



JAN - 9 2015

200 Independence Avenue SW
Washington, DC 20201

Ms. Cynthia B. Jones
Director
Department of Medical Assistance Services
Commonwealth of Virginia
600 East Broad Street
Richmond, VA 23219

Dear Ms. Jones:

The Centers for Medicare & Medicaid Services (CMS) is approving Virginia's application for a five-year Medicaid demonstration entitled, "The Virginia Governor's Access Plan (GAP)" (Project Number 11-W-00297/3). The demonstration is approved in accordance with section 1115(a) of the Social Security Act (the Act) and is effective on January 12, 2015 and is approved through December 31, 2019, assuming the state fulfills the requirements outlined within the Special Terms and Conditions (STC) to continue the demonstration beyond December 31, 2016. The demonstration extends access to a limited set of behavioral and physical health services to a population of uninsured adults with effective incomes at or below 100 percent of the federal poverty level who have been diagnosed with a serious mental illness. The Virginia GAP demonstration will receive federal financial participation at the state's regular federal medical assistance percentage.

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

The terms of the demonstration have been incorporated into the accompanying STCs and expenditure authorities for the demonstration approval. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been listed as not applicable to expenditures for demonstration populations and other services not covered under the state plan.

The enclosed STCs define the nature, character, and extent of anticipated federal involvement in the project, and our approval of the demonstration is conditioned upon compliance with these STCs. Our approval is subject to CMS 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. Megan Lepore. She is available to answer any questions concerning your section 1115 demonstration. Ms. Lepore's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-4113
Facsimile: (410) 786-5882
E-mail: Megan.Lepore@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Lepore and to Mr. Francis McCullough, Associate Regional Administrator for the Division of Medicaid and Children's Health in our Philadelphia Office. Mr. McCullough's contact information is as follows:

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

If you have questions regarding this approval, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services, at (410) 786-5647.

Thank you for all your work with us, as well as stakeholders in Virginia, over the past several months on developing this important demonstration, and congratulations on its approval.

Sincerely,

A black rectangular redaction box covers the signature of Andy Slavitt. The name "Andy Slavitt" is printed below the redaction.

Andy Slavitt
Principal Deputy Administrator

Enclosures

cc: Francis McCullough, ARA, Region VI

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY and WAIVER LIST**

NUMBER: 11-W-00297/3
TITLE: Virginia Governor's Access Plan (GAP) Demonstration
AWARDEE: Virginia Department of Medical Assistance Services

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

1. Expenditures for a targeted benefit package for the SMI population eligible for services under the demonstration.

Expenditures for coverage of health care services for up to 20,000 individuals aged 21 through 64, with effective household incomes up to 100 percent of the federal poverty level (FPL), who have been diagnosed with a severe disabling mental illness of schizophrenia spectrum and other psychotic disorders (except for psychotic disorder induced by substance or medication), major depressive disorder, bipolar and related disorders (except for cyclothymic disorder), post-traumatic stress disorder, obsessive compulsive disorder, panic disorder, agoraphobia, anorexia nervosa, or bulimia nervosa, and who are either expected to require services of an extended duration, or have undergone psychiatric treatment more intensive than outpatient care, or have experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation, and have met the SMI criteria as determined by the Behavioral Health Services Administrator, but are otherwise ineligible for Medicaid.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the Virginia GAP demonstration for the period of approval.

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

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

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

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

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

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

4. Amount, Duration, and Scope of Services

Section 1902(a)(10)(B)

To the extent necessary to enable the state to offer a reduced benefit to populations affected by the demonstration.

