Ms. Victoria Wachino
Deputy Administrator and Director
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Wachino,

Enclosed please find West Virginia's formal Medicaid section 1115 waiver application to create a continuum of care for Medicaid enrollees with substance use disorder (SUD) issues. This application is the result of collaboration between the West Virginia Bureau for Medical Services (BMS), the Bureau for Behavioral Health and Health Facilities (BBHHF), a wide range of stakeholders, and your staff at the Centers for Medicare & Medicaid Services (CMS).

West Virginia is facing a public health crisis that needs to be addressed in order to improve the well-being of our residents and the overall economic health of the state. West Virginia has the highest rate of drug overdose deaths in the country, more than double the national average.

Nearly every person in West Virginia knows someone who is suffering from a substance use issue. Preventing and treating SUDs is a high priority for Governor Earl Ray Tomblin, the state legislature and Department of Health and Human Resources Secretary Karen Bowling. Our state has a number of initiatives underway to fight this epidemic and this Medicaid 1115 waiver application is a critical component of that comprehensive effort.

We appreciate the support that your staff has already provided and we look forward to working closely with them to create a strong SUD continuum of care for West Virginia Medicaid enrollees.

Thank you for your consideration.

Sincerely,

[redacted]

Cynthia Beane
Acting Commissioner
Bureau for Medical Services
West Virginia Department of Health and Human Resources

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WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

West Virginia
Medicaid Section 1115 Waiver Application:

Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders

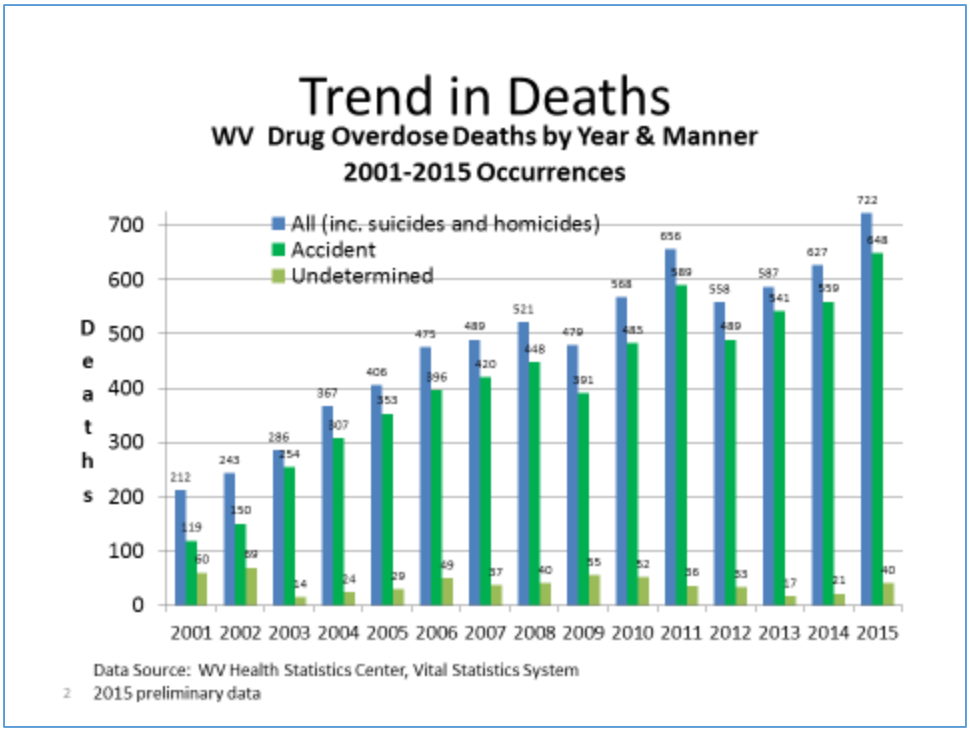
November 22, 2016

Table of Contents

1 West Virginia Substance Use Disorder Delivery System

West Virginia is facing a public health crisis that needs to be addressed in order to improve the well-being of its residents and the economic health of the state. West Virginia has the highest rate of drug overdose deaths in the country (39.5 deaths per 100,000 residents),[1] more than double the national average. Between 2012 and 2015, the death count increased by nearly 31%, from 558 to 722 (Figure 1). Additionally, 31 of every 1,000 births in the state involve a baby born with Neonatal Abstinence Syndrome (NAS) resulting from substance abuse among pregnant women.[2]

Figure 1. WV Drug Overdose Trend



[1] West Virginia Health Statistics Center. Available at: http://www.wvdhhr.org/bph/hsc/.
[2] Centers for Disease Control and Prevention, "Incidence of Neonatal Abstinence Syndrome, 28 States, 1999-2013", August 12, 2016. Available at http://www.cdc.gov/mmwr/volumes/65/wr/mm6531a2.htm?s_cid=mm6531a2_w.

In August 2015, the state's unemployment rate was the highest in the nation at 7.5 percent, despite the national economic recovery in recent years.[3] West Virginia's annual average per capita income was only $28,555 in 2014, with nearly 15% of the population living in poverty.[4] The combination of these socio-economic factors and the prevalence of substance use in the state creates both an acute challenge and a significant opportunity for the Medicaid program, which covers more than one-third of West Virginia's population at some point during the year. West Virginia is submitting this Medicaid Section 1115 waiver application to develop a comprehensive and cohesive continuum of care for individuals with substance use disorder (SUD) issues.

Current Delivery System

West Virginia is one of the 32 states that have adopted the Medicaid expansion under the Affordable Care Act, with nearly 220,000 additional residents enrolled in Medicaid since October 2013.[5] The West Virginia Medicaid program currently provides health coverage to more than 660,000 residents on an annual basis[6] with nearly 70% of members served through the state's managed care delivery system. By the end of calendar year 2016, approximately 80% of Medicaid beneficiaries are expected to have completed the transition from fee-for-service to managed care. The only populations who will remain in fee-for-service Medicaid are individuals receiving long-term care services and supports, home and community-based waiver services, dual eligibles, and foster care children. West Virginia plans to extend managed care to additional populations over the next five years.

In July 2015, West Virginia incorporated behavioral health services into managed care in order to improve the integration of physical and behavioral health. West Virginia recognizes the importance of having an integrated service delivery system and is dedicated to transitioning populations with the highest need for behavioral and mental health services into a managed care model.

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[3] "WV Reports Highest Unemployment Rate in the Nation at 7.5%," The State Sun Journal, August 2015. Available at:http://www.statejournal.com/story/29852205/wv-reports-highest-unemployment-rate-in-the-nation-at-75-percent.
[4] United States Census. Available at: http://www.census.gov/quickfacts/table/PST045215/00.
[5] Centers for Medicare & Medicaid Services, Medicaid and CHIP Eligibility and Enrollment Report, June 2016. Available at https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/june-2016-enrollment-report.pdf.
[6] West Virginia MARS450A Report.

Infrastructure and Delivery System

The Bureau for Medical Services (BMS) is the state agency that administers the Medicaid program in West Virginia. The Bureau for Behavioral Health and Health Facilities (BBHHF) is the federally-designated State Authority for mental health and substance abuse. It also provides funding for community-based behavioral health services for individuals with behavioral health needs, including those who are either uninsured or underinsured. The two Bureaus, which are under the Department of Health and Human Resources (DHHR), work closely together to deliver SUD services to Medicaid beneficiaries, as well as to the uninsured.

West Virginia has four participating Medicaid managed care plans in operation: Coventry Health Care of West Virginia (Aetna), Unicare (Well Point), West Virginia Family Health, and the Health Plan of the Upper Ohio. During State Fiscal Year (SFY) 2017, the state will add an additional managed care organization (MCO), CareSource. Table 1 provides the enrollment distribution of Medicaid beneficiaries across MCOs in West Virginia.[7]

Table 1: West Virginia Medicaid Managed Care Plan Enrollment

Managed Care Plan	Medicaid Enrollment (July 2016)
Coventry Health Care of West Virginia	123,656
Unicare	132,066
West Virginia Family Health	61,392
Health Plan of the Upper Ohio	72,947
Total	**390,061**

West Virginia's publicly-funded, community-based behavioral health system is anchored by 13 regionally-based Comprehensive Behavioral Health Centers (CBHCs) which operate full-service and/or satellite offices in each of the counties located in the center's catchment area. There are 97 Licensed Behavioral Health Centers that have the ability to provide the same array of services that the CBHCs provide. Federally Qualified Health Centers (FQHCs) also play a major

[7] West Virginia Bureau for Medical Services. Managed Care Enrollment, July 2016.

role in providing SUD services – approximately half of the state's FQHCs across 108 sites employ a behavioral health provider. However, the option to employ a behavioral health provider is open to all FQHCs. There are nine licensed social work (LICSW) practices, 164 psychiatric practices, and 219 psychological practices that provide assessments, testing, individual, group, family and crisis therapy to West Virginia Medicaid members across the state. Five of the state's largest CBHCs provide coordinated primary health care services in a community mental health setting and share behavioral health staff with rural primary care centers through co-location and integration agreements.

Current SUD Initiatives and Services

In September 2011, Governor Tomblin established the Governor's Advisory Council on Substance Abuse (GACSA) and six regional task forces to combat the substance use crisis. The GACSA is composed of cabinet-level positions across the West Virginia Departments, behavioral health experts and community leaders. The regional task forces make recommendations to the GACSA, which in turn makes recommendations to the Governor. These groups are charged with providing guidance on implementation of the Comprehensive Statewide Substance Abuse Strategic Action Plan. The GACSA also recommended priorities for improving the statewide substance use continuum of care, identifying planning opportunities with inerrelated systems and providing recommendations to the Governor on enhancing substance use education; collecting, sharing and utilizing data; and supporting policy and legislative action.

The Comprehensive Statewide Substance Abuse Strategic Action Plan includes the following overarching strategic goals for prevention, early intervention, treatment and recovery:

- **Assessment and Planning:** Implement an integrated approach for the collection, analysis, interpretation and use of data to inform planning, allocation and monitoring of the substance use service delivery system.
- **Capacity:** Promote and maintain a competent and diverse workforce specializing in prevention, early identification, treatment and recovery of SUDs and promotion of mental health.
- **Implementation:** Increase access to effective substance use prevention, early identification, treatment and recovery management that is high quality and person-centered.
- **Sustainability:** Manage resources effectively by promoting further development of the substance use service delivery system.

The Governor's Advisory Council and the Regional Task Forces meet regularly and in December 2015 put forth the following recommendations:

- **Statewide Implementation:** Increase public education and outreach regarding the disease of addiction, improve access to appropriate treatment and the multiple pathways to recovery, increase the dissemination and education of naloxone (Narcan®), improve access to licensed medication assisted treatment (MAT) centers and waivered physicians and expand school-based behavioral health services.

- **Regional Capacity:** In order to fill some of the identified service delivery gaps, the Council is working to promote SUD treatment capacity by region across the state and to develop an infrastructure for recovery housing.

- **Legislative and Policy:** Develop and support the "Second Chance for Employment Act" legislation to help remove barriers to obtaining employment, assess an Alcohol and Tobacco User Fee with a percentage set aside for SUD services, review the Certificate of Need process for behavioral health services to recommend ways to reduce barriers for new and existing program expansions, shifting Benzodiazepines from Schedule 4 to Schedule 3, and increasing usage of and accountability measures for the Prescription Drug Monitoring Program (PDMP).

  The West Virginia legislature recently passed SB 454[8] which licenses and regulates MAT programs for SUDs. Over the past five years, West Virginia has implemented several pieces of legislation (including West Virginia Senate Bills 335[9], 437,[10] and 523[11]) to address prescription drug abuse and opioid overuse. Senate Bill 437, passed on March 10, 2012, takes a comprehensive approach to address prescription drug diversion and substance use issues. The law increases regulation of opioid treatment centers, establishes licensing and regulation of chronic pain clinics, and creates mechanisms to

[8] Senate Bill 454. Available at: http://www.legis.state.wv.us/Bill_Status/bills_history.cfm?INPUT=454&year=2016&sessiontype=RS
[9] Senate Bill 335. Available at: http://www.legis.state.wv.us/Bill_Text_HTML/2015_SESSIONS/RS/bills/SB335%20SUB1%20ENR2.pdf.
[10] Senate Bill 437. Available at: http://www.legis.state.wv.us/Bill_Status/bills_text.cfm?billdoc=sb437%20sub3%20enr.htm&yr=2012&sesstype=RS&billtype=B&houseorig=S&i=437.
[11] Senate Bill 523. Available at: http://www.legis.state.wv.us/Bill_Status/bills_text.cfm?billdoc=SB523%20SUB1%20enr.htm&yr=2015&sesstype=RS&billtype=B&houseorig=S&i=523.

flag abnormal or unusual usage patterns of controlled substances by patients and unusual prescribing or dispensing patterns by licensed practitioners. It also implements requirements for continued education for physicians and others who administer controlled substances and establishes a system for tracking sales of pseudoephedrine, limiting the amount that can be legally purchased daily (3.6g), monthly (7.3g), and annually (48g).[12]

Existing SUD Services

As illustrated in Table 2, BMS currently provides a range of SUD services under Medicaid, and BBHHF funds SUD services and programs targeted to specific populations through federal grants and charity care programs. These services include: professional and supportive therapies, assessments, testing services, service planning, case consultation, targeted case management, non-methadone medication assisted treatment, intensive service programs, and crisis stabilization programs.

Thirteen CBHCs are required to offer a full continuum of publically-provided Behavioral Health Services. Outpatient Services currently include: Assessments; Individual, Group and Family Therapy; and Medication Management, and Crisis services. Residential Treatment Facilities are limited and prioritized for intravenous (IV) drug users, pregnant women, transition-aged youth, and individuals transitioning from a higher level of care. These facilities currently provide clinically-managed, high-intensity services that feature a planned regimen of care in a safe, structured, and stable environment. Residential programming is gender-specific, trauma-informed, and in coordination with day habilitation, rehabilitation and peer supports.

With regard to Medication Assisted Treatment, there are currently 187 physicians who are waivered to prescribe buprenorphine. Medicaid provides coverage for buprenorphine, mono-buprenorphine, and vivitrol. There are currently 165 physicians that are licensed under Medicaid to provide these services. West Virginia has nine methadone outpatient clinics. There is currently a moratorium on the addition of any new methadone clinics. At this time, private physicians cannot prescribe methadone for the treatment of substance use.[13]

[12] "West Virginia Legislature Enacts Comprehensive Substance Abuse Laws," Health Law Monitor, 2012. Available at: http://healthlawmonitor.jacksonkelly.com/2012/04/west-virginia-legislature-enacts-comprehensive-substance-abuse-laws.html.
[13] 15-2d-9 West Virginia State Code.

"Opioid treatment program" means all publicly or privately owned medication-assisted treatment programs in clinics, facilities, offices or programs that treat individuals with substance use disorders through on-site administration or dispensing of a medication-assisted treatment medication in the form of an opioid agonist or partial opioid agonist.[14] "Pain management clinics" are all privately owned pain management clinics, facilities, or offices not otherwise exempted, which meet the criteria established in Section 3 of the DHHR Chronic Pain Management Clinic Licensure legislative rule.[15]

The BBHHF has worked with BMS and the Office of Health Facility Licensure and Certification (OHFLC) to develop an Opioid Treatment Center Oversight Committee to review: (1) clinic policies/procedures; (2) implementation of revised quarterly reports for the Health and Human Services Legislative Committee; (3) licensure reports; and (4) exception requests for take home doses.

The Opioid Treatment Center Oversight Committee also developed a waiver process to permit hiring individuals with felony convictions. The administrative rules governing Opioid Treatment Centers were revised in 2010 based on recommendations from BBHHF. The revised rules hold Opioid Treatment Centers more accountable for the services they provide, particularly clinical and recovery-based services. Since the implementation of the rules, 14 pain management initial licensure surveys have been completed, five applications pending survey, five licensed clinics, and 18 pain clinics have closed.

Since the passage of Senate Bill 437 in 2010, more physicians are accessing the Controlled Substance Monitoring Program database at patient intake before administering, prescribing or distributing prescriptions, and physicians receive required continuing education on best prescribing practices. Pharmacists have also received education on dispensing prescription buprenorphine and electronically-submitting certain information to the Multi-State Real-Time Tracking System (MSRTTS) administered by the National Association of Drug Diversion Investigators (NADDI).

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[14] 16-5Y-2 West Virginia State Code.
[15] Notice of Final Filing and Adoption of a Legislative Rule Authorized by the West Virginia Legislature. Title 69 Legislative Rule: Department of Health and Human Resources, Series 8: Chronic Pain Management Clinic Licensure. Available at: http://apps.sos.wv.gov/adlaw/csr/readfile.aspx?DocId=27469&Format=PDF.

Substance Use Prevention and Treatment Block Grant Services[16]

The Substance Use Prevention and Treatment (SAPT) Block Grant is a major source of funding in West Virginia, allocating $6.5 million for substance abuse prevention, early intervention, treatment, and recovery services in FY 2016/2017. BBHHF provides funding support for a continuum of treatment options, including outpatient and intensive services, and short and long-term residential treatment that are not otherwise covered by Medicaid, Medicare, or private insurance. Block grant funds provide for community-based recovery support services that include expanding best practices in peer supports. BBHHF has trained over 200 recovery coaches statewide in every region (with 29 certified as trainers) and has expanded recovery residences that provide focused short and long-term housing access for people who need safe and supportive housing to live drug and/or alcohol free.

