

West Virginia
Medicaid Section 1115 Waiver Demonstration:
Evolving West Virginia Medicaid's Behavioral
Health Continuum of Care

Working DRAFT – March 22, 2022

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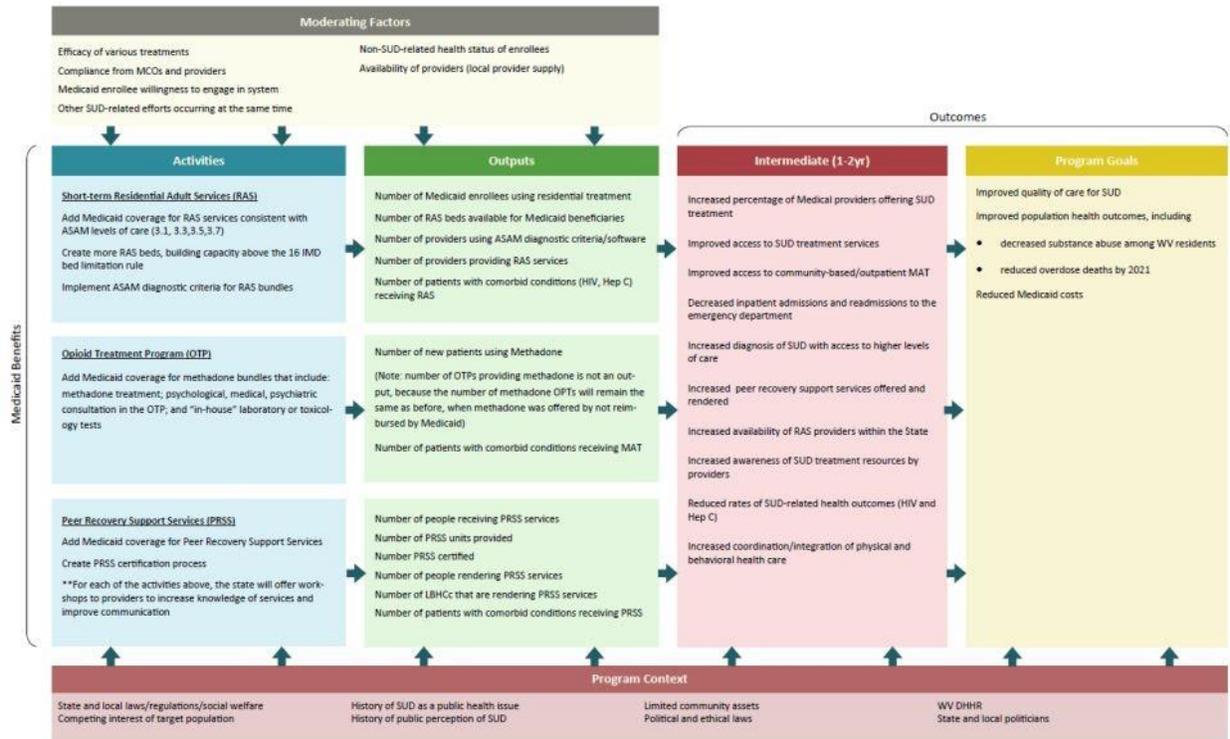
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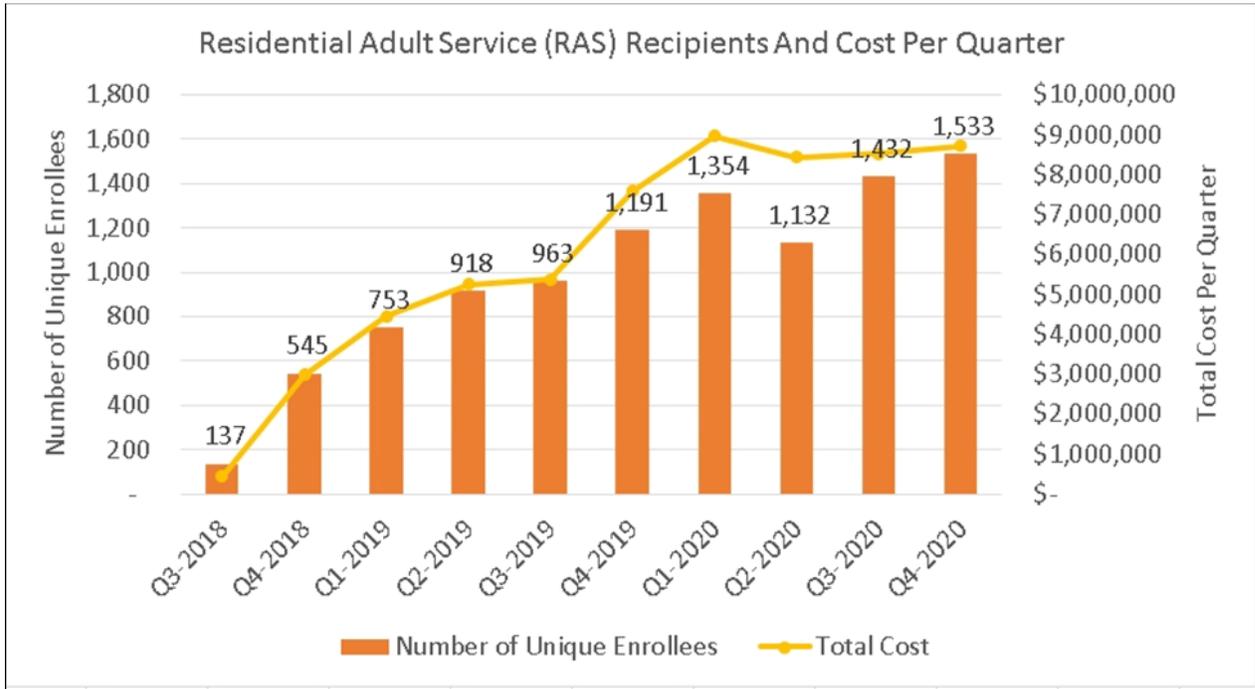
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1. Executive Summary

The State of West Virginia (WV) Bureau for Medical Services (BMS) seeks to extend its Section 1115(a) waiver demonstration, “West Virginia Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders (SUD)”—currently approved through December 31, 2022 (Number 11-W-00307/3)—for another five years.

BMS submitted the initial waiver application to help West Virginia face an ongoing public health crisis involving the highest rate of drug overdose (OD) deaths in the country. The active waiver demonstration helped BMS **increase the availability of SUD prevention and treatment** services for West Virginia Medicaid members, **improve overall health and health outcomes**, and further **improve the integration of physical and behavioral health**. Expanded access to SUD treatment became even more important as a result of the COVID-19 public health emergency (PHE), which has profoundly affected West Virginia residents, BMS operations, and progress toward waiver goals (see Section 2: Introduction).

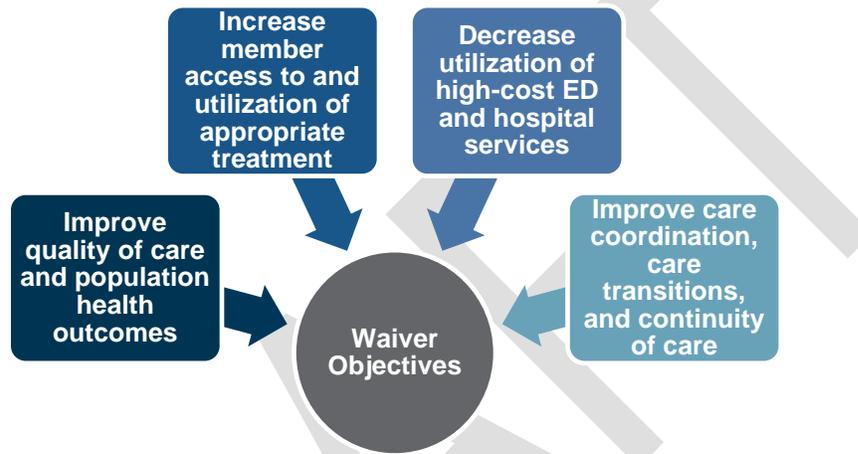
Through this waiver extension, BMS will evolve its continuum of care for individuals with serious mental and behavioral health disorders. BMS requests federal authority to:

- **Continue existing waiver services** to collect additional data on outcomes.
- Engage high-risk individuals in vulnerable settings.
 - **Expand peer support to more settings** (e.g., emergency departments [EDs]).
 - Send **quick response teams (QRTs)** to identify individuals who have overdosed or are experiencing a substance use-related emergency and engage them in order to prevent and reduce incidences of repeat OD and OD fatalities.
 - Provide Medicaid coverage to eligible **individuals incarcerated in state prisons starting 30 days prior to release**.
 - **Offer involuntary secure withdrawal management and stabilization (SWMS)** for individuals deemed a danger to themselves or others—or other eligibility criteria to be determined in state code—by a designated crisis responder.
 - Support a more holistic and integrated approach to **treatment, education, and outreach for Human Immunodeficiency Virus (HIV) and Hepatitis C (HCV)** in relation to substance use.
- Address social determinants of health (SDOH) to cultivate self-reliance and support continued recovery through **recovery housing** offering clinical-level treatment services to SUD members, **supported housing, and supported employment**.
- Offer contingency management, through the **Treatment of Users with Stimulant Use Disorder (TRUST) comprehensive outpatient model**, as an additional evidence-based practice for individuals with stimulant use disorder.

- Reimburse short-term (i.e., average length of stay no longer than 30 days), medically necessary residential and inpatient treatment services within settings that qualify as **institutions for mental diseases (IMDs) for Medicaid-eligible adults with serious mental illnesses (SMIs)**.

BMS' overall goal is to provide the right care at the right time, in the right setting, for individuals with SUD and/or SMI. Figure 2, below, establishes BMS' key objectives toward this goal.

Figure 1: Key Waiver Application Objectives



These objectives, and their intended outcomes, are described further in Section 4.

The program will build on current program successes (see Section 3.1), complementary initiatives by BMS' sister agencies within the West Virginia Department of Health and Human Resources (DHHR),ⁱ stakeholder feedback (see Section 8), and the following federal guidance:

- State Medicaid Director (SMD) #18-011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance," published November 13, 2018
- State Health Official (SHO) #21-001, "Opportunities in Medicaid and the Children's Health Insurance Program (CHIP) to Address SDOH," published January 7, 2021

BMS will provide this comprehensive and coordinated set of behavioral health services to all adult Medicaid members in West Virginia who meet medical necessity criteria (described further in Section 4) with no cost sharing, through either a managed care organization (MCO) or fee-for-service (FFS) delivery system as appropriate for the member.

BMS requests a demonstration period of January 1, 2023 – December 31, 2027.

2. Introduction

BMS intends to continue evolving its continuum of care for individuals with serious mental and behavioral health disorders in response to:

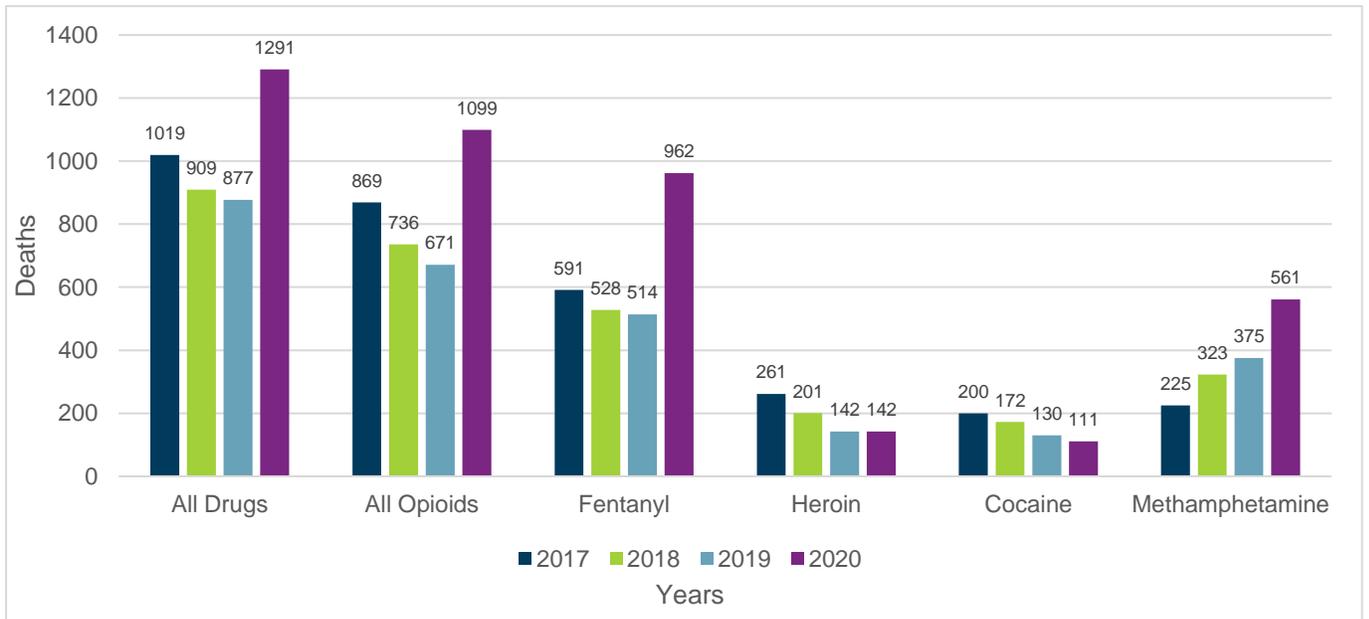
- Preliminary successes of the current waiver program for Medicaid members with SUD
- Opportunities to expand services identified through operational lessons learned and stakeholder feedback
- New federal guidance regarding demonstrations to support individuals with SMI and SDOH needs
- Numerous outbreaks of both HIV and HCV in recent years, a public health crisis intertwined with the SUD public health crisisⁱⁱ

BMS is also requesting this extension in response to impacts from the COVID-19 public health emergency (PHE). The PHE has profoundly affected West Virginia residents, BMS operations, and progress toward waiver goals in ways that include, but are not limited to, the following:

- **Intensified the SUD crisis and other mental health disorders.** A Kaiser Family Foundation (KFF) poll found that 4 in 10 adults in the U.S. reported mental health concerns in July 2020 (up from 1 in 10 the previous year), and 12% of adults reported increases in alcohol consumption or substance use.ⁱⁱⁱ
- **Placed economic strain on many individuals,** with a higher national unemployment rate in April 2020 than has occurred since the Great Depression, and economic hardship peaking around December 2020.^{iv} In West Virginia, the unemployment rate peaked in April 2020 at nearly 16%. While that rate has been improving steadily since April 2020, West Virginia has lost 5% of jobs overall across the state since the start of the PHE. West Virginia Medicaid covered approximately one-third of the state's population, 584,000 residents, in May 2021.^v
- **Suppressed service utilization** as individuals delayed or went without medical care they would otherwise have received. Overall health spending decreased in 2020 for the first time in recorded history.^{vi}
- **Required testing and admission protocols for residential and inpatient facilities** that often meant fewer beds were available, facilities had to operate with reduced staffing, and/or Medicaid members experienced extended lengths of stay due to quarantine requirements.
- **Increased telehealth flexibility and utilization** for many services, including all psychological testing, evaluation, and Assertive Community Treatment (ACT) services.^{vii} Telehealth/telemedicine visits with a SUD diagnosis increased from **12,557** in 2019 to **197,606** in 2020.^{viii}
- **Contributed to inconsistent metrics data** for the waiver program, complicating outcomes measurement and data-driven decision-making.

As an example of PHE impacts on individuals and outcomes, overall fatal ODs in West Virginia declined in 2018 and 2019—achieving one of the waiver’s critical objectives to reduce ODs by 2021, the fourth demonstration year (DY4).^{ix} However, as shown in Figure 1, deaths from ODs then rose in 2020 to above pre-waiver levels.^x

Figure 2: Fatal OD Counts in West Virginia by Drug Type, 2017 – 2020^{xi}



This is consistent with Centers for Disease Control and Prevention (CDC) preliminary data showing “concerning acceleration” of ODs nationally during the PHE, with the largest increase between March 2020 and May 2020.^{xii} During the 12-month period ending in September 2020, West Virginia had the second-highest drug OD deaths in the nation at 72.1 per 100,000.^{xiii} Additionally, most fatal overdoses in 2020 involved polysubstance use (e.g., heroin and fentanyl, cocaine and any opioid).^{xiv}

While these PHE-related trends represent challenges, waiver metrics and independent evaluator results offer successes to build upon. Examples include steady increases in members receiving any SUD treatment, SUD and medication assisted treatment (MAT) providers serving West Virginia Medicaid members, members accessing MAT, and the availability and demand for peer recovery support services.^{xv}

BMS will use the requested five-year waiver extension to meet increased demand for a continuum of mental health/SUD services and collect more data on the waiver’s impact to improve the wellbeing of West Virginians by:

- Engaging high-risk individuals in treatment

- Addressing SDOH related to housing and employment for qualifying individuals with SUDs
- Offering additional evidence-based practices for individuals with stimulant use disorder
- Providing holistic and integrated care for SUD and HIV/HCV

BMS is also seeking to extend the behavioral health continuum of care to include individuals with SMI who need extended services in a high-quality, clinically appropriate institution for mental diseases (IMD) setting while residing short term in the IMD primarily to receive mental health treatment.