5. Reasonable Promptness

Section 1902(a)(8)

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

6. Comparability.

Section 1902(a)(17)

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

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

NUMBER: 11-W-00297/3

TITLE: Virginia Governor's Access Plan for the Seriously Mentally Ill (GAP) Demonstration

AWARDEE: Virginia Department of Medical Assistance Services (DMAS)

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Virginia Governor's Access Plan (GAP) for the Seriously Mentally Ill Section 1115 Demonstration (hereinafter "demonstration"). The parties to this agreement are the Virginia Department of Medical Assistance Services (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. All requirements of the Medicaid and CHIP programs expressed in law, regulation and policy statement, not expressly waived or made not applicable in the list of Waivers and Expenditure authorities, shall apply to the demonstration project. The STCs are effective January 12, 2015, unless otherwise specified. This demonstration will be statewide and is approved through December 31, 2019, assuming the state fulfills the requirements outlined within the STCs to continue the demonstration beyond December 31, 2016.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility
- V. Benefits
- VI. Cost Sharing
- VII. Delivery Systems
- VIII. General Reporting Requirements
- IX. General Financial Requirements
- X. Monitoring Budget Neutrality for the Demonstration
- XI. Evaluation of the Demonstration
- XII. Monitoring
- XIII. Health Information Technology
- XIV. T-MSIS Requirements
- XV. Schedule of State Deliverables During the Demonstration

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

Attachment A: Diagnoses Eligible for Virginia GAP Demonstration

Attachment B: Demonstration Benefits

Attachment C: Informal Network of Benefits

Attachment D: Demonstration Evaluation Plan (reserved)

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Virginia GAP Demonstration provides a specified benefits package to childless adults and non-custodial parents who have household incomes at or below 95 percent of the federal poverty level (FPL), effectively 100 percent of the FPL with a 5 percent income disregard, who have been diagnosed with a serious mental illness (SMI). The Demonstration extends access to a limited package of behavioral and physical health services to adults who are not otherwise eligible for Medicaid, CHIP, or Medicare and are uninsured.

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

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

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
- 2. Compliance with Medicaid and Children’s Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.
- 3. Changes in Federal Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP

program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment.

4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.

- a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change.
- b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. State Plan Amendments. The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs.

6. Changes Subject to the Amendment Process. Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, and budget neutrality must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

7. Amendment Process. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

- a. An explanation of the public process used by the state, consistent with the requirements of paragraph 14, to reach a decision regarding the requested amendment;
- b. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- c. An up to date CHIP allotment neutrality worksheet, if necessary;
- d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
- e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. Option to Continue Demonstration beyond DY 2. If the state intends to continue operating this demonstration beyond DY 2, the state must submit a letter of intent to CMS no later than 6 month prior to the end of each DY for which the state seeks continuation of the demonstration.

9. Extension of the Demonstration. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 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 or a transition and phase-out plan consistent with the requirements of STC 9.

- a. Compliance with Transparency Requirements at 42 CFR §431.412.
- b. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 14.

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

- a. **Notification of Suspension or Termination.** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must

submit a notification letter and a draft plan to CMS. To be assured of approval, if the phase-out of the demonstration will be accompanied by the termination of coverage, the state must submit the notification letter and a draft plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with 42 CFR 431.408. 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 plan. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of activities must be no sooner than 14 days after CMS approval of the plan.

- b. **Transition and Phase-out Plan Requirements.** The state must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries determined eligible, as well as any community outreach activities including community resources that are available.
- c. **Phase-out Procedures.** The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as described in 42 CFR §435.916.
- d. **Exemption from Public Notice Procedures 42.CFR §431.416(g).** CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR §431.416(g).
- e. **Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of disenrolling beneficiaries.

11. Post Award Forum. Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide

meaningful comment on the progress of the demonstration. At least 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 can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments in the quarterly report associated with the quarter in which the forum was held. The state must also include the summary in its annual report.

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

- a. **Expiration Requirements.** The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- b. **Expiration Procedures.** The state must comply with all notice requirements found in 42 CFR Sections 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR Section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
- c. **Federal Public Notice.** CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR Section 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.
- d. **Federal Financial Participation (FFP).** FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of disenrolling participants.

- 13. Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.
- 14. Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.
- 15. Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration are proposed by the state.

 - a. In states with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).
 - b. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).
 - c. 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.
- 16. Federal Financial Participation (FFP).** No federal matching for administrative or service expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY

The Virginia GAP Demonstration provides a specified benefits package to uninsured adults age 21 to 64 with SMI who have household incomes at or below 95 percent of the FPL (effectively 100 percent FPL with a 5 percent income disregard). Specific diagnoses which may qualify a person for eligibility in the demonstration are included in Attachment A.