Recovery Services

The number of Peer-Operated Recovery Homes and Facilities has increased, providing safe housing for individuals age 18 and older who are recovering from substance use and/or co-occurring substance use and mental health disorders. These facilities house individuals for up to twelve months. Residents are encouraged to participate in outpatient and intensive services provided off-site so that Medicaid may pay for Medicaid reimbursable services that do not occur at the facility. Service areas provided by the facility include prevention, health promotion and wellness, and recovery support services.

One of the key components of this system is the availability of Recovery Residences. Services provided in these residences include, but are not limited to: drug screening, house/resident meetings, mutual aid/self-help meetings, discussion of structured house/resident rules, peer-run groups, life skill development emphasis, and clinical treatment services in the community. Staff positions include Facility Managers, Certified Peer Coaches, Case Managers, and other Certified Peer support staff. The resident capacity ranges from six to eight for home settings to 60 – 100 beds for recovery housing. All grantees abide by National Association of Recovery Residence Standards. In 2010, there were no funded Recovery Coaches. Through BBHHF's

[16] West Virginia FY 2016-2017 State Behavioral Health Assessment and Plan Block Grant Application. Available at: http://www.dhhr.wv.gov/bhhf/newsandevents/Documents/2016%202017%20Combined%20MHSA%20Block%20Grant%20Application1.pdf.

capacity development efforts, West Virginia now has a total of 251 Recovery Coaches trained and available in all regions of the state.

Transportation for Substance Use Services

MTM has been awarded a contract to be the state of West Virginia's non-emergency medical transportation (NEMT) transportation broker. The organization provides rides, free of charge, for eligible Medicaid members throughout the state for covered medical services. The state put the program in place to alleviate transportation barriers to treatment in a rural state.

Health Homes

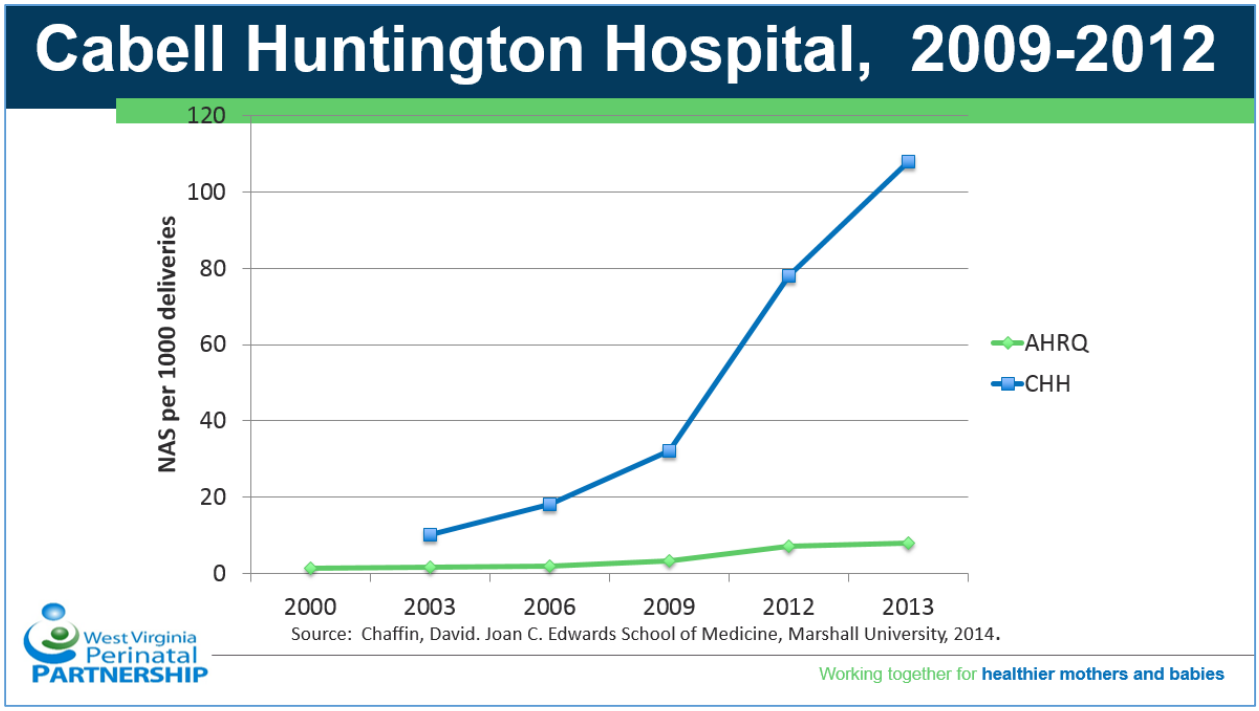
West Virginia has also implemented a Medicaid Health Homes initiative in six counties for individuals who have a bipolar disorder and have, or are at risk of having, Hepatitis B or C. Health Homes provide a place for individuals to have their health care needs identified and to receive the medical, behavioral health, and related social services and supports they need in a coordinated manner. Services include comprehensive care management, care coordination, health promotion, and community and social supports. There are seven organizations enrolled as Health Home providers. As of June 30, 2016, 681 individuals were enrolled in a Medicaid Health Home. Since launching in July 2014, nearly 1,500 individuals have participated in the Health Home program.[17]

Addressing Neonatal Abstinence Syndrome

Another population that West Virginia has been focusing on are mothers with addiction whose babies are born substance-exposed. According to data from the state Health Care Authority from the Hospital Discharge Data Set, 637 babies were born with Neonatal Abstinence Syndrome (NAS) in 2014. The state currently has an NAS rate of 31 per 1,000 births (approximately 3%).[18] At 11%, Cabell County had the highest rate of babies born with NAS (Figure 2). Of all of the NAS births in West Virginia, 86.5% (551) were born to Medicaid mothers.[19]

[17] West Virginia DHHR Health Homes Data, July 2016.
[18] Ko, Jean et al., Centers for Disease Control and Prevention, "Incidence of Neonatal Abstinence Syndrome, 28 States, 1999-2013," August 12, 2016. Available at http://www.cdc.gov/mmwr/volumes/65/wr/mm6531a2.htm?s_cid=mm6531a2_w.
[19] West Virginia Perinatal Partnership, 2014 Uniform Billing Data.

Figure 2. Cabell Hunting Hospital NAS Rates, 2009-2012



DHHR is currently working with the West Virginia Perinatal Partnership on an NAS prevention and education project and for the last year has focused on reaching consensus on how to improve data quality. Acknowledging that the data currently collected on NAS is undercoded, the Partnership is working with the provider community on how to properly code babies with NAS so the state's statistics can more accurately reflect this epidemic and inform the development of a project plan to help reduce NAS births.

West Virginia established its first residential infant recovery center, Lily's Place, which provides short-term medical care for infants suffering from prenatal drug exposure and offers non-judgmental support, education and counseling to families. In August 2016, BMS released a State Plan Amendment (SPA) for public comment that establishes requirements, standards and a payment methodology to enable the state to use pediatric residential treatment nursing facilities to provide specialized care and treatment for infants born with NAS.[20] The changes

[20] Pediatric Residential Treatment Nursing Facilities State Plan Amendment. Posted for public comment on August 12, 2016. Available at: http://www.dhhr.wv.gov/bms/Public%20Notices/Pages/Pediatric-

proposed under this SPA will contribute to building the comprehensive continuum of care. West Virginia will use the Medicaid section 1115 waiver as an opportunity to augment its efforts in this area.

2 Transforming the Substance Use Disorder Delivery System

Building on the foundation of both legislative and operational efforts to combat substance use in West Virginia, this proposed Medicaid section 1115 waiver will permit the state to increase the availability of SUD prevention and treatment services for all Medicaid enrollees and create a continuum of care that will improve overall health and health outcomes, while simultaneously promoting economic stability across the state. Reducing the number of West Virginia residents that are substance users will broaden the employment pool and hopefully generate economic advancement. Given that managed care plans are already responsible for providing the full continuum of care to meet the physical and behavioral health needs of most beneficiaries, this waiver presents a tremendous opportunity to improve care for enrollees with chronic conditions. This integration will also move West Virginia toward value-based purchasing for both physical and behavioral health services. The waiver will also provide SUD services to beneficiaries receiving Medicaid through the fee-for-service delivery system, including individuals receiving long-term care services and supports, home and community-based waiver services, dual eligibles, and foster care children. Upon approval, the state plans to have a six-month planning period, with a tentative date for the initial launch of the waiver in July 2017. The state's goal is to have all MCOs achieve certification for network adequacy by January 2018 and to fully launch the waiver program at that time.

2.1 Waiver Goals and Objectives

The overall goal of this waiver is to create a continuum of care that will enable the state to effectively prevent and treat SUDs in West Virginia. West Virginia seeks to increase standardization of SUD assessment and treatment to ensure that the right care is provided to individuals at the right time, and in the right setting. West Virginia's specific objectives for this comprehensive waiver are outlined below.

Residential-Treatment-Nursing-Facilities-State-Plan-Amendment-Available-for-Public-Comment-Until-September-16,-20.aspx.

Objective 1: Improve quality of care and population health outcomes for Medicaid enrollees with SUD issues.

- Reduce overdose deaths by 2021.
- Decrease the number of active substance abusers among West Virginia residents.

Objective 2: Increase enrollee access to, and utilization of, appropriate SUD treatment services based on American Society of Addiction Medicine (ASAM) criteria.

- Increase the availability of community-based and outpatient SUD treatment services.
- Make residential treatment opportunities available to Medicaid beneficiaries, as appropriate.
- Build on MAT, including adding access to Methadone as a treatment strategy.
- Widely distribute naloxone (Narcan®).

Objective 3: Decrease utilization of high-cost emergency department and hospital services by enrollees with a SUD.

- Decrease emergency department visits, inpatient admissions, and readmissions to the same level of care or higher for a primary SUD diagnosis.
- Leverage prevention strategies and design and implement a public awareness campaign around naloxone (Narcan®) in order to prevent and reverse overdoses.
- Provide recovery support services designed to promote and sustain recovery.

Objective 4: Improve care coordination and care transitions for Medicaid enrollees with SUD issues.

- Improve the coordination of SUD treatment with other behavioral and physical health services.
- Improve care transitions to outpatient care, including hand-offs between different levels of care within the SUD care continuum and linkages with primary care upon discharge.

Eligibility

This comprehensive and coordinated set of SUD services and supports will be available to all Medicaid enrollees in West Virginia.

All enrollees under the age of 21 receive the services available under Early Periodic Screening, Diagnostic and Treatment (EPSDT), which includes appropriate services needed to address behavioral health issues. The state will ensure that any SUD-related services provided to individuals under age 21 also meet the ASAM criteria.

Individuals who are not eligible for Medicaid may still receive the same services listed in Chapter 503, but would receive them through the Charity Care funding made available through BHHF, which funds the 13 CBHCs to render services to these individuals.

Delivery System

For the majority of West Virginia Medicaid beneficiaries who are enrolled in a MCO, the health plans will be responsible for contracting with providers to deliver the SUD services, conducting provider recruitment and credentialing, and working with the state to ensure network adequacy. The MCOs will receive a financial incentive in the form of increased capitation rates for facilitating this effort, as well as additional incentives for providing high-quality care and meeting required reporting and performance metrics. Since MCOs will be responsible for integrating physical health and behavioral health, this waiver presents a tremendous opportunity to improve the health of beneficiaries with chronic conditions.

The state anticipates that a small number of individuals who are not enrolled in a managed care plan who will need SUD services, including individuals receiving long-term services and supports and home and community-based services, dual eligibles and foster care youth. These beneficiaries will have access to services to treat SUD issues and promote long-term recovery through the fee-for-service delivery system.

Continuum of Care

The waiver will provide a critical vehicle for enhancing the scope of SUD services that are available to Medicaid beneficiaries in West Virginia, including coverage of SUD services provided in residential treatment settings, coupled with an enhancement of inpatient and outpatient SUD services and MAT. West Virginia proposes to add Medicaid coverage of methadone and to design and implement an initiative that will make naloxone (Narcan®) widely available and increase awareness of it across the state. Under the waiver, West Virginia proposes to enhance the availability of detoxification, withdrawal management and MAT in regionally identified settings that BMS will develop, add a comprehensive set of peer-recovery support strategies and coverage of recovery housing supports that will help promote successful transitions and promote long-term recovery.

One of the key goals of the waiver is to ensure that individuals have access to the approach to achieving recovery that is most appropriate based on their circumstances. Building on the delivery system integration efforts that are already underway, and working to establish a seamless continuum of care, will enable West Virginia to move toward value-based purchasing

for SUD services and facilitate meeting the goals of the Triple Aim of improved quality of care, improved population health and decreased costs.

2.2 Comprehensive Evidence-Based Benefit Design

West Virginia has designed a comprehensive set of SUD prevention and treatment benefits that, when combined with the existing foundation of Medicaid and BBHHF-funded behavioral health services, will provide a full continuum of care. Table 2 provides a complete listing of current and proposed Medicaid benefits. These services will be provided to beneficiaries with no cost sharing requirements. The key expansions in Medicaid coverage designed to support and augment West Virginia's continuum of care include:

- **The Screening, Brief Intervention, and Referral to Treatment (SBIRT)** method will be adopted across the state to ensure a consistent and effective enrollment process for the waiver.
- Expanded **coverage of withdrawal management** in regionally identified settings.
- **Short term, residential substance abuse treatment** for all Medicaid enrollees.
- **Enhanced access to outpatient SUD treatment** as appropriate when residential treatment is not required.
- Coverage of **methadone and methadone administration** as part of the state's Opioid Treatment Services.
- Comprehensive initiative for **distributing naloxone (Narcan®) and cross-training staff on administration of naloxone** as part of the effort to reduce overdose deaths.
- Coverage of a set of **clinical and peer recovery support services and recovery housing supports** designed to promote and sustain long-term recovery.

Medical Necessity Criteria[21]

In order to receive SUD services under the waiver, individuals must be enrolled in the West Virginia Medicaid program and have a SUD diagnosis. The medical necessity criteria for SUD services will include an assessment of:

- Diagnosis (as determined by a physician or licensed psychologist)
- Level of functioning
- Evidence of clinical stability
- Available support system

[21] West Virginia BMS Provider Manual, Chapter 503-Behavioral Health Clinic Services. Available at: http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20503%20Behavorial%20Health%20Rehab%20Services/Chapter_503_Behavioral_Health_Rehabilitation_Services.pdf.

- Service is the appropriate level of care

Services must be:

- Appropriate and medically necessary for the symptoms, diagnosis, or treatment of an illness
- Provided for the diagnosis or direct care of an illness
- Within the standards of good practice
- Not primarily for the convenience of the plan member or provider
- The most appropriate level of care that can be safely provided.

2.3 Appropriate Standards of Care

The proposed continuum of care for SUD services is modeled after the levels of care identified in ASAM. BMS will require that all providers of SUD services meet ASAM criteria prior to participating in the Medicaid waiver. BMS will work with the MCOs and providers to ensure that licensing, credentialing and training requirements align with ASAM criteria. Through revisions to its health plan contract requirements, Medicaid state plan, state regulations, and provider manuals, West Virginia will work with MCOs and providers to establish standards of care for SUD services that incorporate industry standard benchmarks for covered services and provider qualifications.

All of the ASAM levels of care and the other services outlined in Table 2 will be provided to Medicaid enrollees. In order to show the full landscape of services that West Virginia will make available to combat SUDs, this table includes both ASAM levels of care that are currently being provided under Medicaid and the levels of care that will be provided under the waiver.