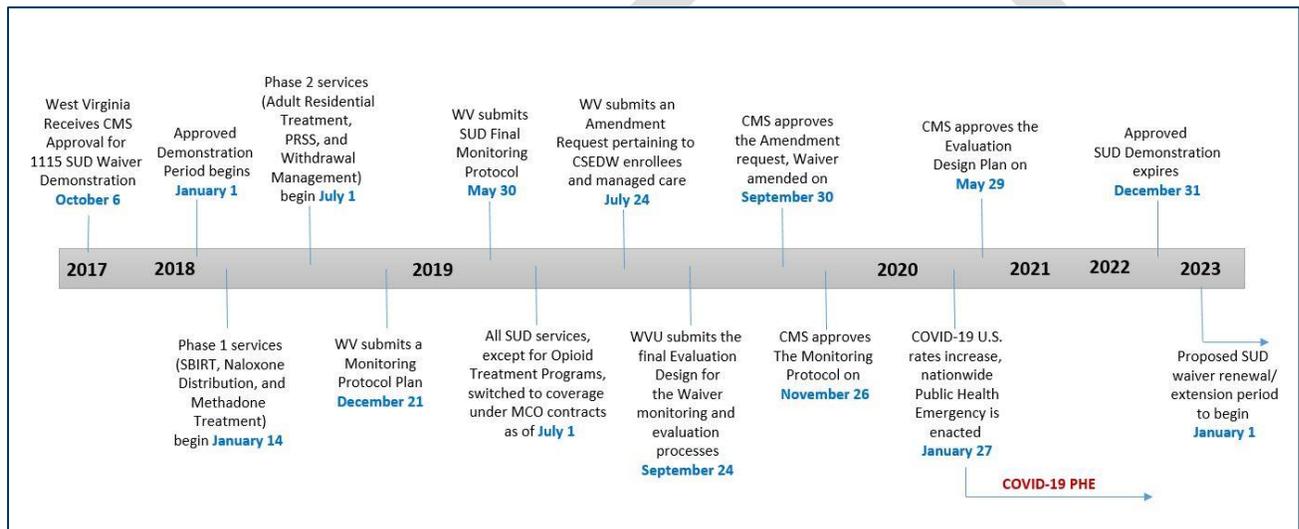
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3. History of the Demonstration and Overview of System of Care

3.1 West Virginia Creating a Continuum of Care for Medicaid Enrollees with SUD

West Virginia has faced a consistently worsening substance use public health crisis in recent years, with detrimental effects on West Virginians who have SUD diagnoses, their families, and their broader communities. BMS took significant steps to combat the crisis in a targeted yet comprehensive manner with the first iteration of this waiver, “West Virginia Creating a Continuum of Care for Medicaid Enrollees with SUD,” which went into effect on January 1, 2018, following Centers for Medicare & Medicaid Services (CMS) approval. The figure below shows a timeline of key dates from 2017 – 2023.

Figure 3: West Virginia 1115 SUD Waiver Key Dates 2017 – 2023



The active waiver tests how the implementation of comprehensive and high-quality SUD care improves the health of Medicaid members while decreasing costs in other parts of the healthcare system, such as EDs and inpatient hospitals. The waiver expands the SUD continuum of care beyond what was previously available for West Virginian Medicaid members through the State Plan, with expenditure authorities in several areas:

- Expanded service offerings
 - Residential treatment services
 - Methadone treatment services
 - Peer recovery support services
- Expenditures related to administrative simplification to improve delivery systems.^{xvi}

Through expanded coverage for residential treatment services to include facilities that meet the definition of an IMD, BMS aimed to help ensure coverage for waiver members requiring residential services in institutional care settings.

In addition, the waiver made MAT available (also referenced as the Opioid Treatment Program [OTP]), providing SUD members with physician-supervised medication and counseling services in BMS-licensed clinics.^{xvii}

The existing continuum of care also enhanced peer recovery support services offered to SUD members, implementing a support structure that has proven highly effective in helping individuals get to a point of and maintain recovery. Individuals with personal lived experience with SUD (called Peer Recovery Coaches, or Peer Recovery Support Specialists [PRSS]) deliver these services. PRSS provide counseling to waiver members, support recovery, and help prevent potential relapse.

Additionally, the waiver has improved the administration of service delivery systems. The waiver transitioned to cover program service expenditures (except for methadone) under contracts with MCOs on July 1, 2019, the third year of the waiver.^{xviii} BMS made this shift to improve administrative processes and promote integration of physical and behavioral health, making the delivery system more efficient and effective.

BMS anticipated providing waiver members with better access to the care and support needed to achieve sustainable recovery. BMS accomplished this goal by developing a continuum of care modeled after American Society of Addiction Medicine (ASAM) criteria or another comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines.^{xix} In pursuit of this overarching goal, BMS expected to achieve the following targeted objectives:

- **Improve quality of care and population health outcomes** for Medicaid members with SUD.
- **Increase member access to and utilization of appropriate SUD treatment services** based on the ASAM Criteria, or another comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines.
- **Decrease medically inappropriate and avoidable utilization** of high-cost emergency department and hospital services by members with SUD.
- **Improve care coordination and care transitions** for Medicaid members with SUD.^{xx}

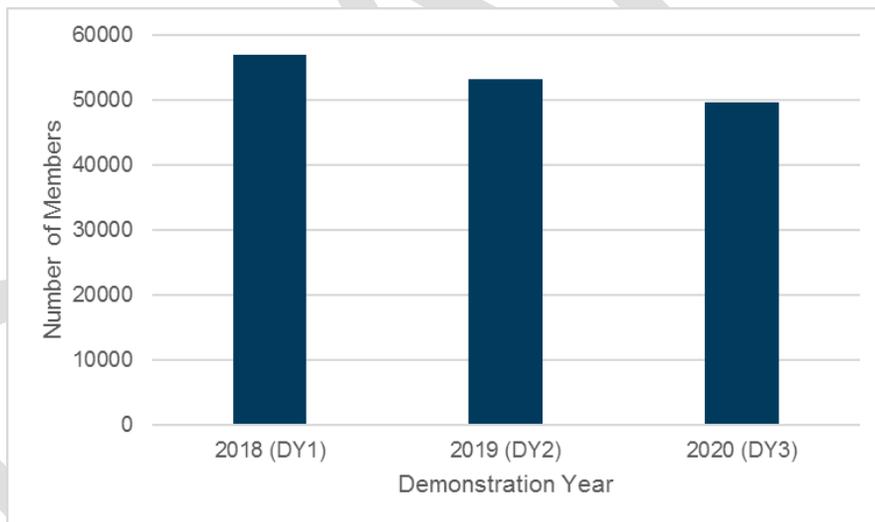
BMS has been successful in addressing several of these program objectives over the course of the waiver period, particularly regarding increasing member access to and utilization of appropriate SUD treatment services. BMS has also identified areas for continued improvement, especially in the context of significant challenges posed by the ongoing COVID-19 PHE.

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

The waiver appeared to have early positive effects on quality of care and population health outcomes, particularly in Demonstration Year 1 (DY1) and DY2. Population health has been, and continues to be, significantly impacted by the onset of the COVID-19 pandemic and ensuing PHE. Prior to early 2020, data indicates that the waiver was effectively reaching more individuals for SUD treatment, therefore improving health outcomes with more individuals receiving services at various points along the continuum of care offered. Since the beginning of the PHE, however, data shows that the rate of progress has receded on several performance measures.

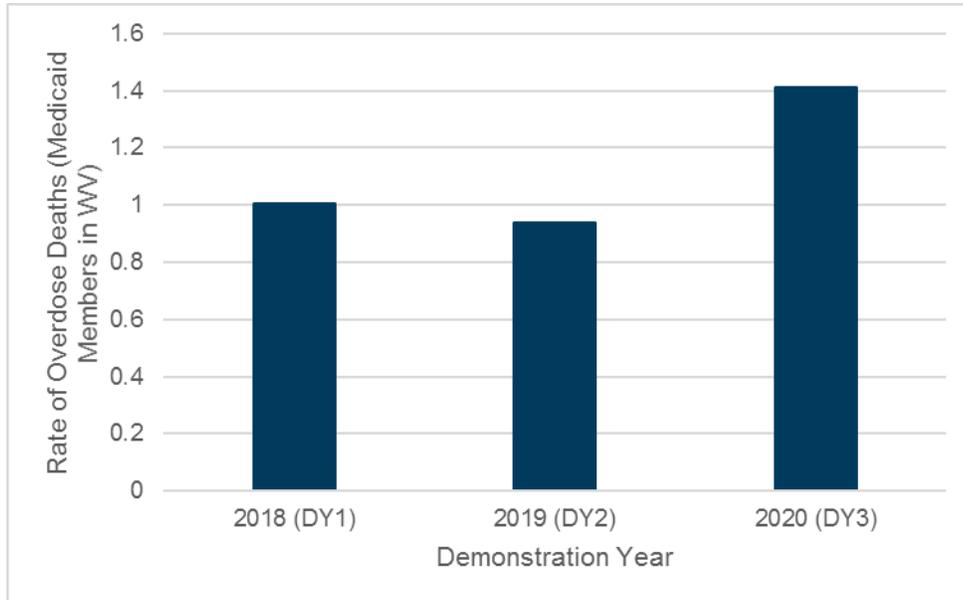
Figure 4 shows the number of Medicaid members with a SUD diagnosis on an annual basis. This number decreased during all three years of available annual data. BMS views this as a successful measure for DY1 and DY2, and an inconclusive measure for DY3. In DY1 and DY2, the number of members assessed for services and receiving treatment both rose steadily, meaning a decrease in members with a SUD diagnosis appeared as a positive outcome. In DY3, assessments generally decreased—almost certainly due to the COVID-19 PHE. Therefore, the decrease in overall members with SUD diagnosis may not be a result of waiver services or a positive outcome.

Figure 4: Medicaid Members with SUD Diagnosis (Annually), DY1 – DY3^{xxi}



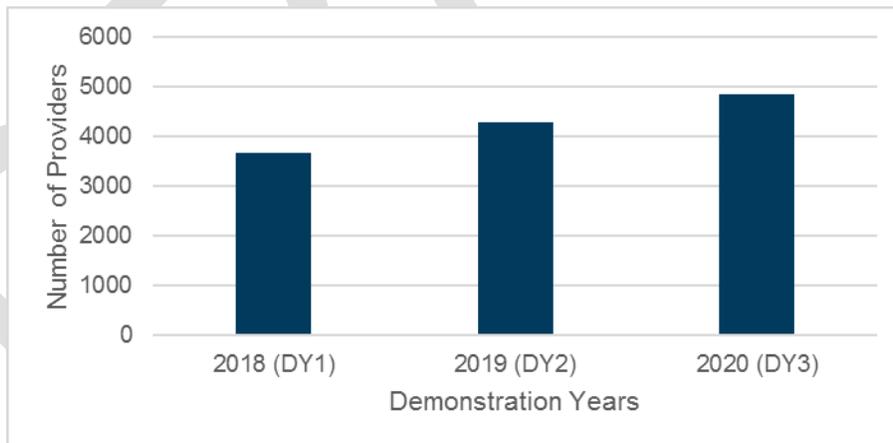
Additionally, as previously discussed, overdose deaths in West Virginia appeared to be declining overall prior to the COVID-19 PHE. Waiver data for Medicaid members is consistent with that trend. Figure 5, on the following page, shows the annual rate of overdose deaths per 1,000 adult Medicaid members living in a geographic area covered by the demonstration.

Figure 5: Overdose Deaths (Rate) Among Adult WV Medicaid Members, DY1 – DY3



Data from the first three years of the waiver period also shows that waiver implementation led to an increase in SUD provider availability—as demonstrated in the figure below—improving access to care and providing opportunities for more individuals to receive treatment.

Figure 6: SUD Treatment Provider Availability, DY1 – DY3

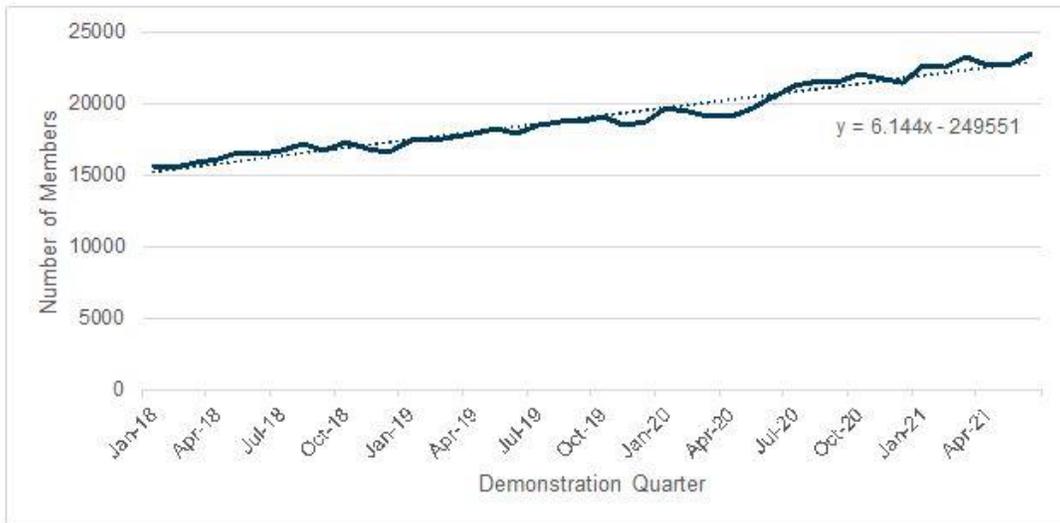


The addition of peer recovery support has been particularly successful. When asked, a focus group of providers from a variety of clinical settings unanimously agreed that peer recovery support services were extremely beneficial for individuals in recovery. Providers recommended increasing support and funding for PRSS roles to increase availability and solidify peer recovery as a key component in the SUD continuum of care.^{xxii}

Objective 2: Increase member access to and utilization of appropriate SUD treatment services based on the ASAM Criteria, or another comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines.

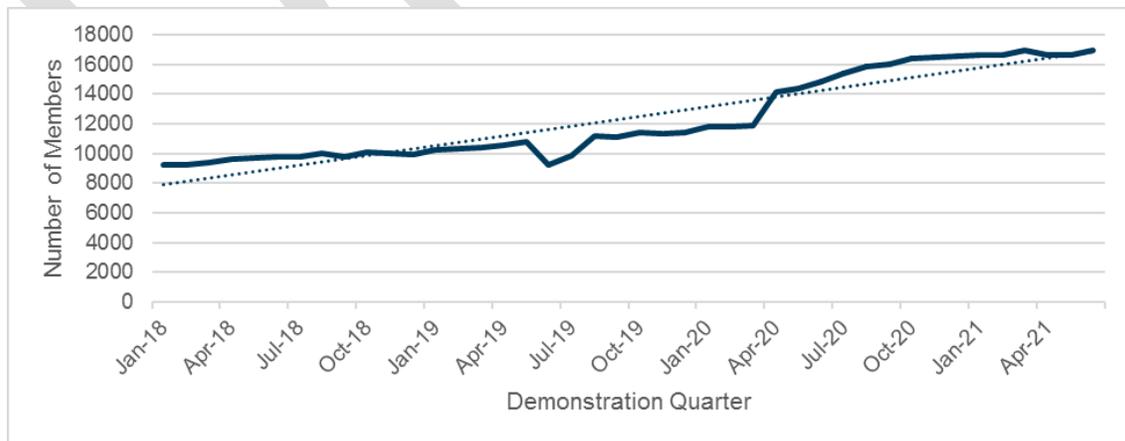
The implementation of the waiver program has increased both member access to and resulting utilization of SUD treatment services, as shown in the graph below. Member enrollment has increased in a relatively linear mode since the waiver began in January 2018, as shown in Figure 7.

Figure 7: Members Receiving SUD Treatment, DY1Q1 – DY4Q2



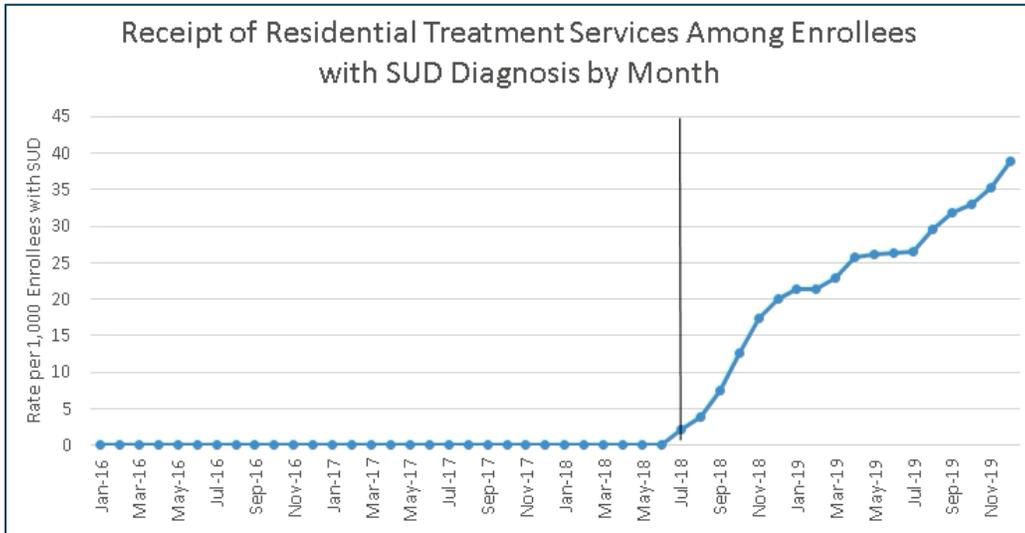
The number of members who used MAT services increased by 126 per 1,000 members with SUD due to the waiver’s implementation.^{xxiii} Notably, MAT has been one of the only services with steady continued growth during the COVID-19 PHE, as illustrated in the figure below.