17. Demonstration population.

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

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

- a. Adult ages 21 through 64 years old;
- b. SMI criteria, including documentation related to the duration of the mental illness and the level of disability based on the mental illness, as described in Attachment A;
- c. Not otherwise eligible for any state or federal full benefits program including: Medicaid, Children's Health Insurance Program (CHIP/FAMIS), or Medicare;
- d. Household income that is below 95 percent of the FPL plus a 5 percent income disregard (effectively 100 percent FPL);
- e. Uninsured; and,
- f. Not residing in a long term care facility, mental health facility, or long-stay hospital.

18. Enrollment. The state may impose an enrollment limit on the population covered under the demonstration, in order to remain within state funding limits, with a target ceiling of 20,000 enrollees.

- a. **Implementation Plan.** No later than 120 days after approval of the demonstration, the state must submit a plan for CMS approval explaining how the waiting list will be implemented.

- b. **Notification Requirements.** The state must notify CMS in advance of opening and closing a waitlist, as per the requirements contained within this STC.
 - i. The state must notify CMS 60 days prior to implementing a waiting list for individuals covered under the Virginia GAP Demonstration. This notification must include updated expenditure documents, reflecting the budgetary constraints necessitating the implementation of the waitlist, and specify any change to the target ceiling enrollment.
 - ii. The state will provide written notification to CMS at least 15 days before re-opening enrollment of the demonstration.

V. BENEFITS

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

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

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

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

21. Minimum Essential Coverage. As the GAP demonstration is limited to a specific category of benefits to treat specific medical conditions, the demonstration is not

recognized as Minimum Essential Coverage (MEC), consistent with the guidance set for in State Health Official Letter #14-002, issued by CMS on November 7, 2014.

VI. COST SHARING

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

VII. DELIVERY SYSTEMS

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

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

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

VIII. GENERAL REPORTING REQUIREMENTS

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

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

27. Monthly Monitoring Calls. CMS will convene periodic conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration; including planning for future changes in the program or intent to further implement the Virginia GAP Demonstration beyond December 31, 2016. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls. Areas to be addressed include, but are not limited to:

- a. Transition and implementation activities,
- b. Stakeholder concerns,

- c. ASO operations and performance,
- d. Enrollment,
- e. Quality of care,
- f. Access,
- g. The benefit package,
- h. Audits,
- i. Lawsuits,
- j. Financial reporting and budget neutrality issues,
- k. Progress on evaluations,
- l. Legislative developments, and
- m. Any demonstration amendments the state is considering submitting.

28. Quarterly Progress Reports: The state will provide quarterly reports to CMS.

- a. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration, including the reports documenting key operational and other 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.
- b. Monitoring and performance metric reporting templates are subject to review and approval by CMS. Where possible, information will be provided in a structured manner that can support federal tracking and analysis.
- c. The state will report quarterly hospital utilization data of key non-GAP benefits by GAP participants including access to inpatient and outpatient hospital services.

29. Compliance with Federal Systems Innovation. As MACBIS or other federal systems continue to evolve and incorporate 1115 waiver reporting and analytics, the State shall work with CMS to revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems.

30. Demonstration Annual Report. The annual report must, at a minimum, include the requirements outlined below. The State will submit the draft annual report no later than 90 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted for the demonstration year (DY) to CMS.

- a. All items included in the quarterly report pursuant to STC 28 must be summarized to reflect the operation/activities throughout the DY;
- b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately; and
- c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the

budget neutrality agreement.

31. Final Report. Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

IX. GENERAL FINANCIAL REQUIREMENTS

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

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

- a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the state will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the State Medicaid Manual. All demonstration expenditures subject to the budget neutrality limit must be reported each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes cost settlements must be recorded on the appropriate prior period adjustment schedules (forms CMS-64.9 Waiver) for the summary line 10B, in lieu of lines 9 or 10C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality limit," is defined below in STC 60.
- b. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (form CMS-64.9P Waiver) for the summary sheet line 10B, in lieu of lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the SMM.
- c. **Pharmacy Rebates.** The state may propose a methodology for assigning a portion of pharmacy rebates to the demonstration populations, in a way that

reasonably reflects the actual rebate-eligible pharmacy utilization of those populations, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the demonstration and not on any other CMS 64.9 form to avoid double –counting. Each rebate amount must be distributed as state and Federal revenue consistent with the Federal matching rates under which the claim was paid.