Table 2: West Virginia Services by ASAM Level of Care

ASAM Level of Care	ASAM Service Title	ASAM Brief Definition	Is this an existing Medicaid service?	Is this a new Medicaid service under the Waiver?	What Medicaid Authority is needed for new services?
0.5	Early Intervention	Screening, Brief Intervention, and Referral to Treatment (SBIRT).	No	Yes	§440.130
1.0	Outpatient Services	Less than nine hours of service/week (adults); less than six hours/week (adolescents) for recovery or motivational enhancement therapies/strategies.	Yes	No	§440.130, §440.50, §440.60, §440.90
2.1	Intensive Outpatient Services	Nine or more hours of service/week (adults); six or more hours/week (adolescents) to treat multidimensional instability.	Yes	No	§440.130
2.5	Partial Hospitalization Services	20 or more hours of service/week for multidimensional instability not requiring 24-hour care.	Yes	No	§440.130
3.1	Clinically Managed Low-Intensity Residential Services	24-hour structure with available trained personnel; at least five hours of clinical service/week and prepare for outpatient treatment.	No	Yes	§435.1010 and 1115(a)(2)
3.3	Clinically Managed Population-Specific High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.	No	Yes	435.1010 and 1115(a)(2)

ASAM Level of Care	ASAM Service Title	ASAM Brief Definition	Is this an existing Medicaid service?	Is this a new Medicaid service under the Waiver?	What Medicaid Authority is needed for new services?
3.5	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full milieu or therapeutic community.	No	Yes	§435.1010 and 1115(a)(2)
3.7	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. 16 hour per day counselor availability.	Yes (covers ages 18-21 and over 64)	No	§430.1010 and 1115(a)(2)
OTS	Opioid Treatment Services	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder. West Virginia is currently OBOT and OTP.	Yes	No (West Virginia will add coverage of methadone)	§440.50, §440.60, §440.90
1-WM	Ambulatory Withdrawal Management Without Extended On-site Monitoring	Mild withdrawal with daily or less than daily outpatient supervision.	Yes	No	§440.130, §440.50, §440.60, §440.90
2-WM	Ambulatory Withdrawal Management with Extended On-site Monitoring	Moderate withdrawal with all day withdrawal management/support and supervision; at night has supportive family or living situation.	Yes	No	§440.130, §440.50, §440.60, §440.90
3.2-WM	Clinically Managed Residential Withdrawal	Moderate withdrawal, but needs 24-hour support to complete withdrawal	No	Yes	§440.130, §440.50, §440.60,

ASAM Level of Care	ASAM Service Title	ASAM Brief Definition	Is this an existing Medicaid service?	Is this a new Medicaid service under the Waiver?	What Medicaid Authority is needed for new services?
	Management	management and increase likelihood of continuing treatment or recovery.			§440.90
3.7-WM	Medically Monitored Inpatient Withdrawal Management	Severe withdrawal, 24-hour nursing care and physician visits; unlikely to complete withdrawal management without medical monitoring.	Yes (for certain ages)	No	§440.130, §440.50, §440.60, §440.90
Other	Targeted Case Management	Services to assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.	Yes	No	§440.169
Other (ASAM Dimension 6 – Recovery / Living Environment)	Recovery Support Services	Services to support the beneficiary's recovery and wellness after completing their course of treatment, whether they are triggered, have relapsed, or as a preventative measure to prevent relapse.	No	Yes	§440.130
Other (ASAM Dimension 6 – Recovery / Living Environment)	Recovery Housing	Recovery environment that encompasses the external supports for recovery.	No	Yes	§440.130

Description of Current SUD Services

West Virginia will leverage the waiver opportunity to further establish and provide a continuum of care for Medicaid enrollees with SUD issues. Below are descriptions of the SUD services currently provided to Medicaid enrollees. West Virginia is in the process of reviewing each of these SUD services and making the necessary changes to ensure that they align with the ASAM criteria.

SBIRT: As noted above, SBIRT will be broadly implemented as part of the eligibility assessment for SUD waiver services. SBIRT is already in practice through BBHHF programs, and so is generally known and understood among the SUD provider community. West Virginia has also worked to extend the use of SBIRT through its Health Homes initiative. West Virginia will leverage an existing Advisory Committee of key stakeholders to provide strategic direction for integrating SBIRT into the current system of care.

Additionally, West Virginia has a comprehensive Safety and Treatment Program for people whose licenses have been revoked for driving a motor vehicle under the influence of alcohol, controlled substances and/or drugs. These efforts include both an in-state and out-of-state component. In state, DHHR is responsible for educating service providers on program developments, including any legislative decisions that would impact the program. During 2015, DHHR closed 1,218 cases for out-of-state offenders.

Outpatient Services: Medicaid currently provides extensive outpatient SUD services, including: professional and supportive individual and group behavioral health counseling, crisis psychotherapy, family therapy, case consultation crisis intervention services screening by licensed psychologists, prescription drugs, medication assisted treatment with buprenorphine, vivitrol and medications used to treat alcohol dependence. The state also provides lab, radiology, and other diagnostic services rendered in hospital outpatient departments and emergency departments, observation services, and partial hospitalization. Providers such as Licensed Clinical Social Workers, Licensed Independent Social Workers, Licensed Independent Clinical Social Workers, Licensed Professional Counselors, Advance Practice Registered Nurses, and Nurse Practitioners may provide some SUD services under the supervision of a physician. These services will continue to be provided under the Medicaid state plan and in support of the continuum of care under the waiver.

Under the waiver, West Virginia will create quarterly performance-based incentives to encourage health plans to expand outpatient services for certain target populations in specified

geographic areas.

Intensive Outpatient Services: Medicaid currently provides individual and group counseling, community psychiatric supportive treatment, case consultation, family therapy, comprehensive medication services, crisis intervention services, mental health service planning, community psychiatric supportive treatment, and assertive community treatment. These Medicaid services will continue to be provided under the state plan.

Partial Hospitalization Services: Medicaid currently provides a four-hour day or evening structured program. This program includes skill-building instruction and supervision designed to assist individuals in achieving greater independence and/or employment in activities of daily living, in accordance with the individual's needs and interests. BMS also provides a short-term intensive program for individuals whose needs can be met through an intensive outpatient program consisting of six to ten hours of group therapy per week, delivered in two hours of group therapy sessions per day. Some prior authorization rules apply. These Medicaid services will continue to be provided in support of the continuum of care established through the waiver.

Clinically Managed Low-Intensity Residential Services: Medicaid currently provides services to children ages 6 – 21 for initial assessments and treatment. BBHHF currently supports the room, board, and supervision for several short-term residential treatment facilities. BMS provides funding for Medicaid members for the treatment components that occur onsite. BBHHF provides funding for treatment services for non-Medicaid eligible individuals who meet income guidelines. All individuals who meet admission criteria are eligible for services and there are currently five facilities in West Virginia that provide ASAM level 3.1 services. Under the waiver, BMS proposes to identify and add regionally-based coverage of residential treatment for adult Medicaid managed care enrollees. The broader availability of Medicaid support for residential treatment will play a critical role in strengthening the continuum of care for SUDs. BMS will ensure that individuals are assigned to the appropriate level of care based on ASAM placement criteria.

Clinically Managed Population-Specific High-Intensity Residential Services: Medicaid currently provides services for initial assessments and treatment. Under the waiver, West Virginia proposes to expand coverage of residential treatment to adult Medicaid managed care enrollees. The broader availability of Medicaid support for residential treatment will play a critical role in strengthening the continuum of care for SUDs. The waiver will also support the state's efforts to recruit additional facilities to provide the ASAM Level 3.3 services to individuals who are cognitively impaired. BMS will ensure that individuals are assigned to the appropriate level of care based on ASAM criteria.

Clinically Managed High-Intensity Residential Services: The broader availability of Medicaid support for residential treatment will play a critical role in strengthening the continuum of care for SUDs. BMS provides funding for Medicaid members for the treatment components that occur onsite. BBHHF currently supports the room, board, and supervision for several long-term residential treatment facilities for pregnant/post-partum women with their children and transitioning youth. BBHHF also provides funding for treatment services for non-Medicaid eligible individuals who meet income guidelines. All individuals who meet admission criteria will be eligible for services.

Medically Monitored Intensive Inpatient Services: Medicaid currently provides inpatient psychiatric residential treatment (PRTF) services for children under age 21. Under the waiver, West Virginia proposes to expand coverage of residential treatment to adult Medicaid managed care enrollees. West Virginia will also augment the availability of detoxification and withdrawal monitoring services that are currently being provided on hospital observation floors. One hospital in West Virginia currently provides these services and the state will work with the MCOs to recruit additional facilities to provide detoxification and withdrawal management services.

Opioid Treatment Services: Medicaid provides general services to assist enrollees in accessing behavioral health medication and medication services. Medicaid covers non-methadone MAT services for individuals seeking opioid addiction treatment for buprenorphine/naloxone (i.e. Suboxone®, Zubsolv®, and Bunavail®, etc.), mono-buprenorphine (formerly known as Subutex®), or depo-naltrexone (Vivitrol®) within specified phases and guidelines. Under the waiver, West Virginia will add Medicaid coverage of methadone and methadone administration as part of its Opioid Treatment Program.

In addition, West Virginia will develop and implement a comprehensive initiative for distributing naloxone (Narcan®) and cross-training staff on the administration of the drug as part of its efforts to reduce overdose deaths across the state. Possible strategies for distribution include making naloxone available for pick-up at local health departments and/or county DHHR offices and ensuring that all community facilities (including licensed behavioral health centers and private practitioners) have adequate supplies of the drug and are trained to administer it. West Virginia will also build on existing efforts that local social service organizations and law enforcement have been undertaking due to recently passed West Virginia legislation to support the distribution of naloxone (Narcan®).

Withdrawal Management: Medicaid currently provides withdrawal management and detoxification as a Medicaid outpatient service in approximately eight crisis stabilization units across the state. Under the waiver, West Virginia will ensure that these services are integrated

into the larger system of care and BMS will pursue additional regionally identified providers to make these services available. For example, now that residential treatment will be available under Medicaid, West Virginia will be able to provide withdrawal management services in residential settings as part of the course of treatment.

Targeted Case Management (TCM): Targeted case management services will continue to be in place under the Medicaid state plan and will provide a critical element of the care transition planning process for many beneficiaries. The state recently implemented changes to the eligibility criteria for TCM that permit case management services to be incorporated into the transition planning process as Medicaid beneficiaries move from residential settings back into the community, and also through outpatient care transitions. Under the waiver, targeted case managers will engage with individuals ten days prior to discharge to create a care coordination plan and ensure that the necessary health and social supports are available to promote and sustain the individuals' recovery. Case managers will also coordinate with the peer recovery coaches that are assisting individuals as they leave treatment and transition back to their communities. In addition, beneficiaries who are determined to be high-risk will be assigned to one MCO care coordinator who will be responsible for coordinating all of their care, including as they change levels of care.

Recovery Support Services: Under the waiver, West Virginia will build on the existing set of clinical and peer recovery support services designed to promote and sustain long-term recovery for individuals with SUD. The availability of Medicaid support for peer and recovery coaches will strengthen the continuum of care in partnership with the initiatives underway through BBHHF. The state will work with the MCOs and providers to create the system of peer coaches and recovery support services.

Recovery Housing: West Virginia will coordinate across programs to provide Medicaid support, where appropriate, for recovery housing. BBHHF currently provides recovery housing through various initiatives, including co-occurring disorder programs/transitional living and housing group homes, peer-operated recovery homes and facilities, permanent supportive housing, treatment provider recovery facilities, youth transitional living services, and justice-involved recovery housing. BBHHF provides peer support, peer coaching, peer center services, and supports for self-directed care as components of recovery housing. Under the waiver, Medicaid will cover services and the associated costs that supplement those covered by the Substance Abuse and Mental Health Services Administration (SAMHSA) block grant.

Current SUD Licensing/Credentialing Requirements

West Virginia will require that providers of SUD services meet ASAM criteria prior to participating in the Medicaid program. BMS contracts with the MCOs and providers will stipulate that they maintain provider credentialing requirements that are compliant with ASAM criteria. Table 3 outlines West Virginia's current provider licensing/credentialing standards. These licensing and credentialing standards will be reviewed to ensure that they meet ASAM criteria.

Table 3: Current Provider Licensing/Credentialing Standards

Service	Licensing/Credentialing Standard
Early Intervention	Licensed as an ambulatory health care facility, ambulatory surgical facility, hospital, or extended care facility by the State Director of Health (Secretary of the Department of Health and Human Resources).[22]
Outpatient Services	Licensed as an ambulatory health care facility by the State Director of Health.[23]
Intensive Outpatient Services	Licensed as an ambulatory health care facility by the State Director of Health.[24]
Partial Hospitalization Services	Licensed as a Behavioral Health Agency.[25]
Clinically Managed Low-Intensity Residential Services	Licensed as a Behavioral Health Agency.[26]
Clinically Managed Population-Specific High-Intensity Residential Services	Licensed as a Behavioral Health Agency.[27]
Clinically Managed High-Intensity Residential Services	Licensed as a Behavioral Health Agency.[28]
Medically Monitored Intensive Inpatient Services	Licensed as a hospital or free-standing psychiatric hospital by the State Director of Health.[29]

[22] West Virginia State Code, West Virginia Office of Health Facility Licensure and Certification (OHFLAC).
[23] West Virginia State Code.
[24] West Virginia State Code.
[25] West Virginia Office of Health Facility Licensure and Certification (OHFLAC).
[26] West Virginia Office of Health Facility Licensure and Certification (OHFLAC).
[27] West Virginia Office of Health Facility Licensure and Certification (OHFLAC).
[28] West Virginia Office of Health Facility Licensure and Certification (OHFLAC).
[29] West Virginia State Code.

Service	Licensing/Credentialing Standard
Opioid Treatment Program	Opioid treatment program shall comply with all federal regulations, provisions and standards contained in "Certification of Opioid Treatment Programs," 42 CFR Part 8, and state regulations, 69 CSR 7 or 69 CSR 11.[30]
Ambulatory Withdrawal Management without Extended On-Site Monitoring	Licensed as an ambulatory health care facility by the State Director of Health.[31]
Ambulatory Withdrawal Management with Extended On-site Monitoring	Licensed as an ambulatory health care facility by the State Director of Health.[32]
Clinically Managed Residential Withdrawal Management	Licensed as a Behavioral Health Agency.[33]
Medically Monitored Inpatient Withdrawal Management	Licensed as a hospital or free-standing psychiatric hospital by the State Director of Health.[34]
Targeted Case Management	Licensed as a Behavioral Health Agency.[35]
Recovery Support Services	Licensed as an ambulatory health care facility by the State Director of Health.[36]
Recovery Housing	N/A

BMS will work with the MCOs and providers to develop and implement a comprehensive plan for ensuring that providers are knowledgeable, trained, and prepared to deliver effective, evidence-based SUD practices across all ASAM levels of care. This will include a robust statewide ASAM training program to encourage standardization and adherence with the ASAM criteria. West Virginia requires training for all providers to be able to implement culturally competent evidence-based programming statewide.

[30] West Virginia Office of Health Facility Licensure and Certification (OHFLAC).
[31] West Virginia State Code.
[32] West Virginia State Code.
[33] West Virginia Office of Health Facility Licensure and Certification (OHFLAC).
[34] West Virginia State Code.
[35] West Virginia Office of Health Facility Licensure and Certification (OHFLAC).
[36] West Virginia State Code.

2.4 Network Development Plan

For beneficiaries served through managed care, all SUD services including the delivery of residential treatment services, will be provided through MCO networks and providers. MCOs will be responsible for contracting with qualified providers that have the ability to deliver services consistent with the ASAM criteria and provide evidence-based SUD practices on a statewide basis. This approach is expected to improve access, increase purchasing and contracting efficiency, and promote opportunities to integrate physical and behavioral health services.

The MCOs will be responsible for ensuring network adequacy through partnerships with health systems, FQHCs, and individual providers throughout the state. The MCOs will manage these networks and be responsible for ensuring that high-quality care is provided and the adherance to program integrity standards.

BMS recognizes that there may be challenges achieving network adequacy in certain regions of the state during the first year of implementation due to the lack of providers. The MCOs will analyze the existing number of service providers by region that meet the ASAM criteria, and develop a plan for recruiting and educating additional providers to ensure network adequacy across the state. BMS will develop a timeline for achieving network adequacy in each region of the state.

The approach for determining network adequacy will be based on the May 2016 CMS Medicaid managed care final rule and requirements already in place under the West Virginia Medicaid 1915(b) waiver.[37] As part of the July 2015 integration of behavioral health into managed care, the MCOs were required to submit plans to BMS illustrating the gaps in available services within their behavioral health networks. These plans described strategies and processes for how the network gaps would be addressed and how member access to all covered behavioral health services would be ensured. Each MCO's plan outlined contracting strategies for missing providers, as well as a process for allowing members to access services at out-of-network providers, if necessary. BMS is continuing to monitor these MCO plans. As part of this waiver, MCOs will be required to build on the existing plans in order to ensure network adequacy for the new and expanded SUD services that will be provided.

[37] West Virginia Medicaid 1915(b) waiver, Attachment A. Available at http://www.dhhr.wv.gov/bms/CMS/SMP/Documents/SPAs/SPAs%202015/Managed%20Care%20SPA/Attachment%20A%20-%20BH%20Network%20Adequacy.pdf.

BMS will work with the state's actuary to determine what adjustments to the per-member per-month (PMPM) payments will be needed to account for the additional services and care coordination activities they will deliver to individuals with SUD issues.

Additionally, in order to promote value-based purchasing, West Virginia plans to offer provider incentives for meeting quality metrics in certain areas, such as to promote outpatient treatment options and comprehensive and coordinated services.

West Virginia will continue to educate providers to encourage them to treat Medicaid beneficiaries. West Virginia will also continue to explore opportunities for expanding the provider network for Medicaid enrollees served through the fee-for-service system.

2.5 Care Coordination Design

Providing strong care coordination services between SUD levels of care and between SUD providers will be a crucial part of ensuring that individuals have access to a comprehensive continuum of care. Care coordination services are defined as services that assist Medicaid members in gaining access to needed medical, behavioral health, social, and educational services. These services involve identifying a member's problems, needs, strengths and resources; coordinating services necessary to meet those needs; and monitoring the provision of necessary and appropriate services.

For both MCO and FFS beneficiaries, West Virginia will leverage existing targeted case managers (SUD case managers) to ensure that beneficiaries successfully transition between levels of SUD care, SUD providers, settings and facilities (e.g. behavioral health, primary care, emergency department), and physical and behavioral health care systems. The current SUD care managers will be trained on the new and expanded SUD services provided under the Medicaid waiver.