Figure 8: Members Receiving MAT, DY1Q1 – DY4Q2



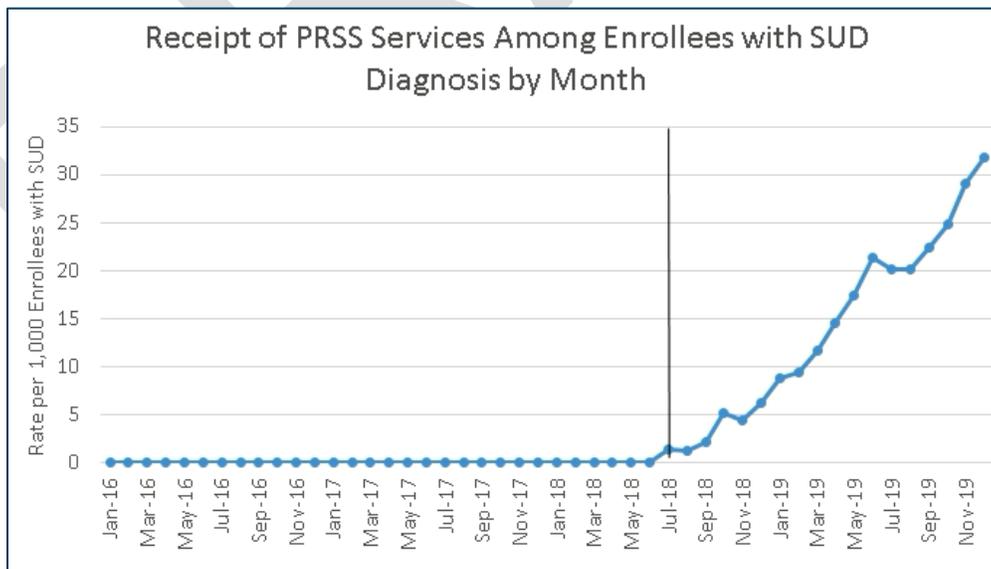
Additionally, with the expansion of facilities able to cover and offer residential treatment services, receipt of these services steadily increased since the waiver program’s beginning in January 2018 to just below 500 per 1,000 members with a SUD diagnosis at the end of December 2019.^{xxiv} This steady increase is shown in the figure below.

Figure 9: Members Receiving Residential Treatment Services, Pre-Waiver – December 2019



PRSS have also increased under the waiver, with 36 per 1,000 members receiving peer recovery support at the close of the fourth monitoring quarter of 2019, per the figure below.^{xxv}

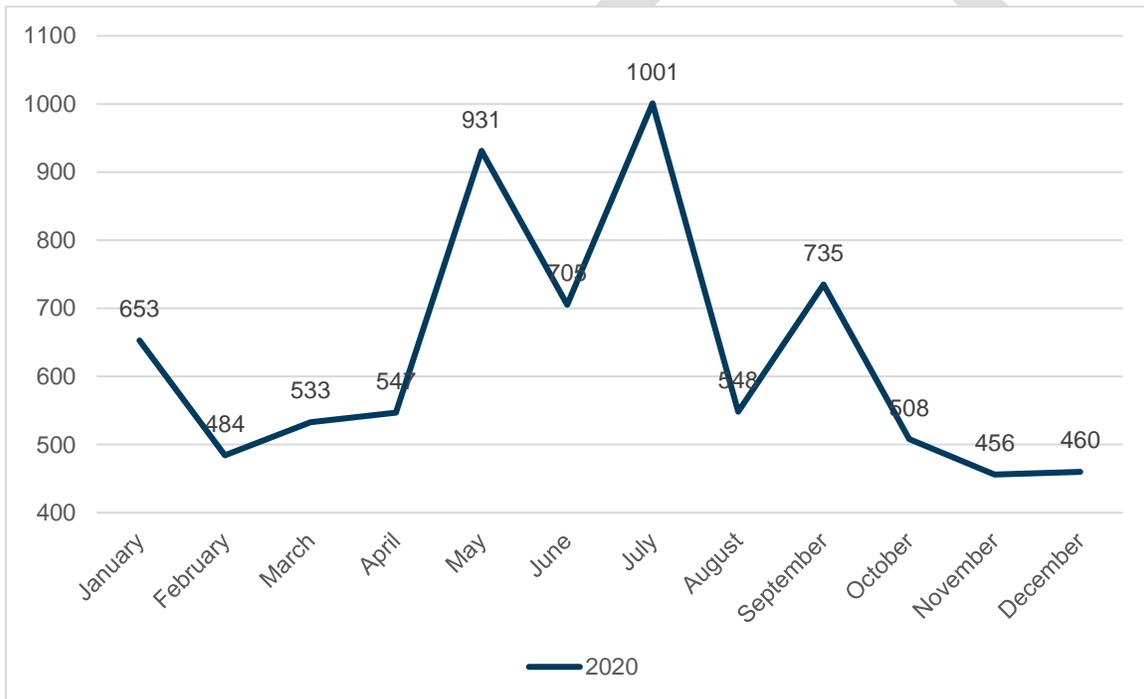
Figure 10: Members Receiving Peer Recovery Support Services, Pre-Waiver – December 2019



Objective 3: Decrease medically inappropriate and avoidable utilization of high-cost ED and hospital services by members with SUD.

BMS projected a decrease in both ED utilization for SUD and inpatient stays for SUD over the waiver period. ED utilization rates among members with SUD saw steady low-level fluctuation, occasionally trending slightly lower than at the waiver’s start, but did not change significantly through the end of 2019.^{xxvi} West Virginia then experienced increases in both ED visits and drug overdoses beginning in 2020, during which time both West Virginia and the nation saw severe increases in drug use, drug overdoses, and SUD-related hospitalizations.^{xxvii} The figure below shows emergency medical services (EMS) responses to suspected overdoses in 2020. This data and its visualization are maintained by the West Virginia Office of Drug Control Policy (ODCP) maintains this data and its visualization in a publicly available dashboard.^{xxviii}

Figure 11: EMS Responses to Suspected Overdoses in 2020



By contrast, in 2019, the highest number of EMS responses to suspected overdoses in one month was 628.

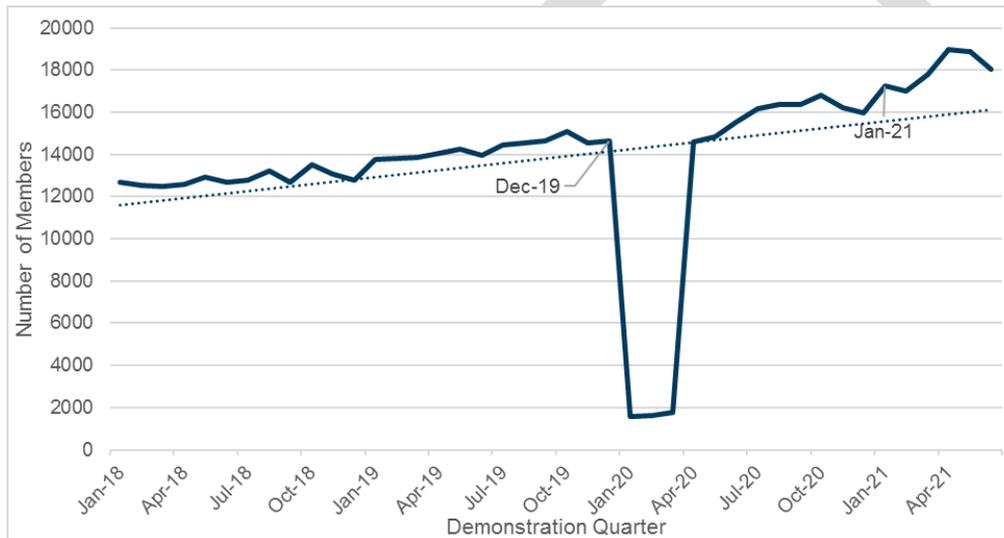
During DY3, ED utilization increased by 11.8%, and inpatient stays for SUD increased by 5.4%.^{xxix} These trends run counter to waiver objectives and what BMS anticipated would happen with the waiver program implementation.^{xxx} The increases were likely a result—at least in part—of the ongoing COVID-19 PHE, which, as stated above, has had drastic impacts on mental health for a substantial proportion of the population.^{xxxi} When asked, several providers

participating in a waiver evaluation focus group mentioned COVID-19 as a barrier to program objectives, increasing both relapse rates and overdose risk among individuals with SUD.^{xxxii,xxxiii}

These trends have influenced BMS decision-making for the waiver extension in two key ways: extending all current services to collect more data and adding services that focus on engaging individuals in treatment who are more likely to access high-cost ED and inpatient services.

While this objective has had mixed results, BMS has built a stronger continuum of care for individuals to receive the level of care (LOC) that is appropriate for their needs. When medically inappropriate and avoidable utilization of ED and inpatient services decreases, community-based options will be more accessible for West Virginians. Figure 12, below, shows both a steady increase and a resilient response to the COVID-19 PHE for outpatient services.

Figure 12: Members Receiving Outpatient Services, DY1Q1 – DY4Q2



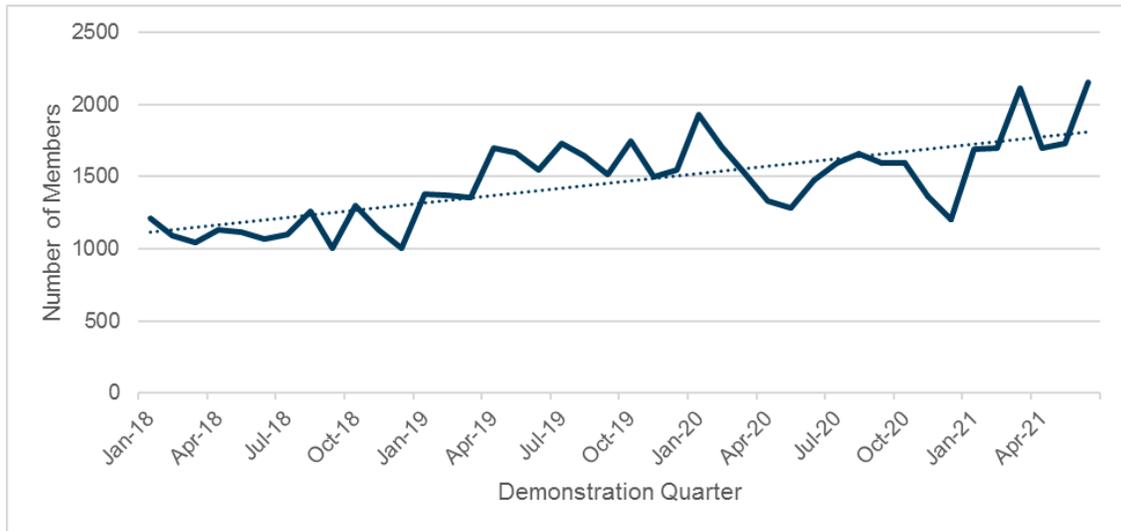
Objective 4: Improve care coordination and care transitions for Medicaid members with SUD.

The waiver showed early successes in improving care coordination and care transitions for Medicaid members with SUD. The percentage of members aged 18 or older with a new episode of alcohol and other drug dependence (AOD) who received initiation of AOD treatment increased by 5% between DY1 and DY2. The percentage of members engaged in ongoing AOD treatment within 34 days of the initiation visit increased by 8%.^{xxxiv,xxxv} Peer recovery support services might have contributed to higher engagement in treatment.

In addition, the utilization of assessments for SUD treatment needs using a standardized screening tool increased well beyond BMS’ projected increase on average, as did the number of Medicaid members with a newly initiated SUD treatment/diagnosis.^{xxxvi} This tool reinforces best practices and helps ensure members are initially placed at the LOC best suited to meet their

treatment needs. Appropriate care can then be coordinated and transitioned as members' needs change over time.

Figure 13: Members Assessed for SUD Treatment Needs Using a Standardized Screening Tool

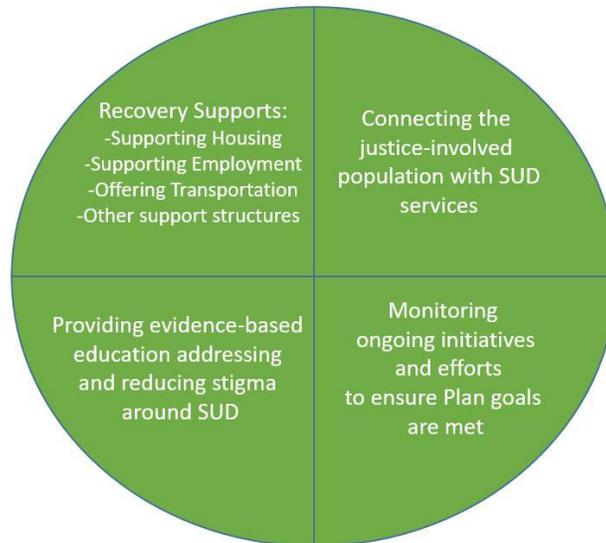


BMS' monitoring protocol projected increases for both metrics; the actual increases are significantly higher than projected.^{xxxvii}

In the approved monitoring protocol, BMS aimed to increase access to critical LOCs, apart from targeting a 2% decrease in the average length of stay in IMDs. BMS has seen significant increases in access to critical levels of care for opioid use disorder (OUD) and other SUDs for any SUD treatment (+7.8% increase), including increased utilization of early intervention, outpatient services, residential and inpatient services, withdrawal management (WM), and MAT.^{xxxviii,xxxix}

West Virginia is intent on addressing SUDs across the full spectrum of individual treatment journeys, from increasing prevention efforts to supporting long-term recovery.^{xi} West Virginia is committed to helping ensure all residents have prompt access to treatment and focused on supporting options that suit individual needs. The Substance Use Response Plan is particularly focused on the areas shown in Figure 14.^{xii}

Figure 14: Substance Use Response Plan 2020 – 2022 Focus Areas



As part of the Substance Use Response Plan, West Virginia is committed to **addressing prescription drug abuse**. The plan contains a goal to monitor opioid prescriptions and distribution, with the following specific strategies for 2020 – 2022:

- Ensuring health professionals in training have appropriate knowledge to reduce inappropriate prescribing of opioid medications for pain
- Continuing to conduct public health surveillance with the West Virginia Prescription Drug Monitoring Program (PDMP) and Controlled Substance Automated Prescription Program (CSAPP) data
- Publicly disseminating timely epidemiological analyses for use in surveillance, early warning, evaluation, and prevention
- Improving interagency communication between law enforcement, the Board of Pharmacy, and the West Virginia PDMP

This SUD waiver is also part of West Virginia’s strategy to address prescription drug abuse. BMS intends to renew this SUD waiver for the next five years, expanding the existing program with the addition of several new services and elements further developing the continuum of care for SUD and/or SMI members. The renewed waiver will build on both the existing waiver and the objectives detailed in West Virginia’s current Substance Use Response Plan.

With this waiver renewal and related efforts, BMS continues to think intentionally and creatively about how the waiver can best recognize, respond to, and support the health and recovery

needs of West Virginians with SUD and/or SMI. Waiver program objectives and specific expected outcomes pertaining to each are described in more detail in Section 4 below.

3.2 Improving Care for Adult West Virginia Medicaid Members with SMI

West Virginia aims to build a more comprehensive continuum of care for adults with SMI. This goal complements both the active 1115 waiver focused on building out a continuum of care for SUD members and the active 1915(c) waiver providing services for children with a serious emotional disorder (CSED). In alignment with SMD #18-011, this continuum will include access to residential and inpatient settings when medically necessary and when other, less restrictive settings and services are not in the individual’s best interest.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines adults with SMI as “persons, age 18 and over, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria, that has resulted in functional impairment which substantially interferes with or limits one or more major life activities.”^{xiii} Between 2017 and 2019, the annual average percentage of individuals with SMI in West Virginia—both adults and young adults, excluding developmental disabilities and SUDs—increased to approximately 16,000 young adults aged 18 – 25 (8.9%) and 87,000 adults (6.1%). This percentage is similar to the regional and national averages for young adults and higher than both the regional (4.5%) and national (4.8%) averages for adults.^{xiii}

8.9% of young adults in West Virginia have an SMI



6.1% of adults in West Virginia have an SMI

In the 12-month period ending on October 15, 2021, 152,022 WV Medicaid members had an SMI diagnosis, per claims data, excluding developmental disabilities and SUD diagnoses. On average, **only 65% of adults with an SMI in the United States receive mental health services in a given year.**^{xiv} For Medicaid members with SMI who seek services, they sometimes receive care in an ED or inpatient hospital setting that does not include adequate stabilization, discharge planning, or connections to outpatient care.

3.3 Overview of West Virginia’s System of Care

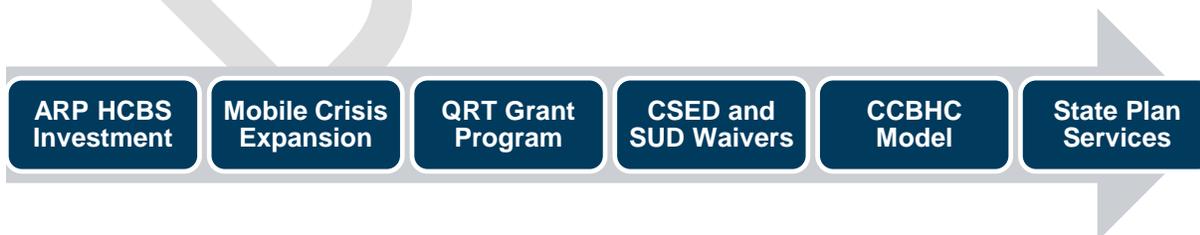
The services under this waiver will allow for the full continuum of care while maintaining focus on developing community-based, individual, and family driven services. BMS has demonstrated its commitment to a responsive and coordinated statewide continuum of care in recent years by:

- Offering an **array of behavioral health services in inpatient, outpatient, and/or community settings** under the State Plan, including, but not limited to: professional and supportive therapies, assessment, screening, service planning, case consultation, ACT, targeted case management (TCM), intensive programs, and crisis services

- Working closely with the Bureau for Behavioral Health (BBH) to deliver mental health and SUD services to Medicaid members (from BMS) as well as to the underinsured and uninsured (from BBH), including, but not limited to, a **statewide mobile crisis helpline**
- Implementing, then expanding, the **CSED waiver (CSEDW)**
- Allocating American Rescue Plan (ARP) funds toward the following complementary **home and community-based services (HCBS) efforts**:
 - Improving **mental health workforce development and sustainability**
 - Strengthening and expanding **mobile crisis response and stabilization teams statewide** for children, youth, and adults in collaboration with BBH
 - Developing **crisis triage sites** for individuals who need a prompt evaluation and assistance in accessing behavioral health services on an emergency basis
 - Expanding a grant-funded program that provides intervention for individuals who have experienced an overdose or acute behavioral health episode through **quick response teams (QRTs)** that visit a current member and help engage them in treatment
 - Designing a program to distribute grants facilitating an enhancement for current mental health providers to transition to the **Certified Community Behavioral Health Center (CCBHC) model**, in order to support an approach to healthcare that emphasizes recovery, wellness, trauma-informed care, and physical/behavioral health integration
 - Improving systems to **increase care coordination and ease of communication**, including, but not limited to, exploring an interface between the West Virginia Division of Corrections and Rehabilitation (DOC) and BMS to help prevent overdose and behavioral health crisis events from occurring
 - Use an online case management system and an incident management system

The figure below summarizes some actions BMS and/or BBH are taking together to improve community-based mental healthcare in West Virginia.