- d. **Use of Waiver Forms for Medicaid.** For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit (Section X of these STCs). The State must complete separate waiver forms for the following eligibility groups/waiver names:
 - i. MEG 1 – “SMI Group”
- e. **Demonstration Years.** The first Demonstration Year (DY1) will begin on January 1, 2015. Pursuant to STC 8, DMAS will submit a letter of intent to extend the demonstration past DY2. Subsequent DYs will be defined as follows:

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

34. Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name State and Local Administration Costs (“ADM”).

35. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During

the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 and Form CMS-21 in order to properly account for these expenditures in determining budget neutrality.

36. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

- a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 28, the actual number of eligible member months for the demonstration populations defined in STC 17. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

- b. The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.

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

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

- a. Administrative costs, including those associated with the administration of the demonstration.

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

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

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

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

- a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
- b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the

state's claim for federal match.

- d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

X. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

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

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

	DY 1	DY 2	DY 3	DY 4	DY 5
Annual limit (total computable)	\$1,915,051,787	\$2,100,298,546	\$2,303,461,873	\$2,526,279,263	\$2,770,646,354

43. Composite Federal Share Ratio. The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see STC 9), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

44. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

45. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

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

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

XI. EVALUATION OF THE DEMONSTRATION

- 49. Submission of Draft Evaluation Design.** The state shall submit a draft evaluation design to CMS no later than 60 days after the award of the demonstration. The state must employ aggressive state-level standards for statewide access.
- 50. Submission of Final Evaluation Design.** The state shall provide the Final Evaluation Design within 30 days of receipt of CMS comments of the Draft Evaluation Design. If CMS finds that the Final Evaluation Design adequately accommodates its comments, then CMS will approve the Final Evaluation Design within and attach to these STCs as Attachment D.
- 51. Evaluation Requirements.** The state shall engage the public in the development of its evaluation design. The evaluation design shall incorporate an interim and final evaluation and will discuss the following requirements as they pertain to each:
- a. The scientific rigor of the analysis;
 - b. A discussion of the goals, objectives and specific hypotheses that are to be tested;
 - c. Specific performance and outcomes measures used to evaluate the demonstration's impact;
 - d. How the analysis will support a determination of that a medically needy determination has been diverted ;
 - e. Data strategy including sources of data, sampling methodology, and how data will be obtained;
 - f. The unique contributions and interactions of other initiatives; and
 - g. How the evaluation and reporting will develop and be maintained.

The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation,

including standards for the evaluation design, conduct, interpretation and reporting of findings. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

The state shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the state will assure no conflict of interest, and a budget for evaluation activities.

52. Program Monitoring. To assess how GAP services improve health and prevent participants' conditions from deteriorating, a quality improvement plan will be developed and approved by CMS. Quality measures for all individuals with SMI including current participants and the demonstration participants will be tracked, monitored and reported to CMS on a quarterly basis. Measures will address the integrated health care needs of individuals with SMI. The quality improvement plan will address consumers' perceptions of the quality of care they receive.

53. Evaluation Design. The Evaluation Design shall include the following core components to be approved by CMS:

- a. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration. At a minimum, the research questions shall address the goals of improving access, improving quality of care thereby leading to enhanced health outcomes, and lowering costs. The research questions will be examined using appropriate comparison groups and studied in a time series. The analyses of these research questions will provide the basis for a robust assessment of medically needy diversion.