West Virginia currently has two levels of behavioral health treatment, with similar but somewhat different credentialing and documentation requirements: (1) Focused Care and (2) Coordinated Care. Members receiving focused care have been determined to have a behavioral health disorder that may be addressed through the provision of low frequency professional treatment services. Members requiring coordinated care are those with severe and/or chronic behavioral health conditions that necessitates a team approach to providing more intensive medically necessary care. The team typically includes a case manager who coordinates and facilitates the members' care.

All high-risk/high-need members with a SUD diagnosis who are enrolled in an MCO will be assigned to one MCO SUD care coordinator, who will be responsible for ensuring that the

member successfully transitions between levels of SUD care and across SUD providers and treatment settings. These MCO SUD care coordinators will work closely with SUD case managers who are currently supporting individuals who meet diagnostic criteria for chronic mental illness or substance abuse under targeted case management. West Virginia will establish metrics for identifying high-risk/high-need members in order to assign them to an MCO SUD care coordinator.

Care coordination services may include:[38]

- Conducting a comprehensive assessment and periodic reassessment of individual needs to determine the need for care coordination services;
- Facilitating transitions to higher or lower levels of SUD care;
- Facilitating transitions between different types of SUD providers;
- Developing and periodically revising the client plan;
- Monitoring service delivery to ensure beneficiaries have access to needed services;
- Monitoring the beneficiary's recovery progress; and
- Advocating for patients and linking them to physical and mental health care, transportation and retention in primary care services.

SUD case managers and MCO SUD care coordinators will work closely together and with the beneficiary to coordinate their care. Care coordination services may be provided in-person or over the phone, but the SUD case manager must have at least one face-to-face contact with the member every 90 days. West Virginia encourages providers that have the capacity to render services via telehealth to do so, particularly in rural and remote areas. Any case management services may be conducted via telehealth, except for the required 90-day face-to-face encounter. There is also a helpline (1-844-HELP4WV) that people can call when they need immediate assistance, information and referrals. Additionally, West Virginia will develop a care coordination strategy for beneficiaries who switch MCOs mid-treatment.

Transitions between levels of care

West Virginia's MCOs will ensure seamless transitions and information sharing between levels and settings of care. Case managers and MCO SUD care coordinators (for high-risk beneficiaries) will serve as the primary point of contact for the member, helping to assess their

[38] West Virginia BMS Provider Manual, Chapter 523-Targeted Case Management. Available at: http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/BMS_Proposed_Targeted_Case_Management_Policy.pdf.

ongoing and changing needs, and sharing information with the treating provider(s) as the member transitions across levels of care. MCO SUD care coordinators will engage with individuals throughout their hospitalization. SUD Case managers will engage with individuals ten days prior to a hospital discharge to create a care coordination plan and ensure that the necessary health and social supports are available to promote and sustain the individuals' recovery.

These services will build on West Virginia's recently implemented changes to the eligibility criteria for targeted case management. The new approach permits care coordination services to be incorporated into the transition planning process as Medicaid beneficiaries move from residential settings back into the community, and also through outpatient care transitions.

Transitions between SUD providers

The case managers and MCO SUD care coordinators will facilitate member transitions between SUD providers by linking them to the appropriate providers, facilitating the transfer of necessary clinical information to avoid disruptions in care, and ensuring that the treating provider has full information. This includes connecting members to peer recovery coaches that will assist individuals as they leave treatment and transition back to their communities.

All SUD providers will be required in to engage in appropriate transition and/or discharge planning, including coordinating with providers at the next level of care to ensure there are no gaps in services and that the new provider is aware of the progress and activities from the prior treatment level. MCOs will provide ongoing education to providers about these expectations and will be responsible for conducting reviews to ensure compliance.

Collaboration between behavioral health and somatic systems, including primary care, emergency departments and hospitalizations, pharmacological, and long-term services and supports

West Virginia and its MCOs will inform entities, including private behavioral health providers, FQHCs, primary care physicians, emergency departments and hospitals of the new SUD services and the resources available to them when integrating services or developing comprehensive care plans for members, including residential treatment. The MCOs and providers will help ensure smooth transitions by facilitating the transfer of necessary clinical information between behavioral health and somatic systems. BMS and the MCOs will also work with providers across health care settings to develop workflows to streamline transitions and

communication, and maximize efficiency. West Virginia is looking for opportunities to share data across health systems and emergency departments.

Medication reconcillation will be a policy requirement to ensure that the indivudals past and current MAR is up to date and shared with the appropriate treatment providers.

Referals and recommendations for long-term supports and services will be required as part of the discharge process from short term services that are received by the Medicaid enrollee.

2.6 Integration of Physical Health and SUD

West Virginia is committed to integrating physical and behavioral health services for enrollees to improve health outcomes and reduce SUD costs. In July 2015, West Virginia integrated behavioral health services into managed care. Since the MCOs will be responsible for managing the physical and behavioral health services provided to the vast majority of enrollees, they will be able to integrate the SUD treatment services with physical health and traditional mental health treatment services. This integration will also move West Virginia toward value-based purchasing for both physical and behavioral health services. West Virginia is exploring mandating providers to share patient information with other providers treating the individual, in accordance with all HIPAA-related federal rules and regulations.

2.7 Program Integrity Safeguards

BMS requires MCOs to have administrative and management arrangements or procedures, including a mandatory compliance plan, designed to guard against fraud and abuse. MCOs are also required to achieve, and keep current, accreditation from the National Committee for Quality Assurance (NCQA) for their Medicaid lines of business. MCOs must provide BMS with the accreditation status reports indicating the MCO evaluation options, measures, results, and length. The accreditation reports must be submitted upon completion of each accreditation survey.

The MCOs must work with BMS, the Medicaid Fraud Control Unit (MFCU), the Office of the Inspector General (OIG), and the Centers for Medicare & Medicaid Services (CMS) to administer effective fraud and abuse practices. MCOs must meet regularly with BMS, the MFCU, and the EQRO to discuss plans of action, and attend fraud and abuse training sessions as scheduled by the state. MCO reporting procedures and timelines for abuse complaints and outcomes must meet state-established guidelines.

In accordance with NCQA credentialing and re-credentialing requirements, MCOs will have the proper provisions in place to determine whether physicians and other health care professionals licensed by West Virginia, and who are under contract with the plan or its providers, are

qualified to perform SUD services. MCOs will have written policies and procedures for the credentialing process.

MCOs will ensure that all providers of SUD services have entered into contracts or provider agreements. MCOs will have rigorous program integrity protocols in place to safeguard against fraudulent billing. They will require their providers to fully comply with federal requirements for disclosure of ownership and control, business transactions, and information for individuals convicted of crimes against federal-related health care programs.

BMS will require MCOs to perform an annual review of all providers to assure that the health care professionals under contract are qualified to perform SUD services, and that services are being provided in accordance with the contract, ASAM criteria, and waiver requirements. MCOs will have in place a mechanism for reporting to the appropriate authorities any actions that seriously impact quality of care and which may result in suspension or termination of a practitioner's license. They will be required to report quarterly on all providers who have failed to meet accreditation/credentialing standards or have been denied application, including program integrity-related adverse actions.

For enrollees who receive services through the fee-for-service delivery system, BMS has a utilization management contractor who completes retrospective reviews to ensure program integrity standards are met.

2.8 Benefit Management

West Virginia will comply with all Mental Health Parity and Addiction Equity Act requirements and will not cap any services or payments for services. Table 4 summarizes the minimum requirements for utilization management and quality review processes. West Virginia will work closely with the MCOs and providers to develop and implement the requirements. MCOs will outline the specific requirements in their provider contracts.

Table 4: Minimum Utilization Management and Quality Review Process Requirements

Process	Description
Standard Benefit Structure	Use of standardized benefit structure that defines service levels and supports placement using American Society of Addictions Medicine (ASAM) levels of care. The policies and procedures will require that providers use ASAM multidimensional assessment criteria to determine the level care needed.
Unified Model of Care	SUD benefits will be administered using a unified model of care that is defined by the use of standardized unit values, reimbursement codes, and a minimum reimbursement value for each service level.
Uniform Clinical Operations	Standardized service review formats will be used to ensure that clinical operation processes are uniform and designed to collect information in line with the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements to ensure appropriate placement and facilitate opportunities for integrated care and coordination of service delivery options for individuals.
Service Review Requirements	ASAM levels 3.1, 3.3, 3.3, 3.5 and OTP will be subject to utilization management requirements, including service review requirements to facilitate initiation of services with quality oversight structures in place as specified in the CMS State Medicaid Director Letter:[39] • Each service review will be provided to assess service needs, coordination needs, and to ensure appropriate placement into an effective level of care based on the individual's needs, as demonstrated in the ASAM multi-dimensional assessment tool.
Quality Reviews	Conduct targeted post-payment quality reviews to ensure fidelity with ASAM service models and access for the use of evidence-based delivery of services.

2.9 Community Integration

West Virginia expects to reach full compliance with the Home and Community-Based Services program regulations during the course of this waiver. The MCOs will work with the state to ensure that requirements for person-centered planning are incorporated into all SUD service planning and service delivery efforts.

[39] July 2015 State Medicaid Director Letter. "New Service Delivery Opportunities for Individuals with a Substance Use Disorder." Centers for Medicare & Medicaid Services. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf.

Individuals who are not eligible for Medicaid may still receive the same services in Chapter 503 but would receive them through the Charity Care funding that is made available through BHHF, which funds the 13 CBHCs to render services to these individuals.

2.10 Strategies to Address Prescription Drug Abuse

West Virginia has launched a number of efforts to curb prescription drug abuse. In September 2011, Governor Earl Ray Tomblin established the GACSA and six Regional Task Forces. These groups are charged with providing guidance on the implementation of the Comprehensive Statewide Substance Abuse Strategic Action Plan, recommending priorities for the improvement of the statewide substance abuse continuum of care, identifying planning opportunities with interrelated systems, and providing recommendations to the Governor on enhancing substance abuse education; collecting, sharing, and utilizing data; and supporting policy and legislative action.

The Regional Taskforces have led the statewide Prescription Drug Take Back program, which seeks to provide a safe, convenient, and responsible way to dispose of prescription drugs, and educates the public about the potential for medication abuse. The Taskforce also advances the expansion of prevention coalitions, evidence-based practice (EBP) programs, SBIRT, and Recovery Coaching.[40]

To support interstate efforts, Governor Tomblin established the Interstate Prescription Drug Task Force with Ohio, Kentucky, and Tennessee. The Task Force's mission is to identify and recommend opportunities for collaboration and cooperation to stem prescription drug abuse and provide for better treatment and recovery to those affected by prescription drug abuse.[41]

Over the past five years, West Virginia has implemented key legislation (including West Virginia Senate Bills 335 (2015), 437 (2012) and 523 (2015)) to address prescription drug abuse. Senate Bill 437, passed on March 10, 2012, takes a comprehensive approach to address prescription drug diversion and substance abuse issues. The law contains five key areas:

[40] West Virginia Comprehensive Substance Abuse Strategic Action Plan, DHHR, 2010. Available at: http://www.dhhr.wv.gov/bhhf/sections/programs/ProgramsPartnerships/AlcoholismandDrugAbuse/Documents/strategicactionplan-info.pdf.

[41] "Governor Tomblin Announces State Participation in Interstate Task Force to Address Prescription Drug Abuse," 2011. Available at: http://www.governor.wv.gov/media/pressreleases/2011/Pages/GovernorTomblinAnnouncesStateParticipationinInterstateTaskForcetoAddressPrescriptionDrugAbuse.aspx.

1. Increases regulation of opioid treatment programs (methadone clinics)
2. Establishes licensing and regulation of chronic pain clinics
3. Establishes review capabilities of the Controlled Substances Database under the Board of Pharmacy to flag abnormal or unusual usage patterns of controlled substances by patients and unusual prescribing or dispensing patterns by licensed practitioners
4. Implements requirements for continued medical education for physicians and continued education for all other prescribers, dispensers and persons who administer controlled substances
5. Establishes a requirement for pharmacies to utilize a Multi-State Real-Time Tracking System to track sales of pseudoephedrine, and limits the amount allowed to be legally purchased daily (3.6g), monthly (7.3g), and annually (48g).

The distribution of prescription pills for pain management is increasingly controlled by West Virginia's OHFLC using the legislative authority of Article 5H Chronic Pain Clinic Licensing Act. The law also requires treating physicians to access the Controlled Substances Monitoring Program (CSMP) database maintained by the Board of Pharmacy to ensure that patients are not seeking controlled substances from multiple sources and places, dispending limits on controlled substances. A primary goal of the legislation is to eliminate pill mills—illicit businesses that prescribe large volumes of opioids without a legitimate medical license or clinic registration. Additionally, any individual suspected of misusing a controlled substance must use a single prescriber and pharmacy (pharmacy lock-in program) to reduce doctor shopping for prescription drugs.[42] Doctor-shopping laws have been introduced to further prohibit patients from withholding information about prior prescriptions from their healthcare provider.

West Virginia requires prescribers to complete training on avoiding diversion of prescriptions drugs in the illicit market. West Virginia University has added a new online course: The Treatment of Pain and Addiction Utilizing Education and Proper Prescribing: The New Paradigm Continued, for academic credit and to meet the state requirement.[43] The state also requires prescribers to require identification prior to dispensing a controlled substance. Prior to prescribing prescription medications, a healthcare provider must either conduct a physical exam

[42] J. Levi, L. Segal and A. Miller, "Prescription Drug Abuse: Strategies to Stop the Epidemic," Trust for America's Health and The Robert Wood Johnson Foundation, 2013. Available at: http://healthyamericans.org/reports/drugabuse2013/TFAH2013RxDrugAbuseRpt12_no_embargo.pdf.
[43] "WVU plans online opioid course for physicians," West Virginia Hospital Association, 2016. Available at: http://www.wvha.org/Media/NewsScan/2016/May/5-5-16-WVU-plans-online-opioid-course-for-physicia.aspx.

of the patient, a screening for signs of substance abuse, or have a bona fide patient-physician relationship that includes a physician examination.[44]

The West Virginia Corrections Department chose to participate in the federal initiative to establish voluntary Drug Court Programs to provide a rehabilitative program for individuals involved in the federal criminal justice system who have substance abuse problems.[45] The program is post-plea, pre-adjudication, of at least one year, designed for individuals who suffer from substance abuse or addiction.[46]

In March 2016, the Centers for Disease Control and Prevention (CDC) National Center for Injury Prevention and Control awarded a $1.3 million Prescription Drug Overdose grant to West Virginia to enhance and maximize the mandatory PDMP to:

(1) Help identify “doctor shoppers,” problem prescribers and individuals in need of treatment;

(2) Implement community and insurer/health system interventions; and

(3) Evaluate existing policies designed to reduce prescription drug overdose morbidity and mortality.[47]

2.11 Strategies to Address Opioid Use Disorder

In West Virginia, opioid use disorder is largely the result of physicians overprescribing opioids for pain management. According to the July 2014 CDC Vital Signs Report, West Virginia ranks third in the nation for the highest number of painkiller prescriptions per person—138 for every 100 people.[48] Between 2011 to 2015, West Virginia disciplinary boards reprimanded more than two dozen doctors.

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[44] J. Levi, L. Segal and A. Miller, "Prescription Drug Abuse: Strategies to Stop the Epidemic," Trust for America's Health and The Robert Wood Johnson Foundation, 2013. Available at: http://healthyamericans.org/reports/drugabuse2013/TFAH2013RxDrugAbuseRpt12_no_embargo.pdf.
[45] West Virginia Code 62-15-2(5). Available at: http://www.legis.state.wv.us/wvcode/ChapterEntire.cfm?chap=62&art=15.
[46] Drug Court Program Summary, United States District Court for the Northern District of West Virginia, 2015. Available at: http://www.wvnd.uscourts.gov/sites/wvnd/files/NDWV%20Drug%20Court%20Program%206-3-15.pdf.
[47] "DHHR to receive $1.3 million grant for prescription drug overdose prevention,” B. Register-Herald, March 2016. Available at: http://www.register-herald.com/news/dhhr-to-receive-million-grant-for-prescription-drug-overdose-prevention/article_e278c442-164b-5252-8781-fba431637790.html.
[48] CDC Vital Reports, July 2014. Available at: http://www.cdc.gov/vitalsigns/opioid-prescribing/infographic.html#map.

The West Virginia state legislature has taken a number of actions to address opioid overuse, including supporting the GACSA and six Regional Task Forces to combat abuse and addiction throughout West Virginia (as previously noted). The Advisory Council has pushed for legislation to track medication sales using the prescription monitoring program and to expand the availability of naloxone.

The legislature has also passed a number of bills to address opioid overuse, including Senate Bill 335.[49] This bill, passed in 2015, allows emergency responders, medical personnel, family and friends to possess and administer naloxone to reverse the effects of an opioid overdose. Under the waiver, West Virginia is developing an initiative for distributing naloxone and cross-training staff on the administration of the drug as part of its efforts to reduce overdose deaths across the state. Possible strategies for distribution include making naloxone available for pick up at local health departments and ensuring that all emergency personnel and community facilities have adequate supplies of the drug available and are trained to administer it.