Figure 15: West Virginia’s Commitment to Community-Based Mental Healthcare



This waiver will complement, and not supplant, the above activities by adding expanded IMD options for members with SMI to the continuum of care.

4. Program Description, Objectives, and Outcomes

The overall goal of this waiver is to evolve the continuum of care for individuals with SUD and/or SMI to provide the right care at the right time, in the right setting. BMS' specific objectives and outcomes are outlined below. BMS has built upon the active waiver's objectives with additional outcomes that align with the proposed scope of the waiver extension.

Objective 1: Improve quality of care and population health outcomes for Medicaid members with SUD and/or SMI.

- *Outcome 1:* Reduce overdose deaths by 2026.
- *Outcome 2:* Reduce incidences of repeat OD and OD fatalities.
- *Outcome 2:* Decrease the period of active substance use among West Virginia residents.
- *Outcome 3:* Increase duration of sobriety among West Virginia residents.
- *Outcome 4:* Decrease recidivism for West Virginia Medicaid members with SUD.

Objective 2: Increase member access to and utilization of appropriate SUD treatment services according to ASAM criteria, or another comparable, nationally recognized set of SUD program standards based on evidence-based SUD clinical guidelines.

- *Outcome 1:* Increase the availability of community-based, outpatient, and residential SUD treatment opportunities for Medicaid members as appropriate.
- *Outcome 2:* Increase access to methadone as a treatment strategy.
- *Outcome 3:* Widely distribute naloxone.
- *Outcome 4:* Increase treatment retention for individuals with a stimulant use disorder.
- *Outcome 5:* Increase justice-involved individuals' access to and utilization of appropriate SUD treatment services starting 30 days prior to release.
- *Outcome 6:* By 2026, reduce average length of stay in an inpatient setting for SUD-related civil commitments.

Objective 3: Decrease utilization of high-cost ED and hospital services.

- *Outcome 1:* Decrease ED visits, inpatient admissions, and readmissions to the same LOC or higher for a primary SUD diagnosis.
- *Outcome 2:* Leverage prevention strategies and a public awareness campaign around naloxone in order to prevent and reverse overdoses.
- *Outcome 3:* Provide services designed to promote and sustain recovery.
- *Outcome 4:* Expand opportunities for HIV/HCV screening, testing, and treatment to more SUD treatment locations.

- *Outcome 5:* Provide education to court, law enforcement, and emergency responders regarding the option for SWMS instead of high-cost ED and hospital services.

Objective 4: Improve care coordination, care transitions, and continuity of care for Medicaid members with SUD and/or SMI.

- *Outcome 1:* Improve the coordination and integration of SUD and/or SMI treatment with co-occurring behavioral and physical health services, particularly for those individuals with co-occurring SUD and HIV/HCV conditions.
- *Outcome 2:* Improve care transitions to outpatient care, including hand-offs between different LOCs within the SUD and/or SMI care continuum, and linkages with primary care upon discharge.
- *Outcome 3:* Screen, and engage members in, recovery/living environment services related to ASAM Dimension 6 (Recovery/Living Environment) as appropriate.
- *Outcome 4:* Establish an interface between the DOC and BMS, and use this interface to automatically initiate reinstating Medicaid member eligibility 30 days prior to release.

Eligibility

This comprehensive and coordinated set of behavioral health services and supports will be available to all Medicaid members in West Virginia aged 18 or older.^{xlv,xlvi} In order to receive SUD waiver services, individuals must also have a SUD diagnosis. In order to receive SMI services, individuals must have a diagnosable mental, behavioral, or emotional disorder (excluding developmental disorders and SUDs) of sufficient duration to meet diagnostic criteria that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities.^{xlvii}

Medical necessity criteria for both SUD and SMI services include an assessment of:

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

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
- Evidence-based and provided within the standards of good practice
- Not primarily for the convenience of the plan member or provider
- The most appropriate LOC that can be safely provided

BMS defines additional criteria for specific services, as needed, in Sections 4.1 – 4.5. Individuals who are not eligible for Medicaid may still receive the services listed in Chapter 503 of the BMS Provider Manual,^{xlviii} but receive them through BBH funding for uninsured or underinsured persons with behavioral needs.

Delivery System and Network Development Plan

For the majority of West Virginia Medicaid members who are enrolled in an MCO (81% as of June 2021), the health plans are responsible for contracting with providers to deliver 1115 waiver services, conducting provider recruitment and credentialing, and for working with BMS to help ensure statewide network adequacy. BMS includes SUD-specific network adequacy standards in annual MCO contracts, reviews the standards for needed updates in response to program outcomes and stakeholder feedback, and monitors MCO compliance. This ongoing process helps BMS ensure the provider network is sufficiently robust and sustainable if a provider stops participating in Medicaid; if a provider is suspended or terminated; or if an MCO does not contract with a provider, as long as the MCO is meeting network requirements.

During the active waiver demonstration, as described in Section 3, BMS and the MCOs oversaw continued SUD provider network growth. BMS will work with its MCOs to analyze existing service providers by region for new or expanded services under the extension, and to recruit and educate additional providers for both managed care and FFS delivery systems as needed.

West Virginia has two managed care programs: **Mountain Health Trust (MHT)**, which covers most adults and children, pregnant women, and members receiving Supplemental Security Income (SSI); and **Mountain Health Promise (MHP)**, which provides specialized service for children in foster care, kinship care, adoptive care, and the CSEDW. Table 1 below provides enrollment distribution of Medicaid members across MCOs and FFS in West Virginia.^{xlix}

Table 1: Medicaid Member Distribution by Delivery System and Health Plan

| Managed Care Plan | Medicaid Enrollment (June 2021) |
|--------------------------------------|---------------------------------|
| Mountain Health Trust | |
| Aetna Better Health of West Virginia | 163,703 |
| The Health Plan | 113,955 |
| Unicare | 181,514 |
| Total | 459,172 |
| Mountain Health Promise | |
| Fee for Service | 111,640 |
| Total | 596,231 |

MCOs 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. BMS will work with its actuary to determine adjustments to the per-member per-month (PMPM) payments that account for the additional services and care coordination activities they will deliver to individuals with SUD and/or SMI.

A small number of individuals who are not enrolled in a managed care plan also need SUD services, including individuals receiving long-term services and supports (LTSS) and/or HCBS, as well as dually eligible individuals. These members will have access to services to treat SUD issues and promote long-term recovery through FFS.

West Virginia requires that providers of SUD services meet ASAM criteria—or another comparable, nationally recognized set of SUD program standards based on evidence-based SUD clinical guidelines—prior to participating in the Medicaid program, and continue to meet these criteria. All providers must meet applicable participation requirements as defined by the West Virginia Office of Health Facility Licensure and Certification (OHFLAC), West Virginia State Code, the BMS State Plan, the BMS Provider Manual, and the provider contract.

BMS and its MCOs have worked alongside the provider community to build a stronger foundation for access to behavioral health services in West Virginia during the current waiver period. West Virginia’s publicly funded, community-based behavioral health system is anchored by 13 regionally-based Comprehensive Behavioral Health Centers (CBHCs).ⁱ Other provider types playing key roles for Medicaid behavioral health services include, but are not limited to, Licensed Behavioral Health Centers (LBHCs), Federally Qualified Health Centers (FQHCs), licensed independent clinical social worker (LICSW) practices, psychiatric practices, and psychological practices.

Additionally, under the current waiver, 79 residential adult services (RAS) programs offer 1,234 beds across the ASAM LOCs as shown in Figure 16 on the following page. LOC 3.7 beds are divided according to whether they are in a community setting (C) or hospital setting (H).

Figure 16: Approved RAS Beds Across the ASAM LOCsⁱⁱ



BMS has worked with RAS providers to establish 749 “flex” beds able to serve either LOC 3.1 or 3.5 depending on member needs. BMS requires prospective RAS providers to submit an application that will help BMS determine which LOC(s), if any, the provider is qualified to offer.ⁱⁱⁱ

All RAS providers must document results of ASAM criteria assessments in the clinical record, as part of the documentation of the need for the service, and as justification for the level and type of service provided.

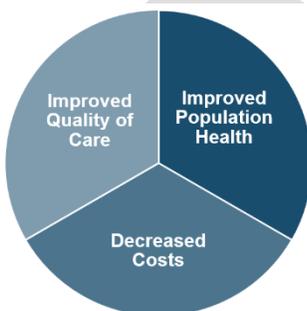
The PRSS program has also grown rapidly under the current waiver, with 1,311 BMS-certified PRSS and 225 West Virginia Certification Board for Addiction & Prevention Professionals (WVCBAPP)-certified PRSS as of October 7, 2021.ⁱⁱⁱⁱ BMS is now requiring all PRSS to be WVCBAPP-certified by September 30, 2022, to promote best practices and program integrity. In addition to the steps described in this section, BMS will comply with all CMS-required program integrity safeguards, including, but not limited to, the expectations for a transformed system in SMD #15-003.

BMS is ready to explore new, innovative services that will give the provider community more options to serve its members holistically, and improve member access to care, quality of care, coordination of care, and continuity of care. As part of this effort, BMS may collaborate with ODCP to consider strategic value-based payment (VBP) initiatives for the future.

BMS will provide 1115 waiver services to members with no cost sharing. BMS will comply with all Mental Health Parity and Addiction Equity Act (MHPAEA) requirements and will not cap any services or payments for services, except for contingency management incentives, which will be subject to a monthly amount and limited to one year per participant, as described in Section 4.4.

Continuum of Care

The 1115 waiver will provide a critical vehicle for enhancing the scope of SUD and SMI services that are available to Medicaid members in West Virginia. The waiver will help ensure that individuals have access to treatment and recovery that is most appropriate for their circumstances—**meeting people where they are.**



Working to establish a seamless continuum of care will enable West Virginia to move toward value-based purchasing for SUD and SMI services and facilitate meeting the goals of the Triple Aim: improved quality of care, improved population health, and decreased costs.

With this waiver, West Virginia continues to evolve its continuum of benefits for individuals with SUD and/or SMI as summarized in Table 2 below and described in the following sections. In order to show the full landscape of services that West Virginia will make available to individuals with SUD and/or SMI, this table includes benefits currently provided under State Plan authority, benefits currently provided under 1115 waiver authority that BMS is requesting to extend, and proposed new services under 1115 waiver authority.

Table 2: West Virginia Continuum of Benefits for Individuals with SUD and/or SMI

| Benefit | Type |
|---|----------------|
| Current State Plan | |
| Targeted Case Management (TCM) | SUD and/or SMI |
| Naloxone Administration Services | SUD |
| Screening, Brief Intervention and Referral to Treatment (SBIRT) – 0.5 ASAM LOC | SUD and/or SMI |
| Outpatient Services – 1.0 ASAM LOC for SUD | SUD and/or SMI |
| Intensive Outpatient Services – 2.1 ASAM LOC for SUD | SUD and/or SMI |
| Partial Hospitalization Services – 2.5 ASAM LOC for SUD | SUD and/or SMI |
| Medically Managed Intensive Inpatient Services – 4 ASAM LOC | SUD |
| Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age | SUD and/or SMI |
| Crisis Intervention Services | SUD and/or SMI |
| Crisis Stabilization Services | SUD and/or SMI |
| Assertive Community Treatment (ACT) | SUD and/or SMI |
| Opioid Treatment Program Services (OTP) | SUD |
| Existing 1115 Waiver Services | |
| Peer Recovery Support Services – 1.0 ASAM LOC | SUD |
| Clinically Managed Low Intensity Residential Services – 3.1 ASAM LOC | SUD |
| Clinically Managed Population-Specific High Intensity Residential Services – 3.3 ASAM LOC | SUD |
| Clinically Managed High Intensity Residential Services – 3.5 ASAM LOC | SUD |
| Medically Monitored Intensive Inpatient Services – 3.7 ASAM LOC | SUD |
| Ambulatory WM Services – 1-WM ASAM LOC | SUD |
| Ambulatory WM Services – 2-WM ASAM LOC | SUD |

| Benefit | Type |
|---|------|
| Clinically Managed Residential WM Services – 3.2-WM ASAM LOC | SUD |
| Medically Monitored Inpatient WM Services – 3.7-WM ASAM LOC | SUD |
| Office Based Opioid Treatment (OBOT) | SUD |
| Proposed New 1115 Waiver Services | |
| Recovery Housing (ASAM Dimension 6 – Recovery/Living Environment) | SUD |
| Supported Housing | SUD |
| Supported Employment | SUD |
| Continuity of Care for Justice-Involved Individuals with SUD | SUD |
| HIV/HCV Service Integration, Education, and Community Outreach | SUD |
| QRTs | SUD |
| SWMS | SUD |
| Contingency Management | SUD |
| Expanded Inpatient Treatment Services in IMDs | SMI |
| Residential Treatment Services for Individuals with SMI | SMI |

West Virginia will work closely with MCOs and providers to build upon existing utilization management (UM) and quality review processes, including, but not limited to, the following:

- **Standardized Benefit Structure:** Use of defined service levels that support placement in the appropriate LOC, with SUD services based on ASAM LOC criteria.
- **Unified Model of Care:** A unified model of care for administering benefits, defined by the use of standardized unit values, reimbursement codes, and a minimum reimbursement value for each service level.
- **Uniform Clinical Operations:** Use of standardized service review formats to help ensure clinical operation processes are uniform and designed to collect information in line with MHPAEA requirements, help ensure appropriate placement, and facilitate opportunities for integrated care and coordination of service delivery for individuals.
- **Service Review Requirements:** For SUD services, ASAM LOCs 3.1, 3.3, and 3.5 will be subject to UM requirements, including service review requirements to facilitate

service initiation with quality oversight structures as specified in SMD #15-003.

Expanded SMI services in IMDs will also be subject to UM requirements.

- 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.
- **Quality Reviews:** Targeted post-payment quality reviews to help ensure fidelity with service models and access for the use of evidence-based delivery of services.

MCOs will outline specific benefit management requirements in their provider contracts.

Additionally, BMS will collect reliable and valid data from MCOs to enable the reporting of SUD and SMI quality measures listed in Table 3 below. BMS 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 monitoring reporting and independent evaluation provided to both CMS and the public.

Table 3: 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 |
| NFQ #2607 | Diabetes Care for Patients with SMI: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) | 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, quality improvement process, and performance measure data systems to ensure continuous improvement of the provision of SUD services. BMS will use the results of these assessments to improve the quality of care provided by Medicaid.

BMS will leverage metrics from its existing monitoring protocol—with modifications based on lessons learned during the active waiver and any updated CMS guidance—and develop additional metrics for expanded services. Specifically, BMS will continue to evaluate care transitions between SUD LOCs and between SUD providers, including the linkages with primary care upon discharge, and meet other quality reporting requirements in SMD #15-003. BMS will also expand the following metrics from the current monitoring protocol to include individuals with SMI, per CMS example measures in Appendix B of SMD #18-011:

- ED use among Medicaid beneficiaries and their lengths of stay in the ED
- Readmissions to inpatient psychiatric or crisis residential settings
- Average lengths of stay in participating psychiatric hospitals and residential settings

4.1 Extension of Current 1115 Waiver Services

BMS is requesting an extension of waiver and expenditure authorities to continue operating all services approved in the active waiver demonstration ending December 31, 2022, through another five-year period to end December 31, 2027. As discussed in Section 3, BMS has identified some positive results through metrics, evaluation data, and stakeholder feedback, giving BMS reason to continue these services; however, the onset of the COVID-19 PHE during the critical middle years (DY3 and DY4) of the waiver program complicates assessing which services BMS will transition into State Plan authority. Therefore, BMS plans to continue these services through waiver authority to gather more results and make data-driven policy decisions.

Below, BMS focuses on the continuation of three particular services and supports that have evolved most since the previous waiver application: PRSS, Care Coordination and Transitions of Care, and MHP Mandatory Enrollment for CSEDW Members.

4.1.1 Expansion of PRSS

BMS will expand PRSS to additional provider types and settings. Peer recovery support services—an evidence-based model of care—are delivered by trained and certified PRSS who have been successful in their own recovery process and can extend the reach of treatment beyond the clinical setting into a member's community and home environment to support and assist a member with staying engaged in the recovery process. Currently, only a CBHC or LBHC, as defined in Chapter 64 of the West Virginia State Code, may provide peer recovery support services. BMS intends to work with additional provider types and settings, such as hospital EDs, FQHCs, and Drug Free Moms and Babies Program facilities.^{liv} PRSS employed by these provider types and settings will be required to have the same credentials and follow the same certification, training, and service documentation requirements as other PRSS. Additionally, as PRSS are increasingly employed by behavioral health providers in multiple settings (RAS, outpatient), BMS will work with providers to encourage continuity of peer support between LOCs.

BMS is expanding peer recovery support service availability due to strong positive reception, identified through evaluation results and stakeholder feedback. In particular, the Mosaic program conducted in 13 hospital EDs—funded by a CDC Overdose Data to Action grant—showed the impact of PRSS activities in hospital EDs for patients receiving brief interventions, referrals, and linkages to treatment. A Mosaic Group cumulative dashboard reports 80,971 SBIRT screenings completed through the grant program during the period of October 2020 – August 2021, with 9% positive screens (7,480) and 753 referrals to treatment and 564 linkages to treatment. Six hospitals in northern West Virginia and seven hospitals in southern West Virginia currently participate in the grant program.

4.1.2 Extended IMD Stays for Individuals with SUD and Co-Occurring Medical Conditions

BMS will clarify policy for its existing coverage of individuals residing short-term in an IMD setting primarily to receive SUD treatment. BMS will continue to strive for an average length of stay (ALOS) of 30 days across all residential and inpatient treatment and withdrawal management LOCs. BMS will note in policy and provide education to MCOs and providers that when a longer length of stay is medically necessary to meet individualized needs and adequately treat the most acute, clinically complex patients with SUD, BMS will reimburse stays up to 60 days. For stays longer than 30 days, two midpoint assessments will be performed: an assessment of the individual's needs by the provider (procedure code 90792 for psychiatric diagnostic evaluation with medical services) and a BMS-focused assessment of whether BMS is meeting the 30-day average LOS requirement.