The following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate:

- i. Integrating care coordination, primary care, specialty care, pharmacy, and behavioral health care for individuals with SMI, who are otherwise uninsured, will result in better medical and behavioral health for participants;
- ii. Integrating care coordination, primary care, specialty care, pharmacy, and behavioral health care for individuals with SMI who are otherwise uninsured will result in fewer Social Security Disability Determinations which often leads to an individual qualifying for Medicaid;
- iii. Providing care coordination services to GAP participants will improve appropriate utilization of emergency department services and reduce admission to state mental health hospitals when compared to utilization among the uninsured;

- iv. Integrating care coordination, primary care, specialty care, pharmacy, and behavioral health care for individuals with SMI who are otherwise uninsured will prevent or reduce the number of documented interactions with the criminal justice system.
 - v. Providing GAP benefits to enrollees aged 25 or younger reduces the prevalence of behaviors associated with psychotic disorders within the population, and improves outcomes for individuals within the population who have already been diagnosed with at least one psychotic disorder.
- b. Study Design: The design will consider through its research questions, hypotheses, and analysis plan the appropriate application of the following dimensions of access and quality:
- i. Comparisons of outcome measures;
 - ii. Trending of outcome measures.
- c. The design will include a description of the quantitative and qualitative study design (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.), including a rationale for the design selected. The discussion will include a proposed baseline and approach to comparison; examples to be considered as appropriate include the definition of control and/or comparison groups or within-subjects design, use of propensity score matching and difference in differences design to adjust for differences in comparison populations over time. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered.
- d. Study Population: This includes a clear description of the populations impacted by each hypothesis, as well as the comparison population, if applicable. The discussion may include the sampling methodology for the selected population, as well as support that a statistically reliable sample size is available.
- e. Access, Service Delivery Improvement, Health Outcome, Satisfaction and Cost Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the effectiveness of the Demonstration. Nationally recognized measures should be used where appropriate. Measures will be clearly stated and described, with the numerator and denominator clearly defined. To the extent possible, the State will incorporate comparisons to national data and/or measure sets. A broad set of performance metrics will be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation, for meaningful use under HIT, and from the Medicaid Core Adult sets. 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.

- f. **Data Collection:** This discussion shall include: A description of the data sources; the frequency and timing of data collection; and the method of data collection. The following shall be considered and included as appropriate:
 - i. Medicaid encounter and claims data,
 - ii. Enrollment data,
 - iii. Provider Network data,
 - iv. Consumer and provider surveys, and
 - v. Other data needed to support performance measurement relative to access and quality metrics.

- g. **Assurances Needed to Obtain Data:** The design report will discuss the state's arrangements to assure needed data to support the evaluation design are available, including from health plans.

- h. **Data Analysis:** This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow for the effects of the demonstration to be isolated from other initiatives occurring in the state. The level of analysis may be at the beneficiary, provider, and program level, as appropriate, and shall include population stratifications, for further depth. Sensitivity analyses shall be used when appropriate. Qualitative analysis methods shall also be described, if applicable.

- i. **Timeline:** This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables.

- j. **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; how the state will assure no conflict of interest, and a budget for evaluation activities.

54. Interim Evaluation Report. The state is required to submit a draft Interim Evaluation Report 90 days following completion of year one of the demonstration. The Interim Evaluation Report shall include the same core components as identified in STC 55 for the Final Evaluation Report and should be in accordance with the CMS approved evaluation design. CMS will provide comments within 60 days of receipt of the draft Interim Evaluation Report. The State shall submit the final Interim Evaluation Report within 30 days after receipt of CMS' comments.

55. Final Evaluation Report. The Final Evaluation Report will include analysis of data from year two of the Virginia GAP Demonstration. The state is required to submit a preliminary report within 180 days of the expiration of the demonstration including documentation of outstanding assessments due to data lags to complete the evaluation. Within 360 days of the expiration date of the demonstration, the state shall submit a draft of the final evaluation report to CMS. The state should respond

to comments and submit the Final Evaluation Report within 30 days.

The Final Evaluation Report shall include the following core components:

- a. **Executive Summary.** This includes a concise summary of the goals of the demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral and cost effective, health outcomes, and policy implications.
- b. **Demonstration Description.** This includes a description of the demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.
- c. **Study Design.** This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in the state and any sensitivity analyses, and limitations of the study.
- d. **Discussion of Findings and Conclusions.** This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.
- e. **Policy Implications.** This includes an interpretation of the conclusions; the impact of the demonstration within the health delivery system in the state; the implications for state and federal health policy; and the potential for successful demonstration strategies to be replicated in other state Medicaid programs.
- f. **Interactions with Other State Initiatives.** This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the state's Medicaid program, and interactions with other Medicaid waivers, the SIM award and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.

