all evaluation activities related to the ARTS program consistent with its existing, approved evaluation plan.

Additional evaluation hypotheses for the new demonstration features are included in the table below.

Table 10: Evaluation Hypotheses under Consideration

Hypothesis	Evaluation Approach	Data Sources
Work and Community Engagement		
Members enrolled in the demonstration will secure sustained employment.	Analyze Medicaid employment outcomes	<ul style="list-style-type: none"> • Eligibility and enrollment data • Evaluation survey data • Other Commonwealth administrative data sources (e.g. Virginia Longitudinal Data Set, workforce, wage, and employment)
The demonstration’s work and community engagement requirements will not cause individuals to lose Medicaid coverage unless the loss is related to obtaining employer sponsored or other commercial health insurance coverage.	Analyze coverage outcomes	<ul style="list-style-type: none"> • Eligibility and enrollment data • State and national survey data
The demonstration’s work and community engagement requirements will not deter eligible individuals from applying for or renewing Medicaid coverage.	Analyze coverage trends pre/post implementation	<ul style="list-style-type: none"> • State and national survey data • Eligibility and enrollment data • Evaluation survey data

1115 Annual Report 2017” (2017). Available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/va/Governors-Access-Plan-GAP/va-gov-access-plan-annl-rpt-2017.pdf>.

²⁰ Virginia Commonwealth University. (2018). Addiction and Recovery Treatment Services: Access and Utilization during the First Year (April 2017 – March 2018). Available at [http://www.dmas.virginia.gov/files/links/1625/ARTS%20one-year%20report%20\(08.09.2018\).pdf](http://www.dmas.virginia.gov/files/links/1625/ARTS%20one-year%20report%20(08.09.2018).pdf).

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Hypothesis	Evaluation Approach	Data Sources
Participation in the demonstration’s work and community engagement requirements will improve enrollee health and well-being.	Analyze member utilization, diagnoses, and self-reported health	<ul style="list-style-type: none"> • Utilization and diagnoses data • Evaluation survey data • Health outcomes data
Premiums for Individuals with Income 100-138 Percent of the FPL		
Conditioning coverage on payment of premiums will promote continuous coverage and continuity of care.	Analyze coverage gaps and utilization trends	<ul style="list-style-type: none"> • Eligibility and enrollment data • Evaluation survey data
Premiums will not deter eligible individuals from applying for, enrolling in or renewing Medicaid coverage.	Analyze coverage trends within and inside/outside Medicaid	<ul style="list-style-type: none"> • State and national survey data • Eligibility and enrollment data
Housing and Employment Supports for High-Need Populations		
Participation in housing and employment supports will improve enrollee housing and employment stability and health and well-being	Analyze employment, housing, and health trends in the high-needs populations	<ul style="list-style-type: none"> • Eligibility and enrollment data • Utilization and diagnoses data • Other Commonwealth administrative data sources
Former Foster Care Children		
Provision of coverage to former foster care youth will increase and strengthen overall coverage and improve health outcomes	Analyze enrollment trends and utilization of medical services, including emergency services and treatments for chronic conditions, such as asthma	<ul style="list-style-type: none"> • Eligibility and enrollment data • Utilization and diagnosis data
ARTS Program		
The demonstration will improve quality of care and population health outcomes for the Medicaid population with a SUD.	Analyze quality and population health outcomes and utilization and cost trends	<ul style="list-style-type: none"> • Utilization and diagnoses data • Health outcomes data from MCOs • Vital statistics data from Department of Health

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Hypothesis	Evaluation Approach	Data Sources
Medicaid members' access to and utilization of community-based and outpatient ARTS services including Medication Assisted Treatment (MAT) will increase.	Analyze member utilization	<ul style="list-style-type: none"> Utilization and diagnoses data
Medicaid members with a SUD will experience a decrease in utilization of high-cost ED and hospital services.	Analyze member utilization and costs	<ul style="list-style-type: none"> Utilization and cost data
The demonstration will improve care coordination and care transitions for Medicaid members with a SUD.	Analyze member and provider experience and utilization of care coordination and case management service	<ul style="list-style-type: none"> Qualitative data from interviews with providers Member satisfaction surveys
The demonstration will increase the number and type of healthcare clinicians, including buprenorphine-waivered practitioners providing ARTS services, including MAT, to Medicaid members with a SUD.	Analyze provider networks	<ul style="list-style-type: none"> Provider network data from MCOs Provider billing data
The demonstration will improve outcomes for Medicaid-covered pregnant women with a SUD and Substance-Exposed Infants, including those with Neonatal Abstinence Syndrome.	Analyze member quality outcomes and utilization	<ul style="list-style-type: none"> Utilization and diagnoses data Health outcomes data from MCOs Vital statistics data from Department of Health

Upon approval of this extension, the Commonwealth will work with CMS to develop an evaluation design plan consistent with the STCs and CMS policy.