Additionally, in September 2015, West Virginia established a 24-hour substance abuse helpline—1-844-HELP4WV—to provide referral support for people seeking treatment and recovery services in their local communities.[50] To combat opioid use by pregnant women, DHHR and the West Virginia Perinatal Partnership are working to develop improved guidelines for diagnosis, reporting, and capturing of data to improve service provision.[51]

West Virginia Medicaid requires prior authorization for all prescriptions of buprenorphine (i.e. Suboxone®) and mono-buprenorphine (formerly known as Subutex®). BMS developed prior authorization criteria that provides adequate doses of both buprenorphines and mono-buprenorphines , when appropriate, for pharmacologic support of addiction treatment. All doses for both of these medications will be prior authorized, and only for the Federal Drug Administration (FDA)-approved indication of opiate dependence/addiction.

All prescribers are required to have a DATA (Drug Addiction Treatment Act of 2000) waiver as proof of qualification to prescribe buprenorphine and mono-buprenorphine, and be enrolled with West Virginia Medicaid in order to bill Medicaid for treatment or management of opiate addiction

[49] Senate Bill 335. Available at: http://www.legis.state.wv.us/Bill_Text_HTML/2015_SESSIONS/RS/bills/SB335%20SUB1%20ENR2.pdf.
[50] Behavioral Health Helpline (2015). Available at: http://www.pds.wv.gov/Annual-Conference/2016/Documents/Sessions/McDaniel,%20Heather%20-%20Help4WV%20-%20Combined.pdf
[51] 2015 GACSA Progress Report. Available at: http://www.wvsubstancefree.org/docs/GACSA%20Progress%20Report%202015%20FINAL%20low-res.pdf.

in the patients for which they are prescribing. Submission of the DEA-X number and the Medicaid enrollment number are required and are verified when prior authorization requests are made. Requests for prior authorization must be submitted in writing to the Rational Drug Therapy Program by fax, mail, or electronic submission using an approved form. Maintenance dosing is limited to 16 mg per day. Dose optimization will be required and may necessitate tablet splitting for Medicaid members. Mono-buprehnorphine is only approved for patients who are pregnant. Concomitant use of benzodiazepines, hypnotics, and opiates with buprenorphine and mono-buprehnorphine are not approved and prescriptions for these agents in combination will be denied at the pharmacy. Other depressants such as sedatives, antidepressants, muscle relaxants, etc., are considered for payment, but patients are required to be educated and warned of the extreme danger of these combinations. Alternative treatment options are encouraged while the patient is receiving buprenorphine/mono-buprehnorphine . As part of this waiver, West Virginia is adding Medicaid coverage of methadone and methadone administration as part of its Opioid Treatment program.

2.12 Services for Adolescents and Youth with an SUD

BMS will work to ensure that the waiver includes strategies focused on SUD prevention and treatment among youth and adolescents in West Virginia, including foster care youth. All youth will continue to have access to SUD services through the EPSDT benefit under Medicaid, which covers the full range of services needed to achieve and maintain children's health.

2.13 Reporting of Quality Measures

BMS will collect reliable and valid data from the MCOs to enable the reporting of the SUD quality measures listed in Table 5. These measures are either required or recommended in the July 2015 CMS State Medicaid Director Letter.[52] West Virginia will explore adding other measures and will incorporate any new behavioral health Healthcare Effectiveness Data and Information Set (HEDIS) measures as they are developed, in order to continue to improve the quality of care based on data-driven results. These quality measures will be assessed as part of the program evaluation and will be reported to CMS.

[52] July 2015 State Medicaid Director Letter. "New Service Delivery Opportunities for Individuals with a Substance Use Disorder." Centers for Medicare & Medicaid Services. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf.

Table 5: Quality Measures

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

BMS and the MCOs will leverage, and expand as necessary, the existing quality improvement infrastructure as well as process and performance measure data systems to ensure continuous improvement of the provision of SUD services. The results of these assessments will be used to improve the quality of care provided by Medicaid.

BMS will identify mechanisms to evaluate care transitions between SUD levels of care and between SUD providers, including the linkages with primary care upon discharge.

BMS will submit mid-year and annual reports to CMS on the status of waiver implementation, including on these reporting metrics.

2.14 Collaboration with Single State Agency for Substance Abuse

BMS is working in close partnership with BBHHF to develop this proposed Medicaid section 1115 waiver proposal. BBHHF has provided feedback and input on all aspects of the proposed design and implementation of the comprehensive Medicaid SUD treatment continuum of care in this waiver and the two agencies have reached consensus on the approach to implementation. BMS has also collaborated with the West Virginia Bureau for Children & Families and Bureau for Public Health.

3 Demonstration Hypothesis and Evaluation Plan

Through an existing contract with BMS, APS/KEPRO will conduct an independent evaluation to measure and monitor the outcomes of the SUD waiver. The evaluation will focus on five key areas: access, service utilization, quality, costs, and integration of care. The researchers will assess the impact of providing the full continuum of SUD treatment services, particularly residential treatment, on emergency department utilization, inpatient hospital utilization, and readmissions rates to the same level of care or higher. It will also assess the impact on the drug overdose death rate and the prevalence of NAS. A mid-point evaluation will be completed, along with an evaluation at the end of the waiver.

The evaluation is designed to demonstrate achievement of the waiver's goals, objectives, and metrics. As required by CMS, the evaluation plan will include the following elements:

- Description of programmatic changes that will result from the demonstration
- Expected outcomes
- Evaluation design
- Evaluation outcome measures and data sources
- Analysis plan

Some key questions that will be evaluated include the impact of the waiver on the following areas:

- Provider supply and capacity across levels of care
- Provider training
- Beneficiary access to and utilization of SUD services across levels of care, including outpatient care to avoid residential treatment
- Patient outcomes and quality of care
    - Emergency department visits
    - Inpatient hospital admissions
    - Hospital SUD readmissions at the same or higher level of care
    - Fatal and non-fatal drug overdose rates
    - NAS prevalence
    - Integration of physical and behavioral health care
- Costs, including those associated with emergency department visits, inpatient states, and hospital readmissions
- Relationship between waiver and broader state and community efforts to combat SUD issues

The details of the evaluation plan will be developed in concert with CMS during the waiver negotiation process.

4 Projected Waiver Impact

The waiver includes two components. The first component is the passthrough of IMD costs anticipated to be spent in the service capacity expansion (both in general and for IMD) that will occur. The second component is the addition of new services to the benefits available to members, which would include methadone, naloxone, SBIRT and recovery homes. In addition, the service spectrum will become compliant with ASAM standards over time, including definition of specific sub-levels of service availability to build a continuum of care that can flexibility accommodate the variety of needs within the SUD population. The other components of the budget neutrality calculation are the savings expected to accrue in overall medical costs as a result of expanding SUD treatment (which will more than offset the increased costs for the new services) and pay-for-performance (P4P) bonus payments that will improve outcomes for providers of SUD services. The offsets to medical spending will amount to more than the cost of the new services, and the additional savings are assumed to be mostly spent on P4P bonuses to incentivize quality care and better outcomes. On net, the program is expected to generate savings of approximately 2.2%. The table below provides a summary of these calculations, and more detailed calculations and explanations can be found in Appendix A.

Table 6: Projected Historical and Waiver Expenditures

5 Waiver and Expenditure Authorities

West Virginia seeks expenditure authority under Section 1115(a)(2) of the Social Security Act to claim expenditures made by the state for services not otherwise covered or included as expenditures under Section 1903 of the Act, such as services provided to individuals residing in facilities that meet the definition of an Institution for Mental Disease (IMD), and to have those expenditures regarded as expenditures under the State's Title XIX plan.

6 Public Notice and Comments Received

West Virginia has a strong history of working with stakeholders on all aspects of administration of the Medicaid program. We have engaged stakeholders throughout the development of the waiver application and appreciated their feedback on the draft application that was released for public comment on September 20th. We look forward to continuing to work closely with our stakeholders as we develop the waiver special terms and conditions and implementation plan.

West Virginia does not have any federally-recognized tribes, Indian Health Programs, or Indian Health Organizations, so tribal consultation was not required.

West Virginia followed the state public notice process as outlined in 42 CFR 431.408. West Virginia issued a comprehensive description of the proposed SUD continuum of care and addressed all of the required elements of a Medicaid section 1115 waiver application. In addition, the draft application included all of the elements described in the July 2015 CMS State Medicaid Director Letter, "New Service Delivery Opportunities for Individuals with a Substance Use Disorder."

The draft waiver application and a summary of it was posted on September 20, 2016 on the West Virginia Public Notice website, http://www.dhhr.wv.gov/bms/Public%20Notices/Pages/default.aspx. BMS and BBHHF sent an electronic notification to a wide range of stakeholders and interested parties including 700 individual providers, group practices, FQHC/FHC, LBHC and community mental health providers. Stakeholders submitted their comments via email at dhhrbmscomments@wv.gov and via mail at 350 Capitol Street, Room 251 Charleston, WV 25301. A dedicated phone line was also provided for those who needed additional assistance in accessing the document.

Public Hearings

West Virginia convened two public hearings on September 28 – 29, 2016 in the cities of Morgantown and Charleston. The Morgantown hearing included teleconferencing and webinar capability. BMS Acting Commissioner Cynthia Beane presented an overview of the waiver proposal and answered questions. The commenters who attended the hearings were supportive of the state's effort to address the SUD crisis in West Virginia. Stakeholders who attended the hearings included: Thomas Memorial Hospital, WV Behavioral Healthcare Providers Association, Beacon Health Organizations, West Virginia University Hospital, Valley Healthcare and Crittenton Services.

Written Comments

West Virginia received comments from 17 stakeholders across the state (see Appendix B). Below is a summary of the comments received, West Virginia responses, and how comments were incorporated into the waiver application.

Overall, commenters were very supportive of the waiver application and see it as an important step toward establishing a comprehensive continuum of SUD care for Medicaid beneficiaries. Commenters expressed support for the waiver objectives, and for ensuring that West Virginia Medicaid enrollees receive the right care at the right time in the right setting. Commenters also supported the waiver's focus on aligning services with ASAM levels of care, providing care coordination, expanding Medicaid Assisted Treatment, and providing peer and recovery support services.

Services

- Commenters expressed the importance of care coordination for beneficiaries at all ASAM levels in the continuum of care. West Virginia agrees that care coordination is an critical component of operationalizing a continuum of care.
- One commenter suggested defining "Opioid Treatment Centers." In the waiver application, West Virginia defined Opioid Treatment Centers and Pain Management Clinics.
- Commenters suggested highlighting the expansion of MAT throughout the application. West Virginia added language on MAT in several places to demonstrate that it is a waiver priority.
- One commenter suggested that West Virginia add ASAM Level 4.0 – Medically Managed Inpatient Treatment/Rehab. To determine which ASAM levels of care to provide under the waiver, West Virginia assessed the current needs for services, reviewed the ASAM levels of care, and identified the ASAM levels that are most critically needed at this time.

Providers

- Several commenters noted concerns about having a sufficient number of providers to meet the demand for services. West Virginia recognizes this challenge and will be working closely with the MCOs to augment the number and types of SUD providers and facilities across the state to ensure geographic access and an adequate range of treatment options.
- One commenter suggested listing the provider types that may provide services under the waiver. In response, West Virginia added that LCSWs, LICSWs, LPCs, APRN-MAC and NPs may provide some SUD services under the supervision of a physician. West Virginia anticipates that the final waiver special terms and conditions will list the specific providers who are eligible to provide services for each ASAM level of care.
- One commenter suggested that a system be established to ensure quality peer recovery support services, including peer operated recovery homes and peer mentoring programs. West Virginia plans to establish a system for training and monitoring of peer recovery support services to ensure the quality of services provided.
- One commenter suggested that state policies regarding hiring ex-offenders for peer support programs should be revised. West Virginia recognizes that policy changes may be needed and would address this outside of the waiver.
- Several commenters requested specific information on how reimbursement rates for services and for certain providers may change under the waiver. Another commenter asked whether the waiver would allow for bundled payments. West Virginia will work to establish provider reimbursement rates and MCOs will have flexibility to negotiate bundled payment rates with providers.
- One commenter acknowledged that the expenditure information in the draft waiver application was preliminary, but asked that the cost per beneficiary specifically illustrate the cost for Medicaid Assisted Treatment. West Virginia appreciates the comment and is continuing to analyze the expenditure information.

Implementation and Other

- One commenter suggested that West Virginia include additional detail on implementation of the waiver, including specific tasks and timelines. West Virginia will develop an implementation plan that will be shared with stakeholders for feedback as the implementation process gets underway.
- Commenters requested that West Virginia consider revising certain state policies, including the Certificate of Need for out-of-state providers and medication dosage limitations. West Virginia appreciates these recommendations, however these policies are outside the scope

of this waiver application. West Virginia will take these comments into consideration as it continues to refine its program policies.

- Many commenters suggested language clarifications throughout the waiver, such as when describing the brand names of prescription drugs. West Virginia incorporated these clarifications into the waiver application.
- West Virginia looks forward to continuing to work closely with stakeholders to develop a high-quality SUD continuum of care that meets the needs of the state's Medicaid population.

Appendix A. Projected Waiver Impact Report

Section 1115 Medicaid Demonstration Waiver: Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorder - Budget Neutrality

State of West Virginia
Department of Health and Human Services

Prepared for:
Commissioner Cynthia Beane
Bureau for Medical Services
West Virginia Department of Health and Human Services

Prepared by: Compass Health Analytics, Inc.

Jeffrey M. Stock
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President

1. Background

Compass Health Analytics was retained to develop the response to the Budget Neutrality Form for the 1115 Medicaid Demonstration Waiver Application by the State of West Virginia, Department of Health and Human Services (DHHR). The Centers for Medicare & Medicaid Services (CMS) requires all 1115 Waivers to demonstrate budget neutrality. DHHR is creating a continuum of care for Medicaid Enrollees with Substance Use Disorder beginning on July 1, 2017 in some markets with full rollout on January 1, 2018.

This report documents the Excel Workbook titled *west virginia budget-neutrality-worksheet.xlxs*, which provides supporting data demonstrating budget neutrality for the 1115 Waiver. This review of budget neutrality will be incorporated into an overall response to CMS regarding the 1115 Waiver application.

When submitting a Section 1115 demonstration waiver, states are required to include an initial view illustrating that they expect the demonstration to be budget neutral. Based on CMS guidance, a budget neutrality workbook will be provided to include historical enrollment trends and expenditures as well as 5 years of projected enrollment and expenditures. Per-capita costs are calculated as total costs divided by total member months for each population measured. For the purposes of demonstrating budget neutrality for this 1115 Waiver, two population groups will be measured: the Medicaid Expansion members and the Pre Expansion Members. The calculation will be completed for each new proposed SUD treatment service including pass through hypothetical treatments. Cost savings associated with offsets stemming from more and more-highly-effective SUD treatments are analyzed in a separate cost projection category.

2. Expenditures under the waiver

West Virginia believes that the investments made under this waiver on high-quality, integrated substance use disorder (SUD) services will slow the rate of growth in per capita Medicaid spending. Under the waiver, West Virginia will increase access to short-term acute treatment services, including detoxification, intensive outpatient programs, and residential treatment services. West Virginia will improve screening and intervention services and integrate these services into primary care. West Virginia will also expand medication assisted treatment (MAT), and recovery support services such as peer recovery supports and recovery coaches. Aftercare support such as transportation, employment, housing, and community and peer support services will also be utilized. West Virginia has the highest death rate from drug overdoses in the nation. With the goal of saving lives, West Virginia will expand the distribution of naloxone,

and address dangerous opioid prescribing practices through electronic prescribing of controlled substance (EPCS) and an expansion of their prescription drug monitoring program (PDMP).