4.1.3 Care Coordination and Transitions of Care

BMS will continue to emphasize care coordination services between LOCs and between providers for individuals receiving SUD and/or SMI services. Care coordination assists 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. Existing targeted case managers and MCO care coordinators will be trained on the waiver's new and expanded services.

TCM services provide help with transition planning for Medicaid members moving from residential settings back into the community, as well as through outpatient care transitions.

MCOs have procedures for identifying and supporting individuals with complex or serious medical conditions. Specifically, MCOs are contractually required to assign an MCO care coordinator to any member identified as having a dependence disorder who is in need of engagement of treatment. The care coordinator must support the member, at a minimum, through the duration of treatment process. MCOs must also initiate care coordination services for members being discharged from crisis stabilization units (CSUs).^{lv}

All SUD and SMI providers enrolled under the waiver will be required to engage in appropriate transition and/or discharge planning, including coordinating with providers at the next LOC to help 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 help ensure compliance.

4.1.4 Mountain Health Promise Mandatory Enrollment for CSEDW Members

BMS will continue to allow CSEDW members to have a lock-in period that requires continuous enrollment with a single MCO in the MHP Specialized Managed Care Plan for Children and Youth. BMS automatically enrolls members on a mandatory basis into a single MCO in order to provide specialized, coordinated, seamless, and cost-effective care to CSEDW members.

If for any reason the member's guardian chooses to disenroll the child from the MCO, the member is informed that disenrolling from the MCO means disenrollment from the CSEDW. Members affected by the lock-in period are children between the ages of 3 and 21 who are West Virginia residents and deemed medically and financially eligible for CSEDW services through the application process described in the CSEDW application (WV.1646.R00.00).

4.2 Engaging High-Risk Individuals with SUD in Treatment

4.2.1 Continuity of Care for Justice-Involved Individuals with SUD

Among the American justice-involved population, about 67% of inmates typically meet clinical criteria for a current SUD, compared to 9% of adults in the general population.^{lvi} Individuals released from prison have a high rate of death soon after release, particularly from drug-related causes.^{lvii} Reentry "is a particularly crucial period for those with behavioral health conditions because it is associated with significant stress and high risk of relapse or crisis... Individuals with opioid use disorder are at particular risk for death post release," and former prisoners are at the highest risk in the first week of release.^{lviii} Members returning to the community after incarceration are estimated to be 12.9 times more likely to die from an overdose than the general population.^{lix} Untreated SUDs also contribute to other health problems and recidivism. Additionally, 70% – 80% of justice-involved individuals, on average, are eligible as part of the Medicaid expansion population upon release from the correctional system.

In March 2021, West Virginia's prison population had 3,831 people, and its regional jail population had 6,135 people.^{lx} This disproportionate emphasis on regional jails will shift as the COVID-19 PHE ends, due to protocols that currently keep the prison population at its lowest since 2003. During the foreseen upward trend in incarcerations, it will be important to make intentional efforts to keep individuals out of jail and prison.

Releasing members who are incarcerated without connections to healthcare providers, medical coverage, safe and stable housing, and a support system can greatly increase their risk of

relapse, overdose, and death. **Combining treatment during detention in jail or prison with treatment following release can reduce recidivism and relapse.** Continuity of care is linked to numerous positive outcomes, including, but not limited to, lower healthcare costs, fewer hospitalizations, reduced ED usage, reduced criminal activity, improved public safety, and decreased mortality.

West Virginia is investing resources into better connecting justice-involved individuals with care. West Virginia suspends, rather than terminates, Medicaid benefits until the individual is no longer incarcerated to improve transitions back to the community. The ODCP Substance Abuse Response Plan aims to provide access to effective treatment for individuals with SUDs in the criminal justice and civil child abuse/neglect systems, including MAT, therapeutic programming, and facilitating transitions to the community upon release.^{ixi} BMS will also explore interface development between the West Virginia DOC and BMS as part of its recently approved ARP HCBS Spending Plan. This interface will help with continuity of care to prevent overdose and behavioral health events. The interface will also improve data collection and reporting, along with standardizing data. Between policy and technology goals, BMS is working with its partners to better support justice-involved individuals.

BMS requests authorization to begin providing Medicaid coverage for otherwise Medicaid-eligible individuals who are incarcerated in the 30 days prior to release from prison. This coverage will emphasize, but will not be limited to, transitioning members to their chosen MCO, community-based clinical consultation services provided in person or via telehealth, in-reach care management services, HIV/HCV screening and treatment (if applicable), and a supply of medication sufficient to facilitate maintenance of medical and psychiatric stability for 30 days upon release.

In-reach care management will include but not be limited to the following:

- Conducting a care needs assessment
- Developing a transition plan for community-based health services
- Making referrals to physical and behavioral health providers for appointments post-release
- Linking justice-involved populations to other critical supports that address SDOH
- Developing a medication management plan

To be eligible, an individual must be a “qualified inmate,” which is defined as an individual who is incarcerated in a state prison with 30 days or less before release, has a known or suspected SUD, and would otherwise meet Medicaid eligibility requirements. BMS will work with corrections stakeholders to collaboratively determine the most efficient and effective way to identify and refer qualified inmates, with a goal to begin the enrollment or reactivation process 90 days prior to release when possible, with an eligibility effective date 30 days prior to release.

West Virginia will also explore collaborating with the West Virginia DOC to develop a program for peer support Medicaid educators in prisons, under the supervision of facility staff, who will serve as volunteers to educate their peers about Medicaid enrollment and MCO selection.^{lxii}

Delivery of services starting 30 days prior to release will require close coordination with state prisons. Recognizing the need for system and operations changes, BMS plans to implement this change in a phased rollout.

4.2.2 HIV/HCV Community Outreach and Education

West Virginia has been an epicenter of the substance use public health crisis for several years. While monitoring rising substance use rates, West Virginia has also been closely monitoring increasing rates of positivity rates for bloodborne viruses statewide in recent years, paying particular attention to notably rising rates among individuals who inject drugs. The significant rises in substance use and overdose deaths that West Virginia is experiencing have co-occurred alongside increasing positivity rates for both HIV and HCV.^{lxiii, lxiv} These public health threats are highly interrelated, to the point where they have collectively evolved into a **syndemic**: a situation in which co-occurring epidemics have a synergistic interaction, fueling one another and posing a severe public health threat at the population level.^{lxv, lxvi}

The onset of the COVID-19 PHE in the United States in early 2020 exacerbated substance use and HIV/HCV rates to an alarming degree, with overdoses and disease positivity steadily increasing and remaining at an elevated and continually rising level nationwide.^{lxvii} In 2020, West Virginia recorded 1,275 confirmed overdoses, an increase from 878 reported in 2019.^{lxviii} In 2019, West Virginia's Kanawha County had 15 substance-use related HIV cases; in 2020, that number increased to 35, leading the CDC to investigate the outbreak.^{lxix}

Historically, these linked crises have been treated as separate epidemics, leading to siloed approaches to testing, treating, and linking patients to other needed services and supports.^{lxx} Through this waiver, BMS seeks to support a more integrated approach with the addition of HIV/HCV community outreach and education services. By increasing awareness of how these diseases frequently co-occur with SUD, and working to decrease stigma surrounding HIV and HCV, BMS will contribute to decreasing positivity rates among West Virginians.

Community education and outreach efforts supported by this waiver for SUD members include:

- Community health educational outreach and materials building awareness of HIV/HCV and eligibility for treatment in West Virginia
- Education on the common co-occurrence between SUD and HIV/HCV diagnoses
- Outreach focused on decreasing stigma around HIV/HCV in communities

This outreach may be street-based and/or take place in health clinics and other facilities offering treatment services.

Medicaid members with a SUD diagnosis will be eligible for outreach and educational services addressing HIV and HCV in relation to substance use. Members meeting those criteria who have a positive HIV and/or HCV diagnosis and those who are at elevated risk of contracting the viruses will both be eligible groups, and will receive outreach and care appropriate for their respective situations. BMS plans to bill for these outreach and educational services alongside screening and testing services in a bundled payment for HIV/HCV services. Providers will be required to add a line to the claim for bundled rate reimbursement to enable data collection about HIV/HCV outreach and education.

BMS will also continue to increase screening and testing availability for both HIV and HCV. Over the past two years, West Virginia has significantly increased screening and testing for HIV in accordance with Health Advisory #158, which recommended several avenues through which healthcare providers were encouraged to increase testing.^{lxxi}

BMS intends to integrate HIV and HCV treatment services into treatment sites and community-based organizations offering SUD services to facilitate easy entry to care for individuals with SUD and co-occurring HIV and/or HCV. Additionally, increasing screening and testing services for these viruses will increase the proportion of individuals receiving timely care, helping those with a positive diagnosis better manage their condition.

In the short term, this category of services will help prevent continued increases in positivity rates for both HIV and HCV and control current outbreaks in West Virginia. The longer-term objective—in alignment with the program objectives and outcomes described in Section 3.1 above—is to decrease the rates of transmission and positive cases among members. BMS believes that the expansion and integration of care will lead to better care coordination and outcomes for individuals with SUD and co-occurring HIV and/or HCV.

4.2.3 Quick Response Teams (QRTs)

The primary goals of QRTs are to **identify** individuals who have overdosed or experienced a substance use-related emergency, **ensure** their safety, and **engage** them in order to prevent ODs and reduce incidences of repeat OD and OD fatalities.^{lxxii} Additional objectives—in alignment with the program objectives and outcomes described in Section 3.1 above—include increasing the number of people in treatment for SUD and lowering avoidable, high-cost ED admissions and stays. QRTs connect with high-risk OD survivors or individuals at high risk of overdosing to offer interpersonal support as well as connections to treatment and recovery services. QRTs reduce barriers to treatment, provide options toward recovery, and guide individuals through the initial treatment and recovery processes in the critical period immediately following an OD or other substance-use related emergency.^{lxxiii}

West Virginia has experienced a rise in EMS responses for suspected overdoses in both 2020 and 2021, with 2020 data peaking at 1,001 responses in July and preliminary 2021 data peaking at 861 responses in August. Both of these peak months nearly doubled the number of EMS

responses to suspected ODs in 2018 and 2019. Similarly, the number of emergency room (ER) visits related to overdoses was higher in 2020 and 2021 (to date) than in 2019. ^{lxxiv}

QRTs make contact with individuals who have overdosed or experienced a substance use-related emergency within 24 – 72 hours of the event, reaching out to individuals via repeated house visits, phone calls, texts, and/or other methods of communication. QRTs assist these individuals with recovery support, social service referrals, and links to treatment options.^{lxxv} Both individuals who have OUD and their family members are greatly affected by ODs and substance use-related emergencies. Recognizing this, QRT teams also provide support to the families of individuals experiencing OUD during an encounter. Additionally, QRTs can provide transportation services to the ED or other treatment, if an individual expresses interest in that form of care.

QRTs are multidisciplinary teams with a composition that varies depending on the specific community's needs; however, they most often include law enforcement personnel, emergency response personnel, and addiction professionals (social workers and/or peer recovery coaches, and sometimes a member of a local faith-based community). They are typically teams of four. The multidisciplinary nature of the group helps ensure the QRT meets members where they are and can respond to individual needs on multiple levels at a critically important moment of care.

West Virginia's first QRT was established in Cabell County in 2017. Cabell County's fatal drug OD rate then fell 24% between 2017 and 2018; between 2017 and 2019, non-fatal OD calls dropped 52%.^{lxxvi} This data indicates that QRTs likely positively contribute to lowering OD rates in counties where they operate.

West Virginia currently has QRTs in 28 high-risk communities across the state, which are currently funded through a combination of several state and federal grants.^{lxxvii, lxxviii} Given that grant funds cover only a specified duration of time, the existing funding stream is not conducive to long-term sustainability for QRTs. Operational QRTs have expressed challenges with grant deadlines and potential loss of funding.^{lxxix}

Recognizing the importance of having QRT services available to assist West Virginia Medicaid members statewide with SUD who have overdosed or are at high risk of overdosing, BMS seeks to cover QRTs under this waiver extension. BMS' goal is to ensure teams have a stable, sustainable source of funding that will continue, expand, and help standardize the current program. BMS intends to provide coverage for existing QRTs and to expand QRT operations to ensure coverage in all geographic areas of West Virginia.

BMS plans to have QRTs operational under the waiver program beginning January 1, 2024, one year after the anticipated start date of the waiver extension. This phased rollout for the QRTs grants BMS necessary time to work collaboratively with existing QRTs and other key stakeholders to plan the QRTs' transition to Medicaid waiver authority.

To be eligible for QRT services, an individual must be an enrolled Medicaid member, have a SUD, and have very recently experienced an OD or substance use-related emergency (within the 24 – 72 hour window). QRT services will be billed and reimbursed using a bundled rate payment structure. All services provided to an individual (such as support, referrals, or transportation) during a QRT encounter will be included in the established bundled rate.

BMS will work collaboratively with existing QRTs and other stakeholders at the local level to develop milestones and performance metrics for QRT service provision. BMS believes that streamlining QRT operations across West Virginia’s counties will increase the availability of data regarding QRT dispatches, members served, services provided, and impacts on OD rates.

The outreach and support offered by QRTs are crucial to the health outcomes of members with SUD. Data indicates a 10% mortality rate in the following two years for individuals who experience a non-fatal OD.^{lxxx} Given this statistic, the State has identified the opportunity to use QRT expansion to lower the mortality rate due to OD.^{lxxxi}

4.2.4 Involuntary Secure Withdrawal Management and Stabilization (SWMS)

Currently, West Virginia does not offer a rapid-entry mechanism into involuntary treatment for individuals who, due to a SUD, cannot meet their essential health and safety needs and/or who are a danger to themselves or others. West Virginia will seek a state legislative change in the 2022 session to align civil commitment for chemical dependency with options available for individuals who are likely to cause serious harm to themselves or others due to other mental health issues (West Virginia Code §27-5-2).

West Virginia will continue to support, and encourage individuals to receive, voluntary treatment in the least restrictive setting possible. SWMS will be a last resort to preserve one or more individuals’ safety in the short term, and motivate individuals to enter voluntary treatment in the long term. Some studies show that secure involuntary detox may result in improved outcomes (e.g., reduced hospitalizations, increased treatment participation).^{lxxxii,lxxxiii} A 2021 survey of 165 addiction physicians, conducted by the *Journal of Addiction Medicine*, showed that 60.7% supported civil commitment for SUDs, particularly related to opioid and alcohol use disorders.^{lxxxiv}

SWMS will be offered by fully secured, licensed facilities that work to stabilize patients from a SUD-related behavioral health crisis through a range of services, including 24-hour admission services, MAT when appropriate, coordination of services, and inpatient medical monitoring. BMS will work with providers that offer ASAM LOC 3.7 services (currently 222 beds across 11 providers) and CSUs (currently 200 beds across 15 facilities) to establish SWMS beds.

SWMS will also include secure transportation to the treatment facility and discharge planning with a “warm handoff” to voluntary or court-ordered less restrictive services. With effective treatment planning and a treatment observation period (TOP)—in which one or more qualified individuals will check if the individual is complying with their treatment plan over a court-

determined period of time—relapses and overdose will likely decrease, along with the average length of stay in a more restrictive setting.

Designated crisis responders (DCRs) trained in holistic crisis investigation will assess whether the individual meets legal criteria for an emergent detention. Specific legal criteria, length of detention, and qualifications to be a DCR will be determined through state legislation. Due to the need for SWMS-designated beds—and possibly SWMS-specific facilities—BMS plans to implement this service in a phased rollout, beginning on January 1, 2024, or another date as determined by state legislation. BMS will provide training and communication for ED, EMS, law enforcement, behavioral health treatment, and court stakeholders about SWMS prior to implementation to improve coordination.

4.3 SDOH Supports for SUD Members

BMS recognizes that a comprehensive understanding and definition of health encompasses more than physical and mental healthcare needs. An expansive definition is inclusive of and dependent on SDOH: the conditions in which people are born, grow, live, work and age. These conditions affect a wide range of health risks and long-term outcomes, influencing an individual's wellbeing and their quality of life.^{lxxxv} These social determinants include, but are not limited to, economic stability, neighborhood and physical environment, housing, employment, access to quality healthcare, and consistent access to nutritious food.^{lxxxvi}

Noting the influential role of social conditions, BMS seeks to concretely address SDOH through this waiver. BMS intends to expand the existing waiver program's continuum of care with the addition of services that specifically address social determinants impacting an individual's ability to achieve and sustain recovery. BMS' aims align with CMS' desire to support states working to better address SDOH. In SHO #21-001, CMS noted services and supports that state Medicaid agencies (SMAs) can cover to address SDOH. The CMS-approved list includes, among other service areas targeting SDOH, housing, and employment services.^{lxxxvii}

BMS proposes to cover Recovery Housing offering clinical treatment services, Supported Housing services, and Supported Employment services under this waiver. BMS modeled its proposed services addressing SDOH after services approved in other 1115 behavioral health waivers, specifically Oregon and Washington D.C.

BMS believes that providing services addressing key SDOH influencing an individual's ability to sustain sobriety will better support members' successful transitions from a higher LOC—such as a hospital or residential setting—to home and community-based settings as they continue recovery.