56. State Presentations for CMS. The state will present to and participate in a discussion with CMS on the final design plan, post approval, in conjunction with STC 53. The State will present on its interim evaluation in conjunction with STC 54. The state will present on its final evaluation in conjunction with STC 55.

57. Public Access. The State shall post the final approved Evaluation Design, Interim Evaluation Report, and Final Evaluation Report on the State Medicaid website within 30 days of approval by CMS.

For a period of 24 months following CMS approval of the Final Evaluation Report, CMS will be notified prior to the public release or presentation of these reports and related journal articles, by the State, contractor or any other third party. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

- 58. Electronic Submission of Reports.** The state shall submit all required plans and reports using the process stipulated by CMS, if applicable.
- 59. Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration or any component of the demonstration, the state shall cooperate fully with CMS or its contractors. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner and at no cost to CMS or the contractor.
- 60. Cooperation with Federal Learning Collaboration Efforts.** The state will cooperate with improvement and learning collaboration efforts by CMS.
- 61. Evaluation Budget.** A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.
- 62. Deferral for Failure to Provide Final Evaluation Reports on Time.** The state agrees that when draft and final Interim and Final Evaluation Reports are due, CMS may issue deferrals in the amount of \$5,000,000 if they are not submitted on time to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS.

XII. MONITORING

- 63. Quarterly Evaluation Operations Report.** The state will provide quarterly reports to CMS. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration and whether there has been progress toward the goals of the demonstration, including the reports will document key operational and other challenges, to what they attribute the challenges and how the challenges are being addressed, as well as key achievements and to what conditions and efforts they attribute the successes.
- 64. Annual Discussion with CMS.** In addition to regular monitoring calls, the state shall on an annual basis present to and participate in a discussion with CMS on

implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned.

65. Rapid Cycle Assessments. The state shall specify for CMS approval a set of performance and outcome metrics and network characteristics, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycle assessment in Medicaid fee-for-service, and for monitoring and evaluation of the demonstration.

XIII. HEALTH INFORMATION TECHNOLOGY

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

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

XIV. T-MSIS REQUIREMENTS

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

Should the MMIS fail to maintain and produce all federally required program management data and information, including the required T-MSIS, eligibility, provider,

outcome measures, participant satisfaction, and managed care encounter data, in accordance with requirements in the SMM Part 11, FFP may be suspended or disallowed as provided for in federal regulations at 42 CFR 433 Subpart C, and 45 CFR Part 95.

XV. SCHEDULE OF STATE DELIVERABLES

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

Per award letter - Within 30 days of the date of award	Confirmation Letter to CMS Accepting Demonstration STCs
Per paragraph 24	Submit Outreach Plan
Per paragraph 49	Submit Draft Evaluation Design
Per paragraph 8	Submit Demonstration Extension Application
Per paragraph 11 Within 6 months of amendment implementation	Post-award Forum Transparency deliverable
Quarterly	Deliverable
Per paragraph 28	Quarterly Progress Reports
Per paragraph 32	Quarterly Expenditure Reports
Annual	Deliverable
Per paragraph 11	Annual Forum Transparency deliverable
Per paragraph 30	Demonstration Annual Report
Renewal/Close Out	Deliverable
Per paragraph 54	Draft Final Evaluation
Per paragraph 55	Final Evaluation

**ATTACHMENT A
DIAGNOSES ELIGIBLE FOR VIRGINIA GAP DEMONSTRATION**

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

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

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

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

1. Duration of Illness: The person must meet at least one of these criteria:
 - a. Is expected to require services of an extended duration.
 - b. Has undergone psychiatric treatment more intensive than outpatient care, such as crisis response services, alternative home care, partial hospitalization, or inpatient hospitalization, more than once in his or her lifetime.
 - c. Has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.
2. Level of Disability: The person must meet at least two of these criteria on a continuing or intermittent basis. There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitation in major life activities. Due to the person's mental illness:
 - a. Is unemployed; employed in a sheltered setting or a supportive work situation; has markedly limited or reduced employment skills; or has a poor employment history.
 - b. Requires public and family financial assistance to remain in the community and may be unable to procure such assistance without help.
 - c. Has difficulty establishing or maintaining a personal social support system.
 - d. Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.
 - e. Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.