3. Cost savings under the waiver

While SUD treatment programs require significant investment, numerous empirical studies show that investment in SUD treatments also reduce unnecessary hospitalizations, emergency room spending, and other physical healthcare costs. Several studies cited in a memo from CMS[i] as well as additional studies provide evidence that if West Virginia can more effectively provide care to beneficiaries with co-occurring conditions, there will be an enormous opportunity to improve their care and reduce costs. These studies include following conclusions:

- Massachusetts found that monthly Medicaid expenditures were significantly less for beneficiaries receiving SUD treatment compared to diagnosed but untreated beneficiaries. Treatment included ambulatory detoxification and MAT services.[ii]

- Washington found that Screening, Brief Intervention and Referral to Treatment (SBIRT) services significantly reduced healthcare costs among Medicaid beneficiaries, resulting in savings of $250 per member per month associated with inpatient hospitalization from emergency department admissions.[iii]

- According to the institute for clinical systems improvement, a study cited that patients with a SUD diagnosis generated $523 in savings from SBIRT.[iv]

- In addition, Washington tackled SUD and emergency department (ED) usage by adopting seven best practices. As a result, ED visits decreased by 9.9 percent; the number of people with frequent ED use dropped by 10.7 percent; and the number of visits resulting in narcotic prescription dropped by 24 percent. The state attributed savings of about $34 million.[v]

- For individuals in managed care with alcohol dependence, total healthcare costs were 30 percent less for individuals receiving MAT than for individuals not receiving MAT.[vi]

- Medical costs decreased by 33 percent for Medicaid patients over three years following their engagement in SUD treatment. This included a decline in expenditures in all types

of health care settings including hospitals, emergency departments, and outpatient centers.[vii]

- Persons with untreated alcohol use disorders use twice as much health care and cost twice as much as those with treated alcohol use disorders,[viii] and medications treating SUDs in pregnant women resulted in significantly shorter hospital stays for SUD treatment than drug addicted pregnant women not receiving MAT (10.0 days vs. 17.5 days).[ix]

- A California study investigating if SUD treatment pays for itself suggests that there is a 7:1 ratio of benefits to cost when factoring in reduced cost of crime and increased employment earnings.[x]

- A Kaiser study concluded that expansion of outpatient SUD treatment resulted in a substantial decline in inappropriate utilization and cost (hospital and ER) in the post-treatment period. Researchers found a 35% decrease in inpatient costs, a 39% decrease in ED costs, and a 26% decline in total medical costs which were statistically significant ($p < .01$).[xi]

- A meta analysis of Methadone MAT studies concluded that methadone treatment for opioid addictions generated savings equal to 2-4x the cost of the treatment. "Methadone maintenance treatment ranges in costs from just over $6,000 per year to over $12,000 per year depending upon the nature and frequency of counseling and social services provided. Various studies have seen clinically and statistically significant reductions in opioid use and opioid use-related incidence of infectious diseases and crimes with averted costs ranging from two to four times the costs of methadone per year."[xii]

4. Waiver budget neutrality and pass through costs

West Virginia believes that this waiver will follow the examples from other states and studies and will be budget neutral. In accordance with the waiver guidance, short term IMD costs are treated as a pass through for budget neutrality purposes up to 30 days for ASAM levels 3.1, 3.3, 3.5, and 3.7. These are clinically managed and medically monitored services typically provided in freestanding, appropriately licensed facilities or residential treatment facilities without acute medical care capacity, in settings that meet the definition of an IMD. For ASAM level 4.0, the short term residential cost pass through period is limited to 15 days. To ensure budget

neutrality, West Virginia Medicaid will also achieve cost savings from a range of sources including:

1. Designing a value-based payment and delivery system that pays for results and performance.

2. Using early intervention to treat conditions before costs escalate.

3. Deflecting members with behavioral health conditions away from high-cost institutional services when unnecessary.

4. Reduction to high cost emergency room and inpatient visits.

5. Though not part of the budget neutrality model, more effectively treating SUD will improve employment and reduce crime, thereby reducing reliance on other publicly supported programs.

West Virginia also currently treats substance use disorder and mental health issues through various Block Grants including SAMHSA funding to IMDs. The 1115 waiver will redirect funds to treatments currently provided through these Block Grants. The state of West Virginia intends to follow CMS guidance and reinvest these to further expand SUD treatment capacity and commitments consistent with SAMHSA's maintenance of effort requirements for its Substance Abuse Prevention and Treatment Block Grant.

5. Budget Neutrality Reporting Form and Supporting Calculations for Without-Waiver and With-Waiver Projections

Compass was asked to develop the response to the Budget Neutrality section of West Virginia's section 1115 demonstration waiver application. The budget neutrality expenditure projections follow CMS guidance. We have provided the actual historic enrollment and cost data for five years from state fiscal year (SFY) 2011 to SFY 2015 (7/1/2010 to 6/30/2015). We modeled two populations under the 1115 Waiver, the 2014 Expansion Population, and the Non Expansion Group. We budgeted cost estimates for each SUD treatment services added within the waiver. Note this excludes all SUD treatments that are already funded through Medicaid, this budget neutrality calculation only includes new SUD services which include IMD costs as well as new treatments including recovery homes, methadone, naloxone, and SBIRT.

A. Recent Historical Actual or Estimated Data

Historic data for the last five years pertaining to the Medicaid population has been provided. The data is included on the "Historic Data" tab of the *west virginia-budget-neutrality-worksheet.xlxs*.

Historic data is presented for two population subsets: Medicaid Expansion, and Medicaid Pre Expansion members. The data was sourced from the West Virginia data warehouse and was provided by Molina Healthcare who helps manage West Virginia data systems. We performed checks against published results from CMS64 and feel comfortable that the data is complete. Because the services under the waiver are either hypothetical pass through costs in the case of IMD, or are new services, in the case of recovery homes, MAT treatments, naloxone and SBIRT, the historical data are very limited in scope for Medicaid.

B. Bridge Period

In July 2015, West Virginia transitioned their behavioral health services to Managed Care Organizations (MCOs) under capitation arrangements. The ending date of the most reliable and detailed behavioral health data was June 2015. The demonstration bridge period therefore is 24 months from 7/1/15 through 6/30/17. The waiver will begin rollout on 7/1/17 with full roll-out projected for 1/1/18.

C. Without- Waiver Trend Rates, PMPM cost and Member Months with Justification

These are included in the WOW tab of the Excel Workbook west virginia-budget-neutrality-worksheet.xlxs. On the without waiver tab, we included only data for hypothetical pass through costs.

D. Risk

The Per Capita method is being used, which means that if membership increases or decreases, the PMPM levels not the aggregate costs will be measure for performance management purposes.

E. Historical Medicaid Populations: With-Waiver PMPM Cost and Member Month Projections

The "WW" tab of the Excel Workbook projects with waiver PMPM cost and member months.

F. Justification for With-Waiver Trend Rate, PMPM Costs and Member Months

As context for the budget neutrality calculations, historical spending on behavioral health claim services for members with a SUD diagnosis during the year displayed, and are projected to expand with or without the waiver. The focus of West Virginia's budget neutrality calculation is

the addition of several new SUD treatments to align the treatment system with ASAM guidelines that focus on providing an appropriate continuum of treatment for each individual treated.

Benchmarking Approach to Estimating Cost at Full Capacity

In order to create service access and utilization goals consistent with a well-developed system that has had behavioral health in managed care for 20 years, Compass calculated benchmark SUD utilization and expense summaries of SUD services incurred in calendar 2015 from the paid claim and enrollment data approximately 800,000 Pennsylvania Medicaid behavioral health managed care enrollees. The statistics developed from these data were calculated over the entire population and separately for the Affordable Care Act (ACA) Medicaid expansion population and the pre-expansion population.

Compass also calculated benchmark methadone and naloxone utilization and expense summaries for almost 80,000 average monthly members in one high-population Pennsylvania county.

Penetration rates were calculated for SUD services: hospital inpatient drug and alcohol services, non-hospital residential drug and alcohol services, and outpatient drug and alcohol services.

Rates were calculated for the population overall and by expansion status for all services, for all SUD services combined, for SUD services by the services types above, and for SUD services at the procedure code level. In addition, penetration rates were calculated over only those claims with an SUD diagnosis in the primary or secondary diagnosis field on the claim and over only those claims incurred by members who had a primary or secondary SUD diagnosis on a paid claim at some time during 2015.

These penetration rates were used to model the expected increases in West Virginia's Medicaid penetration rates for SUD services by year 5 of the waiver.

Compass calculated a utilization and cost summary for all behavioral health services incurred by over 800,000 average Medicaid members in 2015. Hospital inpatient drug and alcohol services, non-hospital residential drug and alcohol services, and outpatient drug and alcohol services were flagged as SUD services; all other services were flagged as "other" services. Possible waiver or pass-through SUD services methadone maintenance treatment (procedure code H0020), short term residential (procedure codes H0018, H2036, and T2048; revenue codes 991-995), and targeted case management (T1017) were identified and summarized as specific categories.

These results were further broken out by Medicaid expansion status, whether or not the claim reported a primary or secondary SUD diagnosis, and whether or not the member receiving the service had at least one paid claim with a primary or secondary SUD diagnosis during the year.

Pharmacy data was available for the almost 80,000 average monthly members in one urban Pennsylvania county.

Compass summarized paid claim utilization and expenses for the drugs methadone and naloxone; the resulting expenses were counter-intuitively small, resulting in annual cost per user estimates well below those documented in publicly-available reports on medication-assisted treatment, and these results were not used. Compass also reviewed the same statistics for the first half of 2016, and used 2016 levels where the 2015 results would have included pent up demand in the plan experience.

Below is a summary table of the benchmarking results based on 2015, and with adjustment for the first half of 2016 showing moderating utilization.

West Virginia Benchmarked to Other State Full Capacity

Expansion	Dollars	Users	Member Month	PMPM
Residential IMD	$ 33,872,087	7,392	1,904,437	$ 17.79
Residential Recovery	$ 14,676,582	3,548	1,904,437	$ 7.71
Methadone	$ 1,517,570	2,571	1,904,437	$ 0.80
Other BH with SUD Dx	$ 51,755,868	38,021	1,904,437	$ 27.18
Pre-Expansion	**Dollars**	**Users**	**Member Month**	**PMPM**
Residential IMD	$ 17,128,403	3,136	4,427,634	$ 3.87
Residential Recovery	$ 3,977,756	1,135	4,427,634	$ 0.90
Methadone	$ 1,737,058	2,460	4,427,634	$ 0.39
Other BH with SUD Dx	$ 49,253,308	30,195	4,427,634	$ 11.12

*Note users are not unique users, they are the sum of various services

New Expansion Services Under the Waiver

New services proposed under the with waiver calculation of budget neutrality include:

1. Residential SUD treatment facilities up to 30 days.
2. Recovery home facilities
3. Methadone administration
4. Distribution of naloxone kits
5. Screening, Brief Intervention, Referral and Treatment (SBIRT)

6. Performance Based Capitation incentive payments

For each new service on the with waiver side of the budget neutrality, we generated estimated program costs using the benchmarking approach described above, as well as savings suggested by peer reviewed research that asserts that SUD treatments avert other high cost emergency care.

1. Residential services

Under the waiver, cost estimates for residential services are considered a pass through for budget neutrality. To estimate ultimate residential potential expenditures, we used Pennsylvania as a benchmark. We obtained cost, utilization, and expenditures for PA for SUD residential services and split costs between pre expansion and expansion population. We applied per member per month costs to West Virginia membership to estimate full capacity expenditures. Then we assumed that the glide path to full capacity would happen over a five year period. We assumed 2 percent unit cost trend and 1 percent membership growth per year on all calculations.

2. Recovery home facilities

According to research, recovery homes significantly improve effectiveness of drug recovery. The projected costs for this service were made using the benchmark approach, with costs increasing ramping up to the full benchmark cost over time from the historical cost which was largely funded through block grant programs. For cost offsets, several studies have pointed to recovery facilities improving health care expenditures. One meta-analysis called the economic benefits of drug treatment showed a 4.34 to 1 benefit to cost ratio for residential treatment programs. While most of the benefit ratio was due to reduction in criminal activity, excluding that amount, the resulting savings was approximately 70% of the cost of residential treatment programs[xiii].

3. Methadone administration and counseling

Methadone administration cost has several components. There is the drug prescription cost, the administration of the treatment, and a counseling component to treatment. The national institute on drug abuse projected the total cost of methadone treatments to be approximately $4,700 annually.[xiv] A meta-analysis put the range between $6k and $12k. We assumed $4,700 to match the national drug institute estimate. To estimate the number of people seeking treatment, we assumed the Methadone SUD treatment penetration rate would ramp up over the 5 year demonstration period until it matched the utilization rate of Methadone in Pennsylvania. The

Pennsylvania user count was divided by Pennsylvania member months for expansion and pre-expansion separately to calculate utilization. The rates were applied to West Virginia membership and we used a cost of $4,700 annually.

To estimate the savings of Methadone treatment to health care costs. We used a combination of sources and took the more conservative estimates. A meta-analysis estimated savings from methadone to be 2-4 times cost.[xv] We assumed 2X as the savings to reflect the range is projected savings and that the studies that generate higher savings include some non health care related savings such as savings to criminal justice. Additionally, the national institute on drug abuse cites that "According to several conservative estimates, every dollar invested in addiction treatment programs yields a return of between $4 and $7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to healthcare are included, total savings can exceed costs by a ratio of 12 to 1." The 2:1 saving ratios is approximately the impact of going to 12:1 from 6:1 which was in the range of the estimate. Finally, SAMHSA refers to a study that concluded that the savings ratio was 4.87, although we chose to use a more conservative 2:1 savings estimate due to the low significant of the number of individuals in the sample population n=102 from the SAMHSA reference.[xvi]

4. Distribution of naloxone kits through licensed medical providers

West Virginia has the highest incidence of opioid deaths in the nation. Access to emergency naloxone kits saves lives. West Virginia intends to distribute kits to medical professionals as well as train emergency responders and police officers on administration. For estimating the projected cost, we assumed that kits purchased for medical professionals would receive funding under the demonstration waiver, although we recognize that some portion of these costs may need to be supplemented through block grants.

Cost per kit using Pennsylvania benchmarking data ranged from about $40 to around $500 with an average cost paid of $377 per kit. This data generated projected costs for naloxone of approximately $5 million when applied to West Virginia's membership base. According to the CDC, West Virginia had an age adjusted overdose death rate of 35.5 per 100,000 in 2014 versus a national average of about 14.7 per 100,000.[xvii] If naloxone kits reduced the death rate by even 10 percent, this would result in approximately 60 lives saved and approximately 20 within Medicaid. The cost per life saved is very low. We did not project any medical cost offsets, however, for this important SUD treatment service.

5. SBIRT

Screening, brief intervention, referral and treatment are estimated to cost about $52 per SBIRT.[xviii] West Virginia's goal is to provide SBIRT to about 44,000 members per year.[xix] This is an investment of about $2.3 million. According to the institute for clinical systems improvement, a study cited that patients with a SUD diagnosis generated $523 in savings from SBIRT.[xx] We applied a 15% SUD diagnosis rate based on FFS data to this savings estimate for a total savings of $3.45M (44,000 x $523 x 15%).

6. Performance-Based Capitation Incentive Payments

West Virginia uses MCOs to help effectively manage and control expenditures and build out provider support networks. The expected savings generated through better ASAM compliant SUD treatment will also for performance based incentive to MCOs that can effectively meet targeted improvements in treatment performance measurements determined by West Virginia.

Services not included in the Waiver calculation

Other services and programs related to West Virginia's expanded SUD treatment system are not included in the waiver calculation, as they are not reimbursed under the Medicaid system. These include, for example, the state's Prescription Drug Monitoring Program, which may be eligible for grant funding from the U.S. Department of Justice Bureau of Justice Assistance (BJA), as well as potential non licensed distribution of naloxone such as to first-responders and others who are not licensed medical providers. While naloxone is reimbursed under Medicaid when provided in a medical setting, including emergency departments and by paramedics/emergency medical technicians, broader distribution to non-medical agencies and organizations such as police forces and schools is not covered under the Medicaid program. Instead, these types of programs may be eligible for funding through grants through the BJA and the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). Additionally, services that are already paid for in West Virginia, with plans to be expanded, are not included in the waiver calculation for budget neutrality, as no caps are required for existing services capacity expansion.

Note also that the proposed waiver does not imply any changes to the eligible population, nor does it include use of DSH to offset incremental costs of the waiver.

The Excel Workbook summary tab contains a summary of with-waiver and without-waiver costs demonstrating budget neutrality. The tables from the summary tab are also included below.