Additionally, services targeting housing and employment as SDOH will position the waiver to address members' needs holistically, allowing for a person-centered and individualized planning process as individuals recover. Incorporating recovery housing, supported housing, and supported employment services will enable BMS to act according to the HCBS Final Rule,

asserting that members receiving Medicaid-funded HCBS can receive these services in a way that promotes full community integration.^{lxxxviii} Each of these sets of SDOH services will:

- Help individuals **integrate** into their greater communities
- Help individuals **optimize autonomy and initiative** in making life choices, therefore building members' confidence in self through self-determination practices^{lxxxix}
- Help ensure members are supported and treated with **dignity and respect** as they transition into community-based settings

4.3.1 Recovery Housing

Recovery housing is an intervention designed to address a recovering individual's need for a safe and healthy living environment while also providing associated recovery and peer supports.^{xc} Lack of a stable, substance-free living environment can be a serious obstacle to sustained abstinence and continued recovery for individuals with SUD.^{xcii} ASAM recommends that the SUD treatment continuum of care seamlessly transition individuals between LOCs as treatment and recovery needs change, including services such as housing that reduce barriers to recovery.^{xcii}

The structured and communal environments of recovery homes give members the support needed to be successful in their continued recovery when transitioning out of LOCs that are more intensive. While recovery housing does not have a widely operationalized limit on how long an individual may stay, with some individuals staying for as little as a month and others staying for several years, the average length of stay in a recovery home falls between three and six months.^{xciii}

Evidence shows that people returning to risky living environments (such as those where drugs or other substances are present) after treatment are much more likely to relapse than those who do not. Individuals leaving treatment are also at higher risk of relapse if they lack recovery support and continued care.^{xciv} Recovery housing targets each of these risk factors and therefore is an effective approach in supporting recovery from SUD and preventing relapse. Inclusion of recovery housing in this waiver will bolster the continuum of care for SUD members on the recovery end of the continuum while directly addressing ASAM criteria's sixth dimension, Recovery and Living Environment.^{xcv}

To be eligible for recovery housing and associated clinical services, an individual must meet all of the following criteria:

- Have a SUD diagnosis
- Be transitioning out of a more intensive LOC to a recovery-oriented treatment stage
- Be expected to benefit from treatment services offered in the recovery home

- Have a willingness and desire to actively work toward maintaining their recovery

BMS recognizes that recovery houses come in a variety of different forms, with different homes addressing a range of member needs and LOCs. Under this waiver, BMS intends to provide expenditure coverage, inclusive of costs associated with room and board, for only recovery homes offering **clinical-level treatment services to SUD members**. Members will be required to receive clinical treatment services as a condition of their in-home residence. Clinical services that would qualify a recovery home for coverage under the waiver might include assessment and evaluation and/or evidence-based interventions such as outpatient therapy, intensive outpatient therapy, or family therapy.

BMS believes that increasing support for and coverage of recovery housing offering clinical treatment services will reduce relapse rates, overdoses, and preventable ED admissions and hospitalizations. Therefore, the increased expenditures for recovery housing included in this waiver will be offset by the decrease in costly expenditures covering avoidable ED admissions and hospitalizations for SUD overdoses and treatment, providing a budget-neutral intervention.

BMS will make every effort to collaborate with relevant stakeholders in determining performance metrics by which to measure the effectiveness of recovery housing services as part of its post-approval monitoring protocol. Such metrics could include, but may not be limited to, the West Virginia Alliance of Recovery Residences (WVARR), Inc. WVARR is a recovery community organization that works to help ensure requirements set by the National Alliance for Recovery Residences (NARR) are consistent across West Virginia recovery houses.^{xcvi} To do so, WVARR assists recovery houses with the certification process and ongoing data collection efforts. WVARR recognizes 45 certified recovery houses currently operating in West Virginia.^{xcvii} BMS will leverage and build the provider network, collaborating to monitor and measure recovery housing utilization and effectiveness under the waiver.

BMS will use nationally recognized, standard quality measures (such as ASAM Criteria and/or NARR Standards) to evaluate the success of recovery housing and associated clinical services included under this waiver.^{xcviii}

4.3.2 Supported Housing

Substantive data indicates that housing plays a vital role in successful long-term recovery for individuals recovering from SUD. Individuals who are not transitioning to a recovery home might need support in obtaining stable housing upon transitioning out of LOCs that are more intensive.^{xcix} The stress of not having stable housing or being at risk of not having such housing can lead an individual recovering from SUD to return to drug seeking behaviors, drug using, and/or relapse. When leveraged as a key component of an individual's treatment and recovery service plan, supported housing is shown to cultivate self-reliance and support an individual's long-term recovery.^c

Eligibility for Supported Housing services will be specific to Medicaid members with a SUD diagnosis. Aside from needs-based criteria that members must meet to be eligible for services, members must also be expected to benefit from the Supported Housing services they receive.

To meet clinical eligibility criteria, an individual must have a substance use need and diagnosis in accordance with ASAM assessment criteria or another comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines. Individuals must additionally meet criteria for at least one set of risk factors targeting outcomes heavily influenced by social conditions, such as homelessness or prolonged housing instability, due to impairment caused by SUD.

Supported Housing services fall into two categories: housing transition and pre-tenancy services, and housing and tenancy sustaining services. The services BMS intends to include are described below.

Housing Transition and Pre-Tenancy Services support individuals as they initially transition out of higher LOC settings into home and community-based settings. These services include:

- Conducting a tenant screening and housing assessment
- Developing an individual stabilization plan
- Assisting with the housing search process and application process
- Covering one-time move-in expenses, such as a security deposit, first month's rent, and/or move-in costs
- Assisting in arranging the details of the move
- Developing a housing support crisis plan that identifies resources for eviction prevention, short-term, and/or long-term rental assistance in the event that housing is jeopardized
- Initially conducting as-needed in-home sessions with the member to link and help ensure the receipt of services and resources necessary to support housing stability

Housing and Tenancy Sustaining Services help individuals maintain tenancy in their housing arrangements as they continue recovery. These services include:

- Education and training on the roles, rights, and responsibilities of both tenant and landlord
- Coaching on developing and maintaining important relationships with landlords and/or property managers with the intent of promoting sustained and successful tenancy
- Assistance in resolving disputes with landlords and/or neighbors to reduce eviction risk or other adverse actions
- Providing advocacy and links to available community resources to prevent eviction when housing is or is at risk of becoming jeopardized
- Provision of ongoing training on good tenancy practices and lease compliance

Members eligible for Supported Housing services may receive one or more of the services detailed above under the waiver program.

Contracted Supported Housing providers must assure staff providing Supported Housing services maintain appropriate qualifications in order to effectively serve members. Staff providing these services must have knowledge of principles, methods, and procedures of services included under Supported Housing and must receive appropriate training to provide services in accordance with evidence-based principles and practices.

4.3.3 Supported Employment

Similar to the impact an individual's housing situation has on recovery outcomes as they transition from a higher LOC, employment status is a crucial element either promoting or hindering long-term recovery as SUD members begin the process of reintegration into daily activities and community settings. Having meaningful employment and earning wages and/or actively engaging in work-related activities promotes self-reliance and supports successful recovery long-term.^{ci} BMS seeks to include Supported Employment services under this waiver, with the aim of supporting individuals through the process of obtaining and maintaining meaningful employment activities that improve chances of sustained recovery.

Eligibility for Supported Employment services is specific to Medicaid members with a SUD diagnosis. Aside from clinical needs-based criteria that members must meet to be eligible for services, members must also be expected to benefit from the Supported Employment services they receive.

To meet clinical eligibility criteria, an individual must have a diagnosed SUD and must additionally meet criteria for at least one set of risk factors targeting outcomes heavily influenced by social conditions, such as an inability to be gainfully employed for a substantial period due to impairment caused by SUD.

Supported Employment services fall into two categories: pre-employment and employment sustaining services. These services will be adapted to meet individual needs, can be offered either individually or in small group settings, and may include one or more of the services described below.

Pre-Employment Services support an individual in their preparations to obtain meaningful full or part-time employment. These services might include:

- Pre-vocational/job-related assessment
- Assessment of workplace readiness
- Person-centered employment planning
- Individualized job development and placement
- Career coaching
- Job carving

- Benefits education and planning
- Soft skill training
- Transportation services

Employment Sustaining Services support an individual in maintaining and sustaining employment. These services might include:

- Job coaching
- Career advancement services
- Negotiation with employers
- Job analysis
- Benefits education and planning
- Financial and health literacy support
- Assistance with linking members to high-quality childcare and other programs that increase an individual's ability to work
- Asset development
- Peer support for employment provided by a co-worker or other job site personnel
- Transportation services

Inclusion of Recovery Housing, Supported Housing, and Supported Employment services will enable BMS to further strengthen the continuum of care for SUD members, expanding support for individuals transitioning into and working to maintain recovery in community-based settings. These services are essential to help ensure social or environmental conditions do not hinder members' recovery processes.

4.4 Contingency Management

BMS is seeking authority to provide evidence-based treatment, including contingency management, to expand access to treatment for Medicaid members with stimulant disorder and address the rise in stimulant-related fatal overdoses throughout the state. ODCP has noted fatal methamphetamine overdoses as an emerging threat in West Virginia, rising from 36 in 2015 to 561 in 2020.^{cii} Methamphetamine is the only drug type with a rising number of fatal ODs every year in West Virginia between 2017 and 2020.^{ciii}

BMS will expand and pilot TRUST, a comprehensive outpatient treatment model that combines evidence-based interventions including contingency management, motivational interviewing, community reinforcement, exercise, and cognitive behavioral therapy. Contingency management allows individuals in treatment to earn small motivational incentives for meeting treatment goals, such as negative urine drug screens or saliva tests. Contingency management is the only treatment that has demonstrated robust outcomes for individuals with stimulant disorder, including reduction or cessation of drug use and longer retention in treatment.^{civ,cv,cvi}

BMS will provide \$75 per month in incentives for each participating member for up to one year. Medicaid members ages 18 and older who are diagnosed with stimulant use disorder (e.g., methamphetamine, cocaine, similar drugs), based on a completed ASAM criteria assessment (or another comparable, nationally recognized SUD assessment based on evidence-based clinical treatment guidelines), will be eligible to participate in this treatment model.

4.5 Expanded Residential and Inpatient Treatment Services

BMS currently has authority through its waiver to provide high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as IMDs. BMS is seeking to expand the authority to encompass treatment services for SMI in accordance with SMD #18-011. Specifically, BMS will make capitated payments to MCOs for individuals residing in mental health IMDs and residential facilities that have an average length of stay of 30 days or less, including IMD facilities that are public and private institutions, while the individual is a short-term resident primarily to receive mental health treatment. BMS will aim for a statewide average length of stay of no more than 30 days in IMD treatment settings for members receiving coverage through this waiver's SMI benefit. Currently, West Virginia has 14 facilities matching the definition of an IMD, offering between 550 and 600 beds to treat individuals with SMI in West Virginia, with some variation due to the use of swing beds in diversion facilities.

BMS will also provide a residential LOC through behavioral health residential facilities (BHRFs) for individuals experiencing a behavioral health issue that:

1. Limits the individual's ability to be independent, or
2. Causes the individual to require treatment to maintain or enhance independence.

SMI residential services will be reimbursed on a per diem basis, with a rate that varies based on the patient's acuity level and required LOC.

Members can continue to access an array of mental health services throughout the state, including services under the Rehabilitative and Clinic Services benefits in the State Plan. Crisis services are provided as a continuum of care ranging from the least restrictive setting—intervention in the home/community—to treatment in a residential facility. If these interventions do not work, then the individual is referred for inpatient psychiatric hospital services.

BMS is working to expand mobile crisis outreach and helpline programs—currently developed by BBH for children and families—to adults under Medicaid State Plan authority, as well as establishing crisis triage sites. BMS plans for mobile crisis service expansion to be complete statewide prior to IMD expansion for adults with SMI. Additionally, BMS offers community-focused treatment and ACT to help prevent institutionalization for individuals with SMI.

BMS will submit SMI Implementation and Health Information Technology (HIT) Plans as part of its post-approval protocol, within 90 calendar days of application approval. In its SMI Implementation Plan, BMS will provide detailed information on its strategy for meeting waiver milestones under the following categories (as identified in SMD #18-011):

- Ensuring quality of care in psychiatric hospitals and residential settings
- Improving care coordination and transitions to community-based care
- Increasing access to continuum of care including crisis stabilization services
- Earlier identification and engagement in treatment including through increased integration

BMS commits to evidence-based planning and to meeting the milestones as identified in SMD #18-011. BMS will also provide additional information on its strategy to promote and leverage HIT in support of the waiver's goals in its SMI HIT Plan.

BMS is committed to assuring the necessary resources will be available to effectively support implementation of a robust monitoring protocol and evaluation. BMS will regularly report on progress toward meeting milestones, as well as collect and report data on performance measures. To the greatest extent possible, BMS will use nationally recognized, standard quality measures (such as CMS core; see Table 3) to evaluate the success of the SMI component of the waiver and will work to streamline reporting and minimize administrative burden for West Virginia providers. In addition, BMS will work collaboratively with MCOs, providers, and facilities to ensure performance measures are appropriate and reportable.

5. List of Proposed Waivers and Expenditure Authorities

BMS is requesting waiver and expenditure authorities of the following sections of the Social Security Act (the Act), to the extent necessary to support implementation of the proposed waiver. To the extent that CMS advises BMS that additional authorities are necessary to implement the programmatic vision and operational details described above, BMS is requesting such waiver or expenditure authority, as applicable. BMS' negotiations with the federal government, as well as state legislative changes, could lead to refinements in these lists as BMS works with CMS to move these behavioral health initiatives forward.

Under the authority of §1115(a)(1) of the Act, the following waivers will enable West Virginia to implement this Section 1115 demonstration through December 31, 2027.

Table 4: Waiver Authority Requests

| Waiver Authority | Use for Waiver |
|---|---|
| §1902(a)(10)(B) Amount, Duration, and Scope and Comparability | To enable BMS to provide tenancy supports, employment supports, and contingency management that are otherwise not available to all members in the same eligibility group, based on individual assessments of need according to criteria described in Sections 4.3 and 4.4 of this application. |
| §1902(a)(23)(A) Freedom of Choice | To enable BMS to restrict freedom of choice of providers for the population affected by this waiver. |
| §1903(m)(2)(A) and §1932(a) | To enable BMS to operate only one managed care plan in urban areas for enrollees in the CSED 1915(c) waiver. |
| §1905(a)(30)(A) | To enable BMS to provide Medicaid coverage to otherwise eligible individuals beginning 30 days prior to release from a state prison. |
| §1905(a)(30)(B) | To enable BMS to provide otherwise covered care and services for any individual who has not attained 65 years of age and who is a short-term patient in an IMD, if the individual is primarily receiving SUD treatment and/or WM services, or if the individual is primarily receiving SMI treatment. |

Under the authority of Section 1115(a)(2) of the Act, BMS is requesting expenditure authorities so that the items identified below, which are not otherwise included as expenditures under Section 1903 of the Act, shall, through December 31, 2027, be regarded as expenditures under

West Virginia's Title XIX plan. These expenditure authorities promote the objectives of Title XIX by improving health outcomes for Medicaid populations.

Table 5: Expenditure Authority Requests

| Expenditure Authority | Use for Expenditure Authority |
|--|---|
| Expenditures related to IMDs | Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and/or WM services for SUD, or primarily receiving treatment for SMI, who are short-term residents in facilities that meet the definition of an IMD. |
| Expenditures related to peer recovery support services | While these services could be covered under the Medicaid State Plan, BMS has elected to cover the services through expenditure authority. |
| Expenditures related to state prison inmates | Expenditure authority as necessary under the pre-release waiver to receive federal reimbursement for costs not otherwise matchable for certain services rendered to incarcerated individuals in the 30 days prior to their release. |
| Expenditures related to contingency management pilot | Expenditure authority to provide contingency management through small incentives to individuals with qualifying stimulant use disorders who are enrolled in a comprehensive outpatient treatment program. |
| Expenditures related to tenancy supports pilot | Expenditure authority to provide tenancy supports to qualifying individuals with SUDs. |
| Expenditures related to administrative simplification and delivery systems | Expenditure authority for expenditures under contracts with managed care entities that do not meet the requirements in 1903(m)(2)(A) and 1932(a) of the Act insofar as they incorporate 42 CFR 438.52(a) to the extent necessary to allow BMS to operate only one managed care plan in urban areas for CSEDW members. |

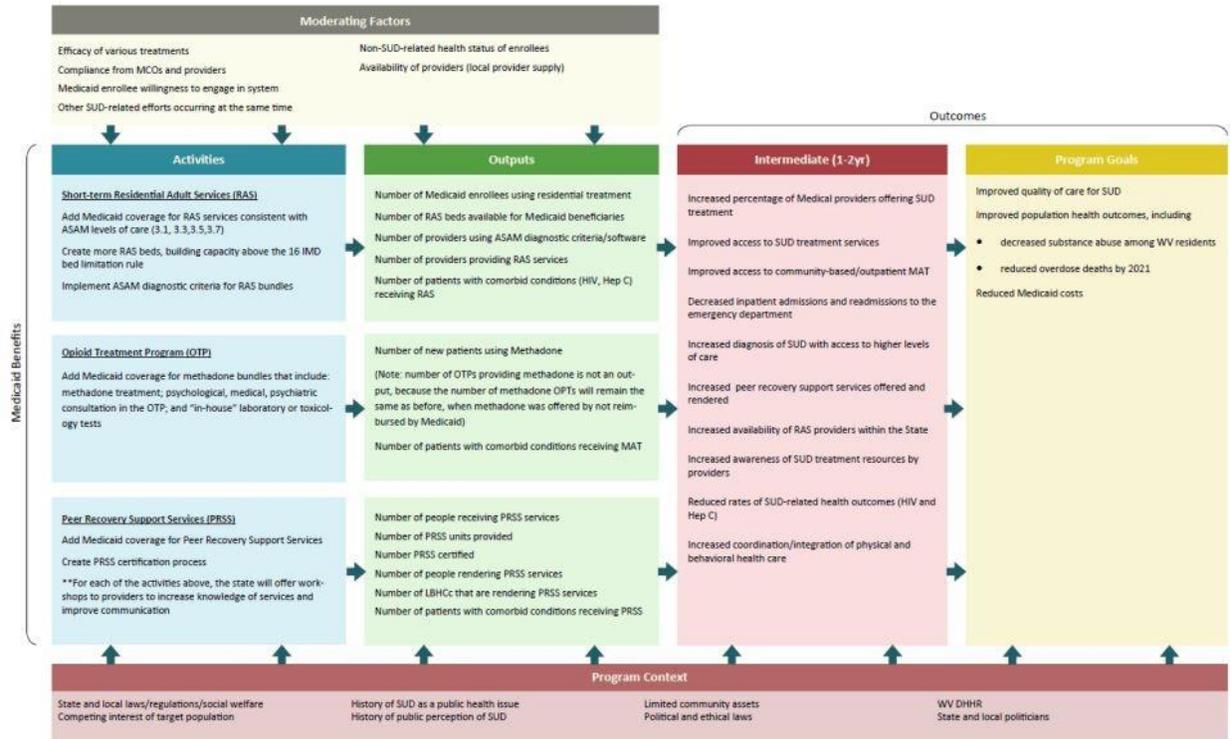
6. Demonstration Evaluation Summary

BMS' overall goal for the 1115 waiver is to provide the right care, at the right time, in the right setting, for individuals with SUD and/or SMI. Contributing to this overarching goal are four key objectives: increasing member access to and utilization of appropriate treatment services, improving care coordination and care transitions, decreasing utilization of high-cost ED and hospital services, and improving quality of care and population health outcomes. The final 1115 evaluation design for the existing waiver, which CMS approved in September 2019, includes metrics relative to each of these four objectives, as well as metrics aimed at evaluating the overall impact of the waiver's implementation. The evaluation design can be accessed in full at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wv/continuum-care/wv-creating-continuum-care-medicaid-enrollees-sud-final-eval-design-20190927.pdf>. The approved evaluation design includes seven evaluation questions and nine associated hypotheses. The State's external evaluator, WVU, is submitting preliminary findings to CMS in the form of an Interim Evaluation Report in March 2022.