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

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

1. Limited Screening: Conducted for individuals who have had a diagnostic evaluation completed by a Licensed Mental Health Professional (LMHP) (including Supervisees and Residents) within the past 12 months and this evaluation is available to the screener. The GAP SMI Screening Tool (DMAS-P-603) may be completed by either an LMHP (including Supervisees and Residents), Qualified Mental Health Professional-Adult (QMHP-A), or QMHP-Eligible(E). The available evaluation is submitted to Magellan as the required attachment along with the signed and dated DMAS-P-603 form.

2. Full Screening: Conducted for individuals who have not had a diagnostic evaluation completed by an LMHP (including Supervisees and Residents) within the past 12 months or for whom the evaluation is not available to the screener. The signed and dated GAP SMI Screening Tool (DMAS-P-603) and diagnostic evaluation conducted at the time of the screening must be completed by an LMHP (including Supervisees and Residents) and submitted to Magellan.

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

**ATTACHMENT B
DEMONSTRATION BENEFITS SPECIFICATIONS**

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

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

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

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

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

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

GAP Benefits, Scope of Service, and Provider Qualifications				
Benefit	Provider Qualifications	Scope and Limitations	Differences from current VA Medicaid Program	Authority
GAP Services to be provided through the Department's Medicaid provider network				
Outpatient physician, FQHC/ RHC, clinic, specialty care, consultation, and treatment; includes evaluation, diagnostic and treatment procedures performed in the physician's office; includes therapeutic or diagnostic injections.	Same as the current VA Medicaid Program	No exclusions where the place of treatment is the physician's office except as shown in Table 9; otherwise, the scope of coverage is within the current Virginia Medicaid coverage guidelines.	No emergency room or inpatient coverage; no coverage for excluded services per Table 9.	State Plan for Medical Assistance Services
Outpatient hospital coverage, including diagnostic and radiology services electrocardiogram, authorized CAT and MRI scans.	Same as the current VA Medicaid Program	No exclusions where the place of service is the physician's office except as shown in Table 9; otherwise, the scope of coverage is within current Virginia Medicaid coverage guidelines.	No emergency room or inpatient coverage. Outpatient hospital treatment coverage is limited; see exclusions in Table 9.	State Plan for Medical Assistance Services
Outpatient laboratory	Same as the current VA Medicaid	No exclusions where the place of service is the physician's office except as shown in	None	State Plan for Medical Assistance

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

GAP Benefits, Scope of Service, and Provider Qualifications				
Benefit	Provider Qualifications	Scope and Limitations	Differences from current VA Medicaid Program	Authority
	for individuals with serious mental illness.	high intensity. Regardless of the level of service, GCM will work with Magellan care managers to assist GAP members in accessing needed medical, behavioral health (psychiatric and substance abuse treatment), social, educational, vocational, and other support services. Individuals who need a higher intensity of service will receive face to face GCM provided in the community. Higher intensity GCM will be paid at the high intensity rate. GAP case managers will work closely with Magellan care coordinators. GCM service registration will be required with Magellan.	<ul style="list-style-type: none"> • GCM (regular intensity) does not require face to face visits. • GCM requires monthly collaboration with Magellan care management • GCM reimbursement rates are different: <ul style="list-style-type: none"> • \$195.90- Regular • \$220.80- High Intensity 	
Crisis Intervention	Same as the current VA Medicaid Program	Scope of coverage is within current Virginia Medicaid coverage guidelines.	None	State Plan for Medical Assistance Services
Crisis Stabilization	Same as the current VA Medicaid	Scope of coverage is within current Virginia Medicaid coverage	Service authorization will be	State Plan for Medical Assistance