	7/1/10 to 6/30/11	7/1/11 to 6/30/12	7/1/12 to 6/30/13	7/1/13 to 6/30/14	7/1/14 to 6/30/15	
Historical member months and expenditures						
	HY01	HY02	HY03	HY04	HY05	Total
Member Months	4,035,510	4,042,375	4,067,445	5,053,544	6,332,071	23,530,945
Currently Covered Behavioral Health (SUD)	79,491,946	87,873,154	87,458,478	93,157,954	100,284,916	448,266,448
Estimated Users of BH SUD					13,192	
Non Residential Cost Per Estimated BH SUD User					$ 7,602	
New Program Expenditures (RH,Methadone, Naloxone, SBIRT)	$ -	$ -	$ -	$ -	$ -	$ -
Max Estimated SUD Residential Grant Funds (IMD)	$ 11,494,438	$ 11,724,326	$ 11,958,813	$ 12,197,989	$ 12,441,949	$ 59,817,515
Max Estimated Recovery Home	$ 10,029,395	$ 10,229,983	$ 10,434,583	$ 10,643,275	$ 10,856,140	$ 52,193,376
BH SUD Spend (Non Waiver Existing Services w/IMD)	$ 101,015,779	$ 109,827,463	$ 109,851,874	$ 115,999,218	$ 123,583,005	$ 560,277,339
BH SUD PMPM	$ 25.03	$ 27.17	$ 27.01	$ 22.95	$ 19.52	$ 23.81
	7/1/17 to 6/30/18	7/1/18 to 6/30/19	7/1/19 to 6/30/20	7/1/20 to 6/30/21	7/1/21 to 6/30/22	
Demonstration member months and expenditures						
	DY01	DY02	DY03	DY04	DY05	Total
Member Months	6,523,939	6,589,178	6,655,070	6,721,621	6,788,837	33,278,646
BH SUD Spend (Non Waiver Existing Services) - Benchmarked	110,439,763	113,775,044	117,211,050	120,750,824	124,397,499	586,574,179
Estimated Users of BH SUD Projected	16,310	18,120	19,965	21,845	23,192	99,432
Non Residential Cost Per Estimated BH SUD User	6,771	6,279	5,871	5,528	$ 5,364	29,812
Without Waiver IMD (hypothetical assume to equal WW)	$ 17,824,719	$ 24,544,639	$ 33,797,967	$ 46,539,801	$ 57,193,118	$ 179,900,244
Without Waiver Recovery Home	$ -	$ -	$ -	$ -	$ -	$ -
Without Waiver Methadone	$ -	$ -	$ -	$ -	$ -	$ -
Without Waiver Naloxone	$ -	$ -	$ -	$ -	$ -	$ -
Without Waiver SBIRT	$ -	$ -	$ -	$ -	$ -	$ -
Without Waiver Savings Generated from new services	$ -	$ -	$ -	$ -	$ -	$ -
Without Waiver Pay for Performance Incentives	$ -	$ -	$ -	$ -	$ -	$ -
Without Waiver Total Cost include IMD hypothetical	$ 17,824,719	$ 24,544,639	$ 33,797,967	$ 46,539,801	$ 57,193,118	$ 179,900,244
With Waiver IMD (hypothetical assume to equal WW)	$ 17,824,719	$ 24,544,639	$ 33,797,967	$ 46,539,801	$ 57,193,118	$ 179,900,244
With Waiver Recovery Home	$ 13,248,716	$ 15,540,744	$ 18,229,293	$ 20,973,671	$ 22,973,685	$ 90,966,109
With Waiver Methadone	$ 9,914,338	$ 15,320,627	$ 21,044,413	$ 27,099,943	$ 27,918,361	$ 101,297,682
With Waiver Naloxone	$ 4,732,455	$ 4,875,375	$ 5,022,612	$ 5,174,295	$ 5,330,558	$ 25,135,296
With Waiver SBIRT	$ 2,428,044	$ 2,476,605	$ 2,526,137	$ 2,576,660	$ 2,628,193	$ 12,635,638
With Waiver Savings Generated from new services	$ (32,554,578)	$ (44,971,574)	$ (58,301,131)	$ (72,333,255)	$ (75,370,102)	$ (283,530,640)
With Waiver Pay for Performance Incentives	$ 1,838,880	$ 6,218,241	$ 10,735,121	$ 15,484,812	$ 15,261,056	$ 49,538,110
With Waiver Total Cost include IMD hypothetical	$ 17,432,576	$ 24,004,656	$ 33,054,412	$ 45,515,925	$ 55,934,869	$ 175,942,438
Without waiver	$ 17,824,719	$ 24,544,639	$ 33,797,967	$ 46,539,801	$ 57,193,118	$ 179,900,244
With waiver	$ 17,432,576	$ 24,004,656	$ 33,054,412	$ 45,515,925	$ 55,934,869	$ 175,942,438
Variance	$ 392,144	$ 539,982	$ 743,555	$ 1,023,876	$ 1,258,249	$ 3,957,805
Savings %	2.2%	2.2%	2.2%	2.2%	2.2%	2.2%
Hypothetical Pass Through Expenditures (IMD) Assumed	$ 17,824,719	$ 24,544,639	$ 33,797,967	$ 46,539,801	$ 57,193,118	$ 179,900,244
With Waiver SUD BH PMPM	$ 19.66	$ 20.99	$ 22.69	$ 24.89	$ 26.75	$ 23.03

6. Limitations

The services provided for this project were performed under the signed contract between Compass Health Analytics, Berry Dunn, and West Virginia DHHR approved April 2016.

The information contained in this report, has been prepared for the state of West Virginia, Department of Health and Human Services and their consultants and advisors. It is our understanding that the information contained in this report may be utilized in a public document. To the extent that the information contained in this report is provided to third parties, the report

should be distributed in its entirely. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Compass makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for DHHR by us that would result in the creation of any duty or liability under any theory of law by us or its employees to third parties.

Other parties receiving this report must rely upon their own experts in drawing conclusions about WV DHHR capitation rates, assumptions and trends. In performing this analysis, we relied on data and other information provided by WV DHHR and its vendors. We have not audited or verified this data and other information.

Differences between our projections and actual amounts will depend on how future experience conforms to the assumptions made in the analysis which may be higher or lower.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in actuarial communications. This report was prepared by a member of the American Academy of Actuaries, by an actuary who meets the qualification standards for performing the analysis in this report.

7. End Notes

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Appendix B. Public Comments Received

The following 17 stakeholders submitted public comments on the draft waiver application:

Acadia Healthcare

Cabin Creek Health Systems

Cardinal Pediatrics

Charlerston Area Medical Center

Highland Hospital Association, Highland Behavioral Health Services, inc.

Partners in Health Network, Inc.

Recovery Point of West Virginia

Thomas Memorial Hospital Administration and Behavioral Health Staff

Valley Healthcare Organization

West Virginia Association of Alcoholism and Drug Addiction Counselors

West Virginia Behavioral Healthcare Providers Association

West Virginia Perinatal Partnership

West Virginia Primary Care Association

West Virginia University School of Medicine – Department of Behavioral Medicine and Psychiatry

Three comments from community members

PUBLIC NOTICE

1. General announcement and for use in notices:

The Draft Substance Use Disorder Waiver Proposal is available September 20th through October 20th 2016

The West Virginia Bureau for Medical Services (BMS) has developed a proposal for a Medicaid Section 1115 waiver designed to establish a continuum of care for treating substance use disorders (SUD) in West Virginia. Section 1115 demonstration projects allow states to test innovative policy and delivery approaches for which States may receive federal financial participation (FFP).

The federal Centers for Medicare & Medicaid Services (CMS) released a guidance letter last year indicating their interest in working with states to combat substance abuse through their Medicaid programs. CMS provided some significant flexibilities and also some clear direction about the type of proposals they are interested in seeing from states. West Virginia has decided to take advantage of this opportunity and has developed a draft proposal that will create a continuum of care for individuals with SUD.

The draft proposal will be posted on the West Virginia Bureau for Medical Services website for a 30 day public comment period prior to submission to the Centers for Medicare and Medicaid Services. State Medicaid stakeholders, inclusive of providers and members, are encouraged to provide comments and feedback. Public comments may be incorporated throughout the final version of the proposal and may influence access to care recommendations going forward.

In addition, during the 30 day public comment period, there will be two public hearings held to receive State Medicaid stakeholder comments and feedback on the draft proposal:

- **Morgantown** - Wednesday, September 28th 10am–12pm
  Ruby Hospital
  1 Medical Center Drive Morgantown WV 26506
  Conference Room 3a and 3b, 4th floor

- **Charleston** - Thursday, September 29th 10am–12pm
  Beni Kedem Temple
  100 Quarrier St, Charleston, WV 25301
  Basement Conference Room

2. Cover paragraph which went on the BMS website:

Draft Substance Use Disorder Waiver Proposal Available for Public Comment through October 20th 2016

The West Virginia Department of Health and Human Resources recognizes that our state is facing a public health crisis as a result of the prevalence of substance use disorder (SUD) issues. The West Virginia Bureau for Medical Services (BMS) has developed a proposal for a Medicaid Section 1115 waiver designed to establish a continuum of care for treating SUD in West Virginia. Section 1115 demonstration projects allow states to test innovative policy and delivery approaches for which States may receive federal financial participation (FFP). State Medicaid stakeholders, inclusive of providers and members, are encouraged to provide comments and feedback. Public comments may be incorporated throughout the final version of the concept paper and may influence access to care recommendations going forward.

Link to Application:
http://www.dhhr.wv.gov/bms/News/Documents/WV%20Proposed%20Medicaid%20SUD%20Waiver%20Application.pdf

Email: dhhrbmscomments@wv.gov

Postal Mail:
350 Capitol Street
Room 251
Charleston, WV 25301

Summary File

7/1/10 to 6/30/11

Historical me		
	HY01	
Member Months		4,035,510
Currently Covered Behavioral Health (SUD)		79,491,946
Estimated Users of BH SUD		
Non Residential Cost Per Estimated BH SUD User		
New Program Expenditures (RH,Methadone, Naloxone, SBIRT)	$	-
Max Estimated SUD Residential Grant Funds (IMD)	$	11,494,438
Max Estimated Recovery Home	$	10,029,395
BH SUD Spend (Non Waiver Existing Services w/IMD)	$	101,015,779
BH SUD PMPM	$	25.03

7/1/17 to 6/30/18

Demonstration		
	DY01	
Member Months		6,523,939
BH SUD Spend (Non Waiver Existing Services) - Benchmarked		110,439,763
Estimated Users of BH SUD Projected		16,310
Non Residential Cost Per Estimated BH SUD User		6,771
Without Waiver IMD (hypothetical assume to equal WW)	$	17,824,719
Without Waiver Recovery Home	$	-
Without Waiver Methadone	$	-
Without Waiver Naloxone	$	-
Without Waiver SBIRT	$	-
Without Waiver Savings Generated from new services	$	-
Without Waiver Pay for Performance Incentives	$	-
Without Waiver Total Cost include IMD hypothetical	$	17,824,719
With Waiver IMD (hypothetical assume to equal WW)	$	17,824,719
With Waiver Recovery Home	$	13,248,716
With Waiver Methadone	$	9,914,338
With Waiver Naloxone	$	4,732,455
With Waiver SBIRT	$	2,428,044
With Waiver Savings Generated from new services	$	(32,554,578)
With Waiver Pay for Performance Incentives	$	1,838,880
With Waiver Total Cost include IMD hypothetical	$	17,432,576
Without waiver	$	17,824,719
With waiver	$	17,432,576
Variance	$	392,144
Savings %		2.2%

Hypothetical Pass Through Expenditures (IMD) Assumed	$	17,824,719
With Waiver SUD BH PMPM	$	19.66

		Historical me
Expenditure Detail	HY01	
Expansion Member Months		0
New Recovery Home, MAT (Methadone), Naloxone, SBIRT	$	-
BH SUD Spend (Non Waiver Existing Services)	$	-
SUD Grant Residential Historical	$	-
SUD Recovery Home (Grant Historical)	$	-
Hypothetical Residential (IMD)	$	-
Pre Expansion Member Months		4,035,510
New Recovery Home, MAT (Methadone), Naloxone, SBIRT	$	-
BH SUD Spend (Non Waiver Existing Services)	$	79,491,946
SUD Grant Residential Historical	$	11,494,438
SUD Recovery Home (Grant Historical)	$	10,029,395
Hypothetical Residential (IMD)	$	21,493,993
Total Member Months		4,035,510
New Recovery Home, MAT (Methadone), Naloxone, SBIRT	$	-
BH SUD Spend (Non Waiver Existing Services)	$	79,491,946
SUD Grant Residential Historical	$	11,494,438
SUD Recovery Home (Grant Historical)	$	10,029,395
Hypothetical Residential (IMD)	$	21,493,993

Membership Growth Factor	1.030
IMD Ramp Up Factor	1.350
Recovery Home Ramp Up Factor	1.150
Methadone % of full capacity assumed	40%
Trend Factor	1.061

		Demonstration
Expenditure Detail	DY01	
Expansion Member Months		1,962,143
Pass Through IMD with Ramp Up Assumption	$	13,519,642

Recovery Home Residential	$	10,048,848
New MAT (Methadone)	$	5,931,751
Naloxone	$	2,855,124
Early intervention (SBIRT)	$	1,214,022
SUD Treatment (Savings)	$	(20,623,596)
Pay for Performance Incentive	$	276,419
BH SUD Spend (Non Waiver Existing Services)- Benchmarked	$	56,587,985
Pass Through Residential (IMD) Full Benchmarked	$	37,034,509
Recovery Home Full Benchmarked	$	16,046,842
Pre Expansion Member Months		4,561,796
Pass Through IMD with Ramp Up Assumption	$	4,305,077
Recovery Home Residential	$	3,199,868
New MAT (Methadone)	$	3,982,587
Naloxone	$	1,877,332
Early intervention (SBIRT)	$	1,214,022
SUD Treatment (Savings)	$	(11,930,981)
Pay for Performance Incentive	$	1,562,461
BH SUD Spend (Non Waiver Existing Services)- Benchmarked	$	53,851,778
Pass Through Residential (IMD) Full Benchmarked	$	18,727,573
Recovery Home Full Benchmarked	$	4,349,134
Total Member Months		6,523,939
Pass Through IMD with Ramp Up Assumption	$	17,824,719
Recovery Home Residential	$	13,248,716
New MAT (Methadone)	$	9,914,338
Naloxone	$	4,732,455
Early intervention (SBIRT)	$	2,428,044
SUD Treatment (Savings)	$	(32,554,578)
Pay for Performance Incentive	$	1,838,880
BH SUD Spend (Non Waiver Existing Services)- Benchmarked	$	110,439,763
Pass Through Residential (IMD) Full Benchmarked	$	55,762,083
Recovery Home Full Benchmarked	$	20,395,976

7/1/11 to 6/30/12	7/1/12 to 6/30/13	7/1/13 to 6/30/14	7/1/14 to 6/30/15

mber months and expenditures

HY02	HY03	HY04	HY05
4,042,375	4,067,445	5,053,544	6,332,071
87,873,154	87,458,478	93,157,954	100,284,916
			13,192
			$ 7,602
$ -	$ -	$ -	$ -
$ 11,724,326	$ 11,958,813	$ 12,197,989	$ 12,441,949
$ 10,229,983	$ 10,434,583	$ 10,643,275	$ 10,856,140
$ 109,827,463	$ 109,851,874	$ 115,999,218	$ 123,583,005
$ 27.17	$ 27.01	$ 22.95	$ 19.52

7/1/18 to 6/30/19	7/1/19 to 6/30/20	7/1/20 to 6/30/21	7/1/21 to 6/30/22

member months and expenditures

DY02	DY03	DY04	DY05
6,589,178	6,655,070	6,721,621	6,788,837
113,775,044	117,211,050	120,750,824	124,397,499
18,120	19,965	21,845	23,192
6,279	5,871	5,528	$ 5,364
$ 24,544,639	$ 33,797,967	$ 46,539,801	$ 57,193,118
$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -
$ 24,544,639	$ 33,797,967	$ 46,539,801	$ 57,193,118
$ 24,544,639	$ 33,797,967	$ 46,539,801	$ 57,193,118
$ 15,540,744	$ 18,229,293	$ 20,973,671	$ 22,973,685
$ 15,320,627	$ 21,044,413	$ 27,099,943	$ 27,918,361
$ 4,875,375	$ 5,022,612	$ 5,174,295	$ 5,330,558
$ 2,476,605	$ 2,526,137	$ 2,576,660	$ 2,628,193
$ (44,971,574)	$ (58,301,131)	$ (72,333,255)	$ (75,370,102)
$ 6,218,241	$ 10,735,121	$ 15,484,812	$ 15,261,056
$ 24,004,656	$ 33,054,412	$ 45,515,925	$ 55,934,869
$ 24,544,639	$ 33,797,967	$ 46,539,801	$ 57,193,118
$ 24,004,656	$ 33,054,412	$ 45,515,925	$ 55,934,869
$ 539,982	$ 743,555	$ 1,023,876	$ 1,258,249
2.2%	2.2%	2.2%	2.2%

$ 24,544,639	$ 33,797,967	$ 46,539,801	$ 57,193,118

$ 20.99	$ 22.69	$ 24.89	$ 26.75

mber months and expenditures

HY02	HY03	HY04	HY05
0	0	701,188	1,904,437
$ -	$ -	$ -	$ -
$ -	$ -	$ 12,262,270	$ 38,410,758
$ -	$ -	$ 6,592,938	$ 9,436,934
$ -	$ -	$ 5,752,624	$ 8,234,134
$ -	$ -	$ 27,267,323	$ 74,058,453

4,042,375	4,067,436	4,352,356	4,427,634
$ -	$ -	$ -	$ -
$ 87,873,154	$ 87,458,478	$ 80,895,685	$ 61,874,158
$ 11,724,326	$ 11,958,813	$ 5,605,051	$ 3,005,015
$ 10,229,983	$ 10,434,583	$ 4,890,650	$ 2,622,006
$ 21,530,558	$ 21,664,038	$ 23,181,583	$ 23,582,530

4,042,375	4,067,436	5,053,544	6,332,071
$ -	$ -	$ -	$ -
$ 87,873,154	$ 87,458,478	$ 93,157,954	$ 100,284,916
$ 11,724,326	$ 11,958,813	$ 12,197,989	$ 12,441,949
$ 10,229,983	$ 10,434,583	$ 10,643,275	$ 10,856,140
$ 21,530,558	$ 21,664,038	$ 50,448,906	$ 97,640,983

1.041	1.051	1.062	1.072
1.823	2.460	3.322	4.484
1.323	1.521	1.749	2.011
60%	80%	100%	100%
1.082	1.104	1.126	1.149

member months and expenditures

DY02	DY03	DY04	DY05
1,981,765	2,001,582	2,021,598	2,041,814
$ 18,616,547	$ 25,634,985	$ 35,299,375	$ 41,715,051

$	11,787,299	$	13,826,502	$	16,218,486	$	18,074,894
$	9,166,335	$	12,590,878	$	16,213,903	$	16,703,563
$	2,941,348	$	3,030,177	$	3,121,689	$	3,215,964
$	1,238,302	$	1,263,068	$	1,288,330	$	1,314,096
$	(28,309,680)	$	(36,586,208)	$	(45,506,647)	$	(47,785,452)
$	2,766,831	$	5,311,612	$	7,887,653	$	7,559,204
$	58,296,943	$	60,057,510	$	61,871,247	$	63,739,759
$	38,152,952	$	39,305,171	$	40,492,187	$	41,715,051
$	16,531,457	$	17,030,707	$	17,545,034	$	18,074,894