Evaluation Activities to Date

Over the past four years, BMS developed and received approval for the waiver evaluation design, procured an external evaluator, provided the external evaluator with the data sources and data-related assistance as requested, and participated in consistently scheduled meetings with the WVU evaluating team to discuss waiver evaluation processes. BMS also developed an expansion to the current evaluation design for the waiver renewal, broadening the planned scope of evaluation in accordance with the expanded Behavioral Health waiver services and objectives (see "Planned Evaluation Activities During the Behavioral Health Waiver Renewal and Expansion" below for further detail).

The approved evaluation design for the current 1115 demonstration is based on the following logic model:



BMS intends to continue all evaluation activities related to this waiver program consistent with its existing approved evaluation design.

Evaluation Findings to Date

The independent external evaluating team completed preliminary findings of the waiver and provided results from their initial evaluation in the 2022 SUD Interim Evaluation Report. A summary of key preliminary findings from this evaluation is provided below. As explained in full in the Report, the evaluation team faced several analytical components for which poor data quality made it challenging for the team to draw conclusive insights. As such, the team asks that these results be interpreted with the understanding that a lack of reliable data impacted the evaluators' confidence in certain results. WVU's Interim Evaluation Report 1115 Substance Use Disorder Waiver Evaluation (Appendix C of this document) provides the full report of preliminary findings provided by the evaluators.

Demonstration Goal 1: Improve quality of care and population health outcomes for Medicaid enrollees with SUD

Evaluation Question 1.1: What is the impact of the demonstration on quality of care for Medicaid enrollees?

With access to more SUD treatment services available, uptake of individual waiver services rose over time during the demonstration period, though the observed rise in overall SUD treatment utilization use appears to be part of a larger trend beginning prior to waiver implementation. At the time of this report, the WVU evaluators cannot claim that the waiver

alone was responsible for these increases. It appears that quality of certain aspects of SUD treatment (e.g., engagement) may have declined during the waiver period. However, this result is also due to broader declines in care quality that began prior to the waiver's implementation. The State is committed to continuous improvement in providing quality care to members and will use these findings to continually consider opportunities to improve quality of care provided under the demonstration during both the end of the current waiver and the renewal period.

Evaluation Question 1.2 What is the impact of the demonstration on population health outcomes among Medicaid enrollees?

The evaluation's operational measurement for population health outcomes among Medicaid enrollees considers morbidity rates for members and their children. It was hypothesized that the demonstration would decrease morbidity and among Medicaid enrollees and their children as a result of better quality of care received; preliminary findings suggest this is not the case. Of heightened relevance to this evaluation question is the ways in which the COVID-19 pandemic has implications on the evaluation study, given that the pandemic directly contributed to a rise in opioid and other drug use, as well as related morbidity and mortality.

Demonstration Goal 2: Increase enrollee access to and use of appropriate SUD treatment services based on the ASAM Criteria

Evaluation Question 2.1: What is the impact of the demonstration on access to SUD treatment among Medicaid enrollees?

Preliminary findings utilization of all three waiver-covered treatments (residential services, methadone, and PRSS services) has increased since the time each was first implemented. This data also suggests that implementation of the waiver significantly improved the supply of residential facilities, beds, providers, and peers for those receiving SUD treatment services. Initial findings also suggest that connecting individuals with a SUD diagnosis to residential beds remains subject to challenges. Including PRSS under the waiver significantly increased the amount of PRSS available to provide critically important support services.

Evaluation Question 2.2: What is the impact of the demonstration on the use of SUD treatment among Medicaid enrollees?

Preliminary findings suggest that uptake of the individual waiver service components rose over time, an observed utilization uptake which appears to align with a broader trend of increased SUD utilization over the demonstration period. Importantly, this result supports the waiver's goal of increasing enrollee use of appropriate SUD treatment services made available by the waiver program.

Demonstration Goal 3: Decrease emergency department and hospital services by enrollees with SUD

Evaluation Question 3.1: What is the impact of the demonstration on ED utilization by Medicaid enrollees with SUD?

Claims data analysis conducted as part of the Interim Evaluation show that the rate of non-emergent ED use among enrollees with SUD remained relatively constant from the onset of the waiver through the end of 2019. As discussed in the treatment outcomes section of the Report, the WVU evaluation team also analyzed changes in ED visits for SUD and OUD among all enrollees and found that while the number of ED visits for both OUD and SUD increased post-waiver implementation, it appears the waiver might have helped postpone the increase in ED visits for OUD.

Evaluation Question 3.2: What is the impact of the demonstration on inpatient hospital use by Medicaid enrollees with SUD?

It was hypothesized that the demonstration would decrease inpatient hospital admissions among Medicaid enrollees with SUD. The preliminary evaluation findings revealed that the trend of inpatient stays continues downward with the waiver, which is consistent with the objective of the demonstration for this evaluation metric.

Demonstration Goal 4: Improve care coordination and care transitions for Medicaid enrollees with SUD

Evaluation Question 4.1: What is the impact of the demonstration on the integration of physical and behavioral healthcare among Medicaid enrollees with SUD and comorbid conditions?

The evaluation team intended to analyze this question by looking at treatment initiation and engagement for enrollees with SUD and HIV comorbidities and for enrollees with SUD and HCV comorbidities. Due to ongoing data improvement efforts, results for the following measures have not yet been finalized. Both measures will be analyzed and discussed in the Final Evaluation Report.

With the renewal of the waiver, the State plans to consider this question more comprehensively, as BMS is seeking to add several services which pertain specifically to the integration of physical and behavioral healthcare. In particular, if approved, the waiver extension would include Extended IMD Stays for Individuals with SUD and Co-Occurring Medical Conditions, HIV and HCV education and outreach services and continuity of care for justice-involved individuals, allowing this population to obtain referrals to physical and behavioral health providers for appointments post-release. By including services that specifically address both behavioral and physical health under the waiver renewal, BMS seeks to further the integration of healthcare and to improve members' health in both behavioral and physical outcomes.

Evaluation Question 4.2: What is the impact of the demonstration on care transitions among Medicaid enrollees with SUD?

Preliminary findings indicate that implementation of the waiver contributed positively to an increase in communication and facilitation of transitions between different LOC for individuals receiving treatment. Interview data from focus groups with providers reveal that most facilities

did not experience difficulties related to communication or transitions, and those providers who had been working prior to the waiver's implementation said the waiver contributed to an increase in communication, helping care transitions. PRSS appear to be particularly valuable in helping make care transitions more seamless.

Planned Evaluation Activities During the Behavioral Health Waiver Renewal and Expansion

As discussed above, BMS intends to add additional evaluation questions and hypotheses for new demonstration features. Upon approval of this waiver renewal application, the WVU team plans to expand measures currently used to evaluate the existing waiver, to capture changes related to new services.

The objectives of the waiver renewal align with and expand upon the objectives of the current waiver. They are as follows:

Goal 1: Improve quality of care and population health outcomes for Medicaid members with SUD and/or SMI

BMS hypothesizes that these objectives can be achieved through efforts such as decreasing the period of active substance use and increasing the duration of sobriety among West Virginia residents and decreasing recidivism rates for West Virginia Medicaid members with SUD.

Goal 2: Increase member access to and utilization of appropriate SUD treatment services according to ASAM criteria, or another comparable, nationally recognized set of SUD program standards based on evidence-based SUD clinical guidelines.

BMS hypothesizes that access to and utilization of appropriate services can be increased via efforts such as increasing the availability of a range of treatment opportunities, increasing access to both methadone and naloxone, and increasing access to treatment for target populations such as individuals who are justice-involved or have a stimulant use disorder.

Goal 3: Decrease utilization of high-cost ED and hospital services.

BMS hypothesizes that by providing services designed to promote and sustain recovery, leveraging prevention strategies and increased public awareness to prevent and reverse overdoses, among other strategies, the waiver will decrease the use of high-cost emergency department and inpatient hospital service admissions and readmissions to the same or higher levels of care for a primary SUD diagnosis.

Goal 4: Improve care coordination, care transitions, and continuity of care for Medicaid members with SUD and/or SMI.

BMS hypothesizes that through improving coordination of behavioral and physical healthcare needs, improving transitions within different LOCs within the care continuum for SUD and/or SMI, engaging individuals in recovery environments as an integrated component of the care continuum, and reinstating justice-involved individuals' Medicaid eligibility prior to release, the expanded demonstration will improve care coordination, care transitions, and overall continuity of care for West Virginia Medicaid members with SUD and/or SMI diagnoses.

Based on the BMS goals identified, the goals were translated into quantifiable targets for improvement. Table 6 below outlines these new target measures and WVU's proposed methods for evaluating each. Of note, these plans should be considered proposed and not final. A comprehensive list of the Evaluation Measures Table can be located in Appendix D.

Upon approval of this renewal, BMS will work with the external evaluator and CMS to develop a new evaluation design plan consistent with the Special Terms and Conditions and CMS policy.

Table 6: Proposed Evaluation Plan Changes for Waiver Renewal and Expansion

| Waiver Extension Service | Change to Evaluation Plan | Proposed Measurement Method |
|--|---|---|
| <p>Decrease utilization of high-cost ED and hospital services with SUD and/or SMI.</p> <p>Hypothesis: The extension of services to individuals with SMI will decrease emergency department and hospital services by enrollees with SMI in addition to enrollees with SUD.</p> | <p>This demonstration goal will replace Demonstration Goal 3: "Decrease emergency department and hospital services by enrollees with SUD."</p> | <p>Use the same measurement method as the replaced demonstration goal.</p> |
| <p>Reimburse short-term residential and inpatient treatment services for adults with SMI at IMDs</p> <p>Hypothesis: Reimbursement for these services for adults with SMI at IMD facilities will improve both care coordination and care transitions for Medicaid enrollees with SMI in addition to enrollees with SUD.</p> | <p>Include SMI in Demonstration Goal 4: "Improve care coordination and care transitions for Medicaid enrollees with SUD and/or SMI."</p> | <p>In addition to HCV and HIV, additional physical health conditions consistent with SMI will be examined separately.</p> |

| | | |
|--|---|---|
| <p>Provide Medicaid coverage to eligible individuals incarcerated in state prisons starting 30 days prior to release</p> <p>Hypothesis: Ensuring continuity of care for justice-involved members will improve health outcomes and decrease recidivism rates upon release from incarceration.</p> | <p>Measure non-emergent ED utilization post-incarceration.</p> <p>Measure number of individuals reinstated in Medicaid within 30 days of incarceration release.</p> | <p>Contingent upon WV DHHR implementing a way to track previously-incarcerated enrollees in claims data, these measures can be completed using Medicaid claims data.</p> |
| <p>Provide integrated access treatment, education, and outreach for HIV/HCV in relation to substance use.</p> <p>Hypothesis: Providing integrated access to care and treatment services for these frequently co-occurring conditions will increase the number of individuals receiving HIV/HCV education and treatment if necessary.</p> | <p>Measure number of individuals receiving HIV/HCV education.</p> | <p>Use CPT codes to flag HIV/HCV testing encounters. Contingent upon data quality issues being addressed, code modifiers can be used to flag educational encounters among these visits.</p> |
| <p>Provide supported housing and supported employment to enrollees with SUD.</p> <p>Hypothesis: The addition of supported housing and supported employment services will allow individuals to access these support services, therefore increasing utilization recovery supports and</p> | <p>Measure number and rate of enrollees with SUD receiving supported housing and/or supported employment.</p> | <p>Use HCPCS codes for supported housing (H0043, H0044) and supported employment (H2023) to analyze changes in utilization.</p> |

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|---|--|--|
| <p>lowering relapse rates for those with SUD diagnoses.</p> | | |
| <p>Implement the TRUST comprehensive outpatient model for contingency management</p> <p>Hypothesis: Inclusion of the TRUST model will increase the number of enrollees with stimulant use disorder receiving treatment services.</p> | <p>Measure the number and rate of enrollees with SUD that have utilized contingency management services.</p> | <p>Contingent on Medicaid claims data changes, this measure can be completed using Medicaid claims data.</p> |
| <p>Provide multidisciplinary Quick Response Teams</p> <p>Hypothesis: The expansion of Quick Response Teams under the waiver will increase access to crisis services and lower the rates of overdoses and overdose related deaths among individuals with SUD diagnoses.</p> | <p>Measure the number and rate of enrollees with SUD that are contacted by a QRT within 72 hours of a SUD-related emergency.</p> | <p>Contingent on Medicaid claims data changes, this measure can be completed using Medicaid claims data.</p> |
| <p>Expand allowable length of stays in IMDs at the ASAM 3.7 level of care for individuals with SUD and co-occurring complex medical conditions for up to 60 days</p> <p>Hypothesis: Expansion of the allowable length of stay at the 3.7 treatment level of care for medically complex individuals will help ensure these individuals receive</p> | <p>Include separate measure for length of RAS stays among ASAM level 3.7.</p> | <p>Number and rate of ASAM level 3.7 visits exceeding 30 days.</p> |

| | | |
|--|--|--|
| the full course of treatment for co-occurring conditions, therefore improving health outcomes. | | |
|--|--|--|

In addition to development of a new evaluation design plan, BMS will work with CMS to determine a target date for the submission of an Interim Evaluation Report for the renewed waiver. The new evaluation design BMS intends to develop for the forthcoming demonstration period will include proposed revisions to the current approved design plan correlating to waiver extension services and proposed measurement methods.

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7. External Quality Review Organization (EQRO), MCO, and Quality Assurance Strategy Summaries

EQRO Reports

BMS strives to ensure delivery of high-quality, accessible care through West Virginia's managed care programs, Mountain Health Trust (MHT) and Mountain Health Promise (MHP). Pursuant to 42 CFR §438.350, 42 CFR §438.364, and 42 CFR §457.1250.31, BMS contracts with an EQRO to conduct annual, independent reviews of MHP and MHT (which contracts with managed care plans Aetna Better Health of West Virginia, The Health Plan of West Virginia [THP], and UniCare Health Plan of West Virginia [UHP]).

To help meet the Bureau's goal of ensuring high-quality and accessible care, BMS uses a three-pronged approach to monitor, assess, and improve program delivery. BMS targets five focus areas in monitoring managed care program quality, as highlighted in the [EQRO's 2020 Annual Technical Report](#) (released in March 2021).

BMS' five focus areas for monitoring managed care program quality are:

- Making care safer by promoting the delivery of evidence-based care
- Engaging individuals and families as partners in care by strengthening the relationship between managed care beneficiaries and their primary care providers
- Promoting effective communication and coordination of care
- Promoting effective prevention and treatment of diseases burdening managed care beneficiaries
- Enhancing oversight of managed care plan (MCP) administration

High-level findings from the 2020 External Quality Review Annual Technical Report include:

- *Commitment to quality improvement:* West Virginia's managed care plans are National Committee for Quality Assurance (NCQA) accredited.
- *Responsive to requirements:* The MCPs are largely compliant with federal and state requirements (demonstrating compliance rates between 94% and 100%). When deficiencies are identified, plans respond quickly with corrective actions.
- *Trending improvement on quality of interventions:* Based on weighted averages, the MHT plans performed better than national average benchmarks in both Healthcare Effectiveness Data and Information Set and Consumer Assessment of

Healthcare Providers and Systems survey results. Overall, plan performance has been trending in a positive direction, with evidence of improved health care access and quality

For links to additional documentation of West Virginia's EQRO reports from the demonstration period, as well as MCO reports and information from this period, see Appendix A.

MCO Reports

In addition to EQRO evaluations and resulting reports, the West Virginia Medicaid Program submits managed care annual reports to the Legislative Oversight Commission on Health and Human Resource Accountability (LOCHHRA), as required by West Virginia Code §9-5-22. The 2020 managed care annual report, submitted in April of 2021, can be accessed [here](#). These reports to the Legislature discuss the contracted WV MCOs geographic areas of service, managed care provider networks, member enrollment, and claims statistics, among other informational areas.

The State also has an established [Managed Care Quality Strategy](#), which details the overarching framework for the State's Medicaid entities to drive quality and performance improvement among its contracted MCOs, with the broader goal of improving WV Medicaid members' health outcomes. The Strategy document includes an analysis that identifies each required element of the Quality Strategy and where it has been addressed, in compliance with CMS quality strategy requirements set forth in 42 CFR §438.340 and 42 CFR §457.1240. The document outlines how the managed care programs prioritize effective organization, financing, and delivery of primary health care services with the aim of improving access to high-quality health care for members.

BMS posts MCO reports (enrollment and annual technical reports) publicly at the following location:
<https://dhhr.wv.gov/bms/Members/Managed%20Care/MCOreports/Pages/default.aspx>.