GAP Benefits, Scope of Service, and Provider Qualifications				
Benefit	Provider Qualifications	Scope and Limitations	Differences from current VA Medicaid Program	Authority
	Program	guidelines.	required to enable effective coordination.	Services
Psychosocial Rehab Assessment and Psychosocial Rehab Services	Same as the current VA Medicaid Program	Scope of coverage is within current Virginia Medicaid coverage and reimbursement guidelines and limitations.	None	State Plan for Medical Assistance Services
Substance Abuse Intensive Outpatient (IOP) Treatment	Same as the current VA Medicaid Program	Scope of coverage is within current Virginia Medicaid coverage and reimbursement guidelines and limitations.	None	State Plan for Medical Assistance Services
Methadone	Same as the current VA Medicaid Program	Scope of coverage is within current Virginia Medicaid coverage and reimbursement guidelines and limitations.	None	State Plan for Medical Assistance Services
Opioid Treatment administration	Same as the current VA Medicaid Program	Scope of coverage is within current Virginia Medicaid coverage and reimbursement guidelines and limitations.	None	State Plan for Medical Assistance Services
Psychiatric evaluation and outpatient individual, family, and group	Same as the current VA Medicaid Program	No exclusions except as shown in Table 9. Under GAP, there are no maximum benefit limitations on	Under GAP, there are no maximum benefit limitations on	State Plan for Medical Assistance Services

GAP Benefits, Scope of Service, and Provider Qualifications				
Benefit	Provider Qualifications	Scope and Limitations	Differences from current VA Medicaid Program	Authority
therapies (mental health and substance abuse treatment).		traditional behavioral health psycho-therapy services.	traditional behavioral health psycho-therapy services. (Current Medicaid program limits for psychotherapy services are 26 visits per year with an additional 26 in the first year of treatment.)	

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

Demonstration Benefits Crosswalk with CMS 64 Reporting Criteria

GAP Benefit	FFP Rate%	CMS Report#	CMS 64 Line#	CMS 64 Line Label	Proc Code	Provider Class	Provider Class Description
Crisis Intervention, Crisis Stabilization, Psychosocial Rehab Assessment, Psychosocial Rehab Services, Substance Abuse Treatment, Intensive Outpatient, Methadone, Opioid Treatment & Admin	50%	64.9	49	Other Care Services	H0020, H0032, H0036, H2016, H2017, H2019, S0109, 99408, 99409, 90846, 90847, 90853, 96372, 96374		
GAP Case Management	50%	64.9	24A	Targeted Case Mgmt Services	H0023		
SMI Assessments - LIMITED	50%	64.10	49	Other Financial Participation	H0032	001, 002, 003, 007, 012, 091, 052, 056	
SMI Assessments – FULL	75%	64.10	3B	Skilled Professional Medical Personnel - Other Agency	H0032	001, 002, 003, 007, 012, 091, 052, 056	
Care Coordination - Claims/Network	50%	64.10	49	Other Financial Participation			
Care Coordination - Auth/QI	75%	64.10	6	Quality Improvement Organizations (QIO)			

Outpatient physician and clinic services, FQHC/RHC services, Outpatient specialty care, consultation and treatment and telemedicine	50%	64.9	5A 2A	Physician & Surgical Services - Regular Payments		020, 095, 040	Physicians, Out of State Physicians, Dentist
	50%	64.9	9A	<i>Other Practitioner Services - Regular Payments</i>		023, 030, 031, 078	<i>Nurse Practitioner, Podiatrist, Optometrist, LCSW</i>
	50%	64.9	10	Clinic Services		051, 093	Health Dept Clinic, Out of State Clinic
	50%	64.9	16	Rural Health		052	Rural Health Clinics
	50%	64.9	28	FQHC		053	FQHCs
Outpatient diagnostic & radiology, outpatient laboratory	50%	64.9	11	Laboratory/ Radiological		070, 098, 001, 091	Independent Laboratory, Out of State Laboratory, Hospital in-state General, Out of State Hospital,
Outpatient pharmacy	50%	64.9	7	Prescribed Drugs		060, 096	Pharmacy, Out of State Pharmacy
Outpatient medical equipment and supplies	50%	64.9	49	Other Care Services		062, 090	Durable Medical Equipment/Supplies, Out of State Supply/Equipment

ATTACHMENT C INFORMAL NETWORK OF BENEFITS

Preferred Pathways – Network of Care Not Covered through GAP Demonstration

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

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

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

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

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

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

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

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

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

**ATTACHMENT D
DEMONSTRATION EVALUTION PLAN**