	4,607,414		4,653,488		4,700,023		4,747,023
$	5,928,091	$	8,162,982	$	11,240,426	$	15,478,067
$	3,753,445	$	4,402,791	$	4,755,185	$	4,898,791
$	6,154,291	$	8,453,535	$	10,886,039	$	11,214,798
$	1,934,027	$	1,992,435	$	2,052,606	$	2,114,595
$	1,238,302	$	1,263,068	$	1,288,330	$	1,314,096
$	(16,661,894)	$	(21,714,923)	$	(26,826,608)	$	(27,584,649)
$	3,451,411	$	5,423,509	$	7,597,159	$	7,701,852
$	55,478,101	$	57,153,540	$	58,879,577	$	60,657,740
$	19,293,146	$	19,875,799	$	20,476,048	$	21,094,425
$	4,480,477	$	4,615,788	$	4,755,185	$	4,898,791

	6,589,178		6,655,070		6,721,621		6,788,837
$	24,544,639	$	33,797,967	$	46,539,801	$	57,193,118
$	15,540,744	$	18,229,293	$	20,973,671	$	22,973,685
$	15,320,627	$	21,044,413	$	27,099,943	$	27,918,361
$	4,875,375	$	5,022,612	$	5,174,295	$	5,330,558
$	2,476,605	$	2,526,137	$	2,576,660	$	2,628,193
$	(44,971,574)	$	(58,301,131)	$	(72,333,255)	$	(75,370,102)
$	6,218,241	$	10,735,121	$	15,484,812	$	15,261,056
$	113,775,044	$	117,211,050	$	120,750,824	$	124,397,499
$	57,446,097	$	59,180,970	$	60,968,235	$	62,809,476
$	21,011,934	$	21,646,494	$	22,300,219	$	22,973,685

Total	
23,530,945	
448,266,448	Not going into calculation. Informational
$ -	
$ 59,817,515	See Allocations tab (not Recovery Home or Forensic)-- Note , Not tracked
$ 52,193,376	See Allocations Tab under labels recovery home
$ 560,277,339	Includes GRANT IMD spending and Grant Recovery Home Spending
$ 23.81	Includes GRANT IMD spending

Total	
33,278,646	
586,574,179	
99,432	
29,812	
$ 179,900,244	
$ -	
$ -	
$ -	
$ -	
$ -	
$ -	
$ 179,900,244	Excludes BH services already funded through Medicaid
$ 179,900,244	
$ 90,966,109	
$ 101,297,682	
$ 25,135,296	
$ 12,635,638	
$ (283,530,640)	
$ 49,538,110	
$ 175,942,438	
$ 179,900,244	
$ 175,942,438	Set Pay for Performance Targets to Equal Without Waiver
$ 3,957,805	
2.2%	

$	179,900,244	Assumed Ramp up until meet capacity

$ 23.03

Total
2,605,625

$	-	
$	50,673,028	Molina Data Used BH Categories with SUD Dx on Member, not part of wa
$	16,029,872	Estimated Prorata Share on Grant
$	13,986,758	
$	101,325,775	IMD Pass Through - Not Actual Cost, Cost Needed to Support a Functionin

20,925,311

$	-	
$	397,593,420	Molina Data Used BH Categories with SUD Dx on Member, not part of wa
$	43,787,643	Estimated Prorata Share on Grant
$	38,206,618	
$	111,452,702	

23,530,936

$	-
$	448,266,448
$	59,817,515
$	52,193,376
$	212,778,478

Membership Growth
IMD Ramp Up Assumptions
Recover Home Ramp Up Assumptions
Methadone Ramp up Speed assumption
Unit Cost Trend Factor (approx CPI)

Total
10,008,903

$	134,785,600

$	69,956,029	
$	60,606,432	https://www.drugabuse.gov/publications/principles-drug-addiction-treatr
$	15,164,301	Used Benchmarking methodology at cost of $377 each plus trend- OTC co
$	6,317,819	$52 each x 44,000 goal (cite two websites)-- Assume 1/2 is expansion
$	(178,811,583)	USE Meta Study that Methadone saves 2-4x treatment cost (better studie
$	23,801,719	
$	300,553,444	Used 1h 2016 of PA BH Data with SUD Dx as a benchmark to compare to \
$	196,699,869	
$	85,228,933	
	23,269,743	
$	45,114,643	Assumed Ramp up until meeting capacity
$	21,010,080	
$	40,691,250	
$	9,970,994	Benchmarked and cost for OTC is $40 but most benchmark spend comes f
$	6,317,819	
$	(104,719,057)	USE Meta Study that Methadone saves 2-4x treatment cost (better studie
$	25,736,391	
$	286,020,735	
$	99,466,991	
$	23,099,375	
	33,278,646	
$	179,900,244	Assumed Ramp up until meeting capacity
$	90,966,109	
$	101,297,682	
$	25,135,296	
$	12,635,638	
$	(283,530,640)	
$	49,538,110	
$	586,574,179	Could improve by showing anticipated treated individuals by ASAM categ
$	296,166,860	
$	108,328,308	

perfectly since not part of Medicaid. SUD & BH intermingled, funding sources varied. (Maximum of all bed costs)

aiver, so WW same as WOW

g Program

aiver, so WW same as WOW

1.01	1.020	Assume 1% member growth rate (get revised number from state estimate)
1.35		
1.15		
See to the left		
1.02	1.040	May be difficult to keep at 2% and expand provider base

ment-research-based-guide-third-edition/frequently-asked-questic https://www.drugabuse.gov/publications/prir
sts are less expensive

http://www.dhhr.wv.gov/bhhf/sections/progr
s are out there, but this one is simple). Residential pass through will produce savings as well, but are those saving

NV, used 2016 which is lower than 2015 which would have pent up demand - Could refine to take out BH only se

Other good summary of savings study
https://www.samhsa-gpra.samhsa.gov/CSAT/view/docs/SAIS_GPRA_CostOffsetSubstanceAbuse.pdf

rom $300-$400 treatment NDC codes.

s are out there, but this one is simple). Residential pass through will produce savings as well, but are those saving

ory or CPT Code - Before and After Waiver

BY 1	BY2

ıciples-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/drug-a

rams/ProgramsPartnerships/AlcoholismandDrugAbuse/Pages/SBIRT.aspx

ȝs also a pass through? Could assume 26% savings on Treated Users (assume 2% Incremental Pen rate)

rvices with some additional data pull.

ȝs also a pass through? Could assume 26% savings on Treated Users (assume 2% Incremental Pen rate)

addiction-treatment-worth-its-cost

. Washington study says SBIRT saves $250pmpm (seems excessive), used $250 per SBIRT. Another stud

. Washington study says SBIRT saves $250pmpm (seems excessive), used $250 per SBIRT. Another stud

y showed $523 in savings (10x savings) for people with an SUD (which is about 15%). https://www.icsi.

y showed $523 in savings (10x savings) for people with an SUD (which is about 15%). https://www.icsi.

org/_asset/2g3rnr/SBIRT-Reduces-Costs.pdf Assume Recovery Home covers 70% of Treatment Cost (se

org/_asset/2g3rnr/SBIRT-Reduces-Costs.pdf

veral studies)

	A	B	C	D	E	F	G	H	I	J
1	**5 YEARS OF HISTORIC DATA**									
2										
3	**SFY 2015 depicts the time period from 7/1/2014 through 6/30/2015 for PreExpansion and Expansion Populations for BH SUD Treatment Spending**									
4										
5										
6	**Medicaid Pop 1 - Pre Expansion Members New BH SUD Treatment**	**SFY 2011**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**5-YEARS**	Comments		
7	**TOTAL EXPENDITURES**	$ -	$ -	$ -	$ -	$ -	$ -	Service Year Expenditures for BH SUD sp		
8	**ELIGIBLE MEMBER MONTHS**	4,035,510	4,042,375	4,067,436	4,352,356	4,427,634				
9	**PMPM COST**	$ -	$ -	$ -	$ -	$ -				
10	**TREND RATES**						**5-YEAR**			
11				**ANNUAL CHANGE**			**AVERAGE**			
12	TOTAL EXPENDITURE		0.00%	0.00%	0.00%	0.00%	0.00%			
13	ELIGIBLE MEMBER MONTHS		0.17%	0.62%	7.00%	1.73%	2.35%			
14	PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			
15										
16	**Medicaid Pop 2 - Expansion Members New BH SUD Treatment**	**SFY 2011**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**5-YEARS**			
17	**TOTAL EXPENDITURES**	$ -	$ -	$ -	$ -	$ -	$ -			
18	**ELIGIBLE MEMBER MONTHS**	-	-	-	701,188	1,904,437				
19	**PMPM COST**				$ -	$ -				
20	**TREND RATES**						**5-YEAR**			
21				**ANNUAL CHANGE**			**AVERAGE**			
22	TOTAL EXPENDITURE					0.00%	0.00%			
23	ELIGIBLE MEMBER MONTHS					171.60%	171.60%			
24	PMPM COST					0.00%	0.00%			
25										
26	**Hypothetical Pass Through IMD Expenditures**	**SFY 2011**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**	**5-YEARS**			
27	**TOTAL EXPENDITURES**	$ 11,494,438	$ 11,724,326	$ 11,958,813	$ 12,197,989	$ 12,441,949	$ 59,817,515	Estimated (hypothetical, wasn't designed f		
28	**ELIGIBLE MEMBER MONTHS**	4,035,510	4,042,375	4,067,436	5,053,544	6,332,071				
29	**PMPM COST**	$ 2.85	$ 2.90	$ 2.94	$ 2.41	$ 1.96				
30	**TREND RATES**						**5-YEAR**			
31				**ANNUAL CHANGE**			**AVERAGE**			
32	TOTAL EXPENDITURE		2.00%	2.00%	2.00%	2.00%	2.00%	Defaulted to 2%, not tracked accept 2017		
33	ELIGIBLE MEMBER MONTHS		0.17%	0.62%	24.24%	25.30%	11.92%			
34	PMPM COST		1.83%	1.37%	-17.90%	-18.60%	-8.86%	Hasn't kept pace with capacity need		

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27	or spend tracking)	
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	A	B	C	D	E	F	G	H	I	J	K
1	**DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS**										
2											
3											
4	**ELIGIBILITY**	**TREND**	**MONTHS**	**BASE YEAR**	**TREND**	**DEMONSTRATION YEARS (DY)**					**TOTAL**
5	**GROUP**	**RATE 1**	**OF AGING**	**DY 00**	**RATE 2**	**SFY2017**	**SFY2018**	**SFY2019**	**SFY2020**	**SFY2021**	**WOW**
6											
7	**Medicaid Pop 1 - Pre Expansion Members New BH SUD Treatment**										
8	**Pop Type:**	**Medicaid**									
9	Eligible Member Months	1.0%	24	4,516,629	1.0%	4,561,796	4,607,414	4,653,488	4,700,023	4,747,023	
10	PMPM Cost	2.0%	24	$ -	0.0%	$ 0.94	$ 1.29	$ 1.75	$ 2.39	$ 3.26	
11	Total Expenditure					$ 4,305,077	$ 5,928,091	$ 8,162,982	$ 11,240,426	$ 15,478,067	$ 45,114,643
12											
13	**Medicaid Pop 2 - Expansion Members New BH SUD Treatment**										
14	**Pop Type:**	**Medicaid**									
15	Eligible Member Months	1.0%	24	1,942,716	1.0%	1,962,143	1,981,765	2,001,582	2,021,598	2,041,814	
16	PMPM Cost	2.0%	24	$ -	0.0%	$ 6.89	$ 9.39	$ 12.81	$ 17.46	$ 20.43	
17	Total Expenditure					$ 13,519,642	$ 18,616,547	$ 25,634,985	$ 35,299,375	$ 41,715,051	$ 134,785,600
18											
24											
25	**IMD Hypothetical With Assumed Ramp Up In Capacity**										
26	**Pop Type:**	**Hypothetical**									
27	Eligible Member Months	1.0%	24	6,332,071	1.0%	6,523,939	6,589,178	6,655,070	6,721,621	6,788,837	
28	PMPM Cost	2.0%	24	$ 1.96	33.9%	$ 2.73	$ 3.72	$ 5.08	$ 6.92	$ 8.42	
29	Total Expenditure					$ 17,824,719	$ 24,544,639	$ 33,797,967	$ 46,539,801	$ 57,193,118	$ 179,900,244

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
Medicaid Pop 1 - Pre Expansion Members New BH SUD Treatment								
Pop Type:	**Medicaid**							
Eligible Member Months	4,516,629	1.0%	4,561,796	4,607,414	4,653,488	4,700,023	4,747,023	
PMPM Cost	$ -	0.0%	$ 0.92	$ 1.26	$ 1.72	$ 2.34	$ 3.19	
Total Expenditure			$ 4,210,366	$ 5,797,673	$ 7,983,396	$ 10,993,137	$ 15,137,549	$ 44,122,121
Medicaid Pop 2 - Expansion Members New BH SUD Treatment								
Pop Type:	**Medicaid**							
Eligible Member Months	1,942,716	1.0%	1,962,143	1,981,765	2,001,582	2,021,598	2,041,814	
PMPM Cost	$ -	0.0%	$ 6.74	$ 9.19	$ 12.53	$ 17.08	$ 19.98	
Total Expenditure			$ 13,222,210	$ 18,206,983	$ 25,071,016	$ 34,522,789	$ 40,797,320	$ 131,820,317
IMD Hypothetical With Assumed Ramp Up In Capacity								
Pop Type:	**Hypothetical**							
Eligible Member Months	6,332,071	1.0%	6,523,939	6,589,178	6,655,070	6,721,621	6,788,837	
PMPM Cost	$ 1.96	33.9%	$ 2.73	$ 3.72	$ 5.08	$ 6.92	$ 8.42	
Total Expenditure			$ 17,824,719	$ 24,544,639	$ 33,797,967	$ 46,539,801	$ 57,193,118	$ 179,900,244

Panel 1: Historic DSH Claims for the Last Five Fiscal Years:

RECENT PAST FEDERAL FISCAL YEARS	20__	20__	20__	20__	20__
State DSH Allotment (Federal share)					
State DSH Claim Amount (Federal share)					
DSH Allotment Left Unspent (Federal share)	$ -	$ -	$ -	$ -	$ -

Panel 2: Projected Without Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)						
State DSH Claim Amount (Federal share)						
DSH Allotment Projected to be Unused (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 3: Projected With Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
State DSH Claim Amount (Federal share)						
Maximum DSH Allotment Available for Diversion (Federal share)						
Total DSH Alltoment Diverted (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Available for DSH Diversion Less Amount Diverted (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Projected to be Unused (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 4: Projected DSH Diversion Allocated to DYs

DEMONSTRATION YEARS		DY 01	DY 02	DY 03	DY 04	DY 05
DSH Diversion to Leading FFY (total computable)						
FMAP for Leading FFY						
DSH Diversion to Trailing FFY (total computable)						
FMAP for Trailing FFY						
Total Demo Spending From Diverted DSH (total computable)		$ -	$ -	$ -	$ -	$ -

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Medicaid Pop 1 - Pre Expansion Members New BH SUD Treatment	$ 4,305,077	$ 5,928,091	$ 8,162,982	$ 11,240,426	$ 15,478,067	$ 45,114,643
Medicaid Pop 2 - Expansion Members New BH SUD Treatment	$ 13,519,642	$ 18,616,547	$ 25,634,985	$ 35,299,375	$ 41,715,051	$ 134,785,600
DSH Allotment Diverted	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 17,824,719	$ 24,544,639	$ 33,797,967	$ 46,539,801	$ 57,193,118	$ 179,900,244

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Medicaid Pop 1 - Pre Expansion Members New BH SUD Treatment	$ 4,210,366	$ 5,797,673	$ 7,983,396	$ 10,993,137	$ 15,137,549	$ 44,122,121
Medicaid Pop 2 - Expansion Members New BH SUD Treatment	$ 13,222,210	$ 18,206,983	$ 25,071,016	$ 34,522,789	$ 40,797,320	$ 131,820,317
	$ -	$ -	$ -	$ -	$ -	$ -
Expansion Populations						
Exp Pop 1 - None	$ -	$ -	$ -	$ -	$ -	$ -
Exp Pop 2 - None	$ -	$ -	$ -	$ -	$ -	$ -
Excess Spending From Hypotheticals						$ -
TOTAL	$ 17,432,576	$ 24,004,656	$ 33,054,412	$ 45,515,925	$ 55,934,869	$ 175,942,438

VARIANCE	$ 392,144	$ 539,982	$ 743,555	$ 1,023,876	$ 1,258,249	$ 3,957,805

HYPOTHETICALS ANALYSIS

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
IMD Hypothetical With Assumed Ramp Up In Capacity	$ 17,824,719	$ 24,544,639	$ 33,797,967	$ 46,539,801	$ 57,193,118	$ 179,900,244
TOTAL	$ 17,824,719	$ 24,544,639	$ 33,797,967	$ 46,539,801	$ 57,193,118	$ 179,900,244

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
IMD Hypothetical With Assumed Ramp Up In Capacity	$ 17,824,719	$ 24,544,639	$ 33,797,967	$ 46,539,801	$ 57,193,118	$ 179,900,244
TOTAL	$ 17,824,719	$ 24,544,639	$ 33,797,967	$ 46,539,801	$ 57,193,118	$ 179,900,244

HYPOTHETICALS VARIANCE	$ -	$ -	$ -	$ -	$ -	$ -