These quality and access-to-care reports are not specific to this 1115 waiver demonstration, but do apply to the managed care delivery system/programs for demonstration services. Each of the State's managed care programs also provide annual reports each fiscal year, as well as monthly MCO enrollment reports. Further documentation of the managed care reports from the duration of the demonstration period to date is included in Appendix V.

Quality Strategy and State Quality Assurance Monitoring

As described in the Quality Strategy report, and in accordance with [Chapter 1000](#) of the BMS Provider Manual detailing quality assurance and monitoring, BMS's Center for Managed Care plays a central role in monitoring and overseeing quality improvement efforts within the WV quality improvement structure. Specifically, BMS' Center for Managed Care administers the MHP and MHT-Medicaid programs. The Chief of this office oversees all aspects of the MHT Medicaid and MHP programs, including quality assurance activities. The BMS Office of Quality Management administers the EQRO contract. The Quality Strategy employs a three-pronged approach to improving the quality of health care delivered to members in the MHT and MHP programs: monitoring, assessment, and improvement. By aligning priorities, measures, and activities, as well as setting achievable goals, the expectation is that the State's planned strategy will drive quality improvement in healthcare delivery.

BMS receives input on quality efforts from several formal and informal groups, including advocates, legislators, providers, other State agencies, the Medical Services Fund Advisory Council, the MCOs, the MHT enrollment broker, WVCHIP Board of Directors, and the EQRO. These groups provide feedback on quality activities and programs on an ongoing basis, both formally and informally, to support quality efforts.

Quality assurance issues were identified under the 1115 waiver demonstration to date in the form of poor quality of provider-reported data. As discussed at length in the Interim Evaluation Report provided by BMS' contracted independent evaluator, WVU, poor data quality posed challenges to the evaluation team's ability to confidently draw conclusions from the available data. BMS will address these data quality assurance issues and the opportunity for improvement in data collection efforts through increased outreach to providers and enhanced education of how to bill and report waiver service delivery. These efforts will ensure that future data reported and assessed is more accurate and of higher quality in the forthcoming years of the demonstration and the expanded demonstration once approved.

8. Demonstration Financial Data

Below is a table of anticipated annual expenditures for each of the benefits included in the proposed waiver.

Table 8: Anticipated Annual Waiver Expenditures

| Benefit | DY 1 (2023) | DY 2 (2024) | DY 3 (2025) | DY 4 (2026) | DY 5 (2027) |
|--|-----------------------|--------------------|--------------------|--------------------|--------------------|
| SUD IMD | \$744,686 | \$810,702 | \$889,926 | \$976,892 | \$1,072,356 |
| SUD Residential | \$48,160,258 | \$50,150,300 | \$52,657,815 | \$55,290,706 | \$58,055,241 |
| Peer Recovery Support Services | \$27,345,676 | \$29,018,027 | \$31,049,288 | \$33,222,739 | \$35,548,330 |
| Recovery Housing | \$2,149,400 | \$2,821,401 | \$3,734,366 | \$4,942,754 | \$6,542,160 |
| Supported Housing | \$376,392 | \$494,070 | \$653,944 | \$865,551 | \$1,145,631 |
| Supported Employment | \$221,325 | \$290,522 | \$384,530 | \$508,959 | \$673,651 |
| Continuity of Care for Justice-Involved | \$9,030,632 | \$9,316,916 | \$9,692,387 | \$10,082,991 | \$10,489,335 |
| HIV/HCV Education and Outreach | \$2,643,253 | \$2,775,724 | \$2,939,127 | \$3,112,149 | \$3,295,357 |
| Quick Response Teams (QRTs) | QRTs to start in DY 2 | \$3,095,040 | \$3,277,241 | \$3,470,168 | \$3,674,452 |
| Contingency Management | \$1,743,072 | \$1,798,330 | \$1,870,802 | \$1,946,196 | \$2,024,627 |
| SMI IMD | \$1,731,910 | \$1,885,443 | \$2,069,693 | \$2,271,948 | \$2,493,969 |
| SMI Residential | \$6,537,839 | \$16,540,733 | \$20,924,028 | \$23,016,431 | \$25,318,074 |
| Expanded 3.7 for Medically Complicated SUD | \$5,200,251 | \$6,188,723 | \$7,426,467 | \$8,911,761 | \$10,694,113 |

| | | | | | |
|---|--|-----------|-----------|-----------|-----------|
| Involuntary Secure WM and Stabilization | | \$719,115 | \$761,449 | \$806,274 | \$853,739 |
|---|--|-----------|-----------|-----------|-----------|

Below is a table of projected annual member enrollment for waiver services.

Table 9: Anticipated Annual Waiver Enrollments

| Benefit | DY 1 (2023) | DY 2 (2024) | DY 3 (2025) | DY 4 (2026) | DY 5 (2027) |
|--|----------------------|-------------|-------------|-------------|-------------|
| SUD IMD (Utilizing Medicaid Members (MM)) | 189 | 197 | 207 | 217 | 228 |
| SUD Residential (Utilizing MM) | 13,097 | 13,639 | 14,321 | 15,037 | 15,788 |
| Peer Recovery Support Services (Utilizing MM) | 1,663 | 2,120 | 2,724 | 3,500 | 4,498 |
| Recovery Housing (Utilizing MM) | 1,663 | 2,120 | 2,724 | 3,500 | 4,498 |
| Supported Housing (Utilizing MM) | 1,641 | 2,092 | 2,688 | 3,454 | 4,439 |
| Supported Employment (Utilizing MM) | 5,144 | 6,555 | 8,423 | 10,824 | 13,910 |
| Continuity of Care for Justice-Involved (Utilizing MM) | 12,102 | 12,122 | 12,243 | 12,366 | 12,489 |
| HIV/HCV Education and Outreach (Utilizing MM) | 158,945 | 162,049 | 166,591 | 171,260 | 176,060 |
| Quick Response Teams (QRTs) (Utilizing MM) | QRTs to start in DY2 | 7,738 | 7,954 | 8,177 | 8,407 |

| | | | | | |
|---|--------|--------|--------|--------|--------|
| Contingency Management (Utilizing MM) | 23,241 | 23,279 | 23,512 | 23,747 | 23,985 |
| SMI IMD (Utilizing MM) | 347 | 361 | 379 | 398 | 418 |
| SMI Residential (Utilizing MM) | 1,048 | 2,651 | 3,354 | 3,689 | 4,058 |
| Expanded 3.7 for Medically Complicated SUD (Utilizing MM) | 753 | 896 | 1,076 | 1,291 | 1,549 |
| Involuntary Secure WM and Stabilization (Utilizing MM) | | 495 | 509 | 523 | 538 |

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9. Public Notice Process

Per the Code of Federal Regulations (CFR) 42 Part 431.408 regarding the State public notice process for demonstrations and CFR 42 Part 431.412 regarding application procedures, a state must provide at least a 30-day public notice and comment period regarding demonstration project applications. In accordance with the CFR requirements, West Virginia held public notice and comment periods for this proposed waiver from December 1, 2021, through January 3, 2022, and from April 4, 2022 through May 4, 2022.

During these periods, BMS posted the proposed 1115 waiver application to the BMS website for stakeholders to review and provide comments on. BMS additionally held two virtual public comment hearing events in December 2021 for stakeholders within the provider community and the public at large to attend. At these hearings, individuals in attendance could ask questions about or provide comments on the proposed waiver.

At the close of the public notice period, BMS collected all comments received (in both public hearings as well as in written comments and emails to a designated State inbox for the waiver), reviewed and responded to all comments received, and determined no changes needed to be made based on comments and questions prior to submitting the final application to CMS. A Stakeholder Summary of the public hearings, inclusive of comments and questions received in addition to BMS responses to these comments, is included in Appendix D of this document.

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

**MEDICAID SECTION 1115 WAIVER DEMONSTRATION
RENEWAL - PUBLIC HEARING**

EVOLVING THE BEHAVIORAL HEALTH CONTINUUM OF CARE

JOIN DHHR'S BUREAU FOR MEDICAL SERVICES (BMS) FOR A
DISCUSSION OF PROPOSED CHANGES TO THE CURRENT
SUBSTANCE USE DISORDER (SUD) 1115 WAIVER

| | |
|--|--|
| DECEMBER 8, 2021: 3:00PM - 4:00PM | DECEMBER 16, 2021: 11:00AM - 12:00PM |
| ZOOM LINK: HTTPS://BERRYDUNN.ZOOM.US/J/96706074245 DIAL-IN BY PHONE: 312-626-6799 MEETING ID: 967 0607 4245 | ZOOM LINK: HTTPS://BERRYDUNN.ZOOM.US/J/94576778118 DIAL-IN BY PHONE: 301-715-8592 MEETING ID: 945 7677 8118 |

HOW YOU CAN PARTICIPATE:

THE ZOOM LINKS ABOVE MAY BE CLICKED ON OR ENTERED IN YOUR
BROWSER TO JOIN A PUBLIC FORUM OF YOUR CHOICE YOU MAY ALSO
DIAL-IN USING THE PHONE NUMBERS ABOVE AND ENTERING THE
RELEVANT MEETING ID.

IF YOU ARE UNABLE TO ATTEND A PUBLIC FORUM, YOU MAY SUBMIT COMMENTS
TO BMS.COMMENTS@WV.GOV

Post-award public engagement

In accordance with 42 CFR § 431.408, 42 CFR § 431.412(c) and 42 CFR § 431.420(c), following CMS approval of the 1115 SUD demonstration waiver in 2017, BMS has engaged with the public on updates to and progress of the demonstration program.

BMS has utilized both SUD provider workshops and WV DHHR ODCP meetings as public forums to discuss the current 1115 waiver in settings with public involvement. Provider workshops occur at regularly scheduled 6-month intervals, in the spring and fall of each year. At these workshops, which BMS has discussed in the quarterly monitoring reports the Bureau submits to CMS in compliance with properly monitoring the 1115 demonstration, the BMS program team gives presentations on the 1115 waiver and relevant updates or changes to the program. Recent SUD topics of discussion at workshops have included the transition to a different PRSS certification process to ensure uniform standards for peers involved with the program.

The most recent provider workshops that serve as public forums for the current waiver demonstration (the Fall workshops) took place from Monday, November 1 through Wednesday, November 10, 2021. Peer recovery support services were a predominant discussion focus at these workshops, as well as the Spring 2021 provider workshops held from April 13 through April 22, 2021.

DHHR meetings occur frequently; the Department holds several of these meetings each year, and has done so since the time the waiver was implemented. BMS staff are present at these meetings, and BMS updates are consistently included as a planned agenda item. At meetings, BMS staff provided updates on the progress of and changes to the 1115 SUD waiver. 1115 SUD waiver Program Manager Keith King was present at Community Engagements and Supports meetings and answered questions from the public about PRSS services. Draft agendas for these meetings are posted on the website prior to the meetings, and minutes from the meetings are posted after they occur. This documentation can be accessed [here](#). Additionally, archived agendas and minutes from meetings held prior to 2021 can be accessed [here](#).

WV BMS has discussed waiver activities in additional public-facing settings as well over the course of the current demonstration period since the waiver became effective in 2018. For example, BMS facilitated a public meeting on January 17, 2018, a training on the ASAM criteria that the SUD waiver services operate in accordance with. The 1115 waiver was discussed at this meeting, with the Commissioner starting the conversation highlighting the SUD services kick-off as of January 14, 2018. The WV Policy and Research Engagement Symposium, held on November 19 and 20, 2019, brought together the BMS team and other policy administrators, state legislators, and researchers from across the state in order to identify challenges to implementing evidence-based policy and craft an action plan to overcome substance use related challenges. The event, held at Stonewall Resort in Roanoke, was open to members of the public who registered to attend.

Going forward, BMS will continue to engage with the public in the ways discussed above for the remainder of the current SUD demonstration period and will continue to offer opportunities for public engagement and input during the post-award period for the 1115 demonstration renewal upon CMS approval. This includes holding a post-award forum within 6 months of when BMS receives approval for the renewed waiver demonstration, and annual forums thereafter for the remaining demonstration years. BMS will continue to speak to these in the quarterly and annual monitoring reports the State provides to CMS.

Appendix A: EQRO, MCO, and Quality and Access to Care Reports

Historical EQRO Reports as well as MCO monthly enrollment reports, MCO annual reports, and the most recent MCO Report to the WV Legislature can be accessed at:

<https://dhhr.wv.gov/bms/Members/Managed%20Care/MCOreports/Pages/default.aspx>

The WV Managed Care Quality Strategy can be accessed at:

https://dhhr.wv.gov/bms/Public%20Notices/Documents/WV%20Managed%20Care%20Quality%20Strategy%202021_3.3.21_For%20Public%20Input.pdf

Appendix B: ASAM LOC Descriptions and Provider Credentials

Tables 10 and 11 on the following pages summarize the ASAM LOC services included in this waiver application, as well as relevant provider credentials per state code and/or OHFLAC.

Table 10: West Virginia Services by ASAM Level of Care

| ASAM LOC | ASAM Service Title | ASAM Brief Definition |
|----------|--|---|
| 0.5 | Early Intervention | Screening, Brief Intervention, and Referral to Treatment (SBIRT) |
| 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. |
| 2.1 | Intensive Outpatient Services | Nine or more hours of service/week (adults); six or more hours/week (adolescents) to treat multidimensional instability. |
| 2.5 | Partial Hospitalization Services | 20 or more hours of service/week for multidimensional instability not requiring 24-hour care. |
| 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. |
| 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. |
| 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. |

| ASAM LOC | ASAM Service Title | ASAM Brief Definition |
|--|--|---|
| 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/day counselor availability. |
| 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. WV is currently OBOT and OTP. |
| 1-WM | Ambulatory Withdrawal Management Without Extended On-site Monitoring | Mild withdrawal with daily or less than daily outpatient supervision. |
| 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. |
| 3.2-WM | Clinically Managed Residential Withdrawal Management | Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery. |
| 3.7-WM | Medically Monitored Inpatient Withdrawal Management | Severe withdrawal, 24-hour nursing care & physician visits; unlikely to complete withdrawal management without medical monitoring |
| Other | Targeted Case Management | Services to assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. |
| 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. |
| Other (ASAM Dimension 6 – Recovery / | Recovery Housing | Recovery Environment that encompasses the external supports for recovery. |

| ASAM LOC | ASAM Service Title | ASAM Brief Definition |
|---------------------|--------------------|-----------------------|
| Living Environment) | | |

Table 11: West Virginia Services by ASAM Level of Care

| Service | Licensing/Credentialing Standard |
|--|---|
| Early Intervention | Licensed as an ambulatory healthcare facility, ambulatory surgical facility, hospital, or extended care facility by the State Director of Health (Secretary of the Department of Health and Human Resources). |
| Outpatient Services | Licensed as an ambulatory healthcare facility by the State Director of Health. |
| Intensive Outpatient Services | Licensed as an ambulatory healthcare facility by the State Director of Health. |
| Partial Hospitalization Services | Licensed as a behavioral health agency. |
| Clinically Managed Low-Intensity Residential Services | Licensed as a behavioral health agency. |
| Clinically Managed Population-Specific High-Intensity Residential Services | Licensed as a behavioral health agency. |
| Clinically Managed High-Intensity Residential Services | Licensed as a behavioral health agency. |
| Medically Monitored Intensive Inpatient Services | Licensed as a hospital or free-standing psychiatric hospital by the State Director of Health. |
| 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 11.3 |
| Ambulatory Withdrawal Management Without Extended Onsite Monitoring | Licensed as an ambulatory healthcare facility by the State Director of Health. |
| Ambulatory Withdrawal Management with Extended Onsite Monitoring | Licensed as an ambulatory healthcare facility by the State Director of Health. |
| Clinically Managed Residential Withdrawal Management | Licensed as a behavioral health agency. |

| Service | Licensing/Credentialing Standard |
|---|--|
| Medically Monitored Inpatient Withdrawal Management | Licensed as a hospital or freestanding psychiatric hospital by the State Director of Health. |
| Targeted Case Management | Licensed as a behavioral health agency. |
| Recovery Support Services | Licensed as an ambulatory health care facility by the State Director of Health. |

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Appendix C: Interim Evaluation Report



Interim Report

1115 Substance Use Disorder Waiver Evaluation

February 15, 2022

Prepared for:

West Virginia Department of Health and Human Resources

Prepared by:

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Document Acronyms

The following acronyms are used throughout this document:

| Acronym | Definition |
|----------|---|
| AMA PCPI | American Medical Association [®] Physician Consortium for Performance Improvement [®] |
| ARP | American Rescue Plan |
| ASAM | American Society of Addiction Medicine |
| COE | Centers of Excellence |
| CSEDW | Children with Serious Emotional Disorder Section 1915(c) Waiver |
| DFMB | Drug Free Moms and Babies |
| DHHR | West Virginia Department of Health and Human Resources |
| FFS | Fee-for-Service |
| MODRN | Medicaid Outcomes Distributed Research Network |
| MAT | Medication-Assisted Treatment |
| MCO | Managed Care Organization |
| MHP | Mountain Health Promise |
| MOUD | Medication for Opioid Use Disorder |
| NAS | Neonatal Abstinence Syndrome |
| OHA | West Virginia Office of Health Affairs |
| ODD | Opioid Use Disorder |
| PPW-PLT | State Pilot Grant Program for Treatment for Pregnant and Postpartum Women |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SMI | Serious Mental Illness |
| SOR | State Opioid Response grant |
| STC | Special Terms and Conditions |
| SUD | Substance Use Disorder |
| WV | West Virginia |

| | |
|---------|--|
| WVCBAPP | West Virginia Certification Board for Addiction & Prevention Professionals |
| WVU | West Virginia University |

Executive Summary

In 2018, the West Virginia Department of Health and Human Resources (DHHR) implemented a Section 1115 Substance Use Disorder (SUD) Medicaid waiver to promote access and use of SUD treatment among Medicaid enrollees. The waiver allows WV Medicaid to reimburse for three services designed to address gaps in the SUD care continuum- peer recovery services, residential adult services, and methadone. As part of the waiver agreement, the WVU Office of Health Affairs (OHA) evaluation team was tasked with measuring resulting changes in the supply of SUD treatment, utilization, and related outcomes. This interim report provides preliminary findings for these measures, as well as a description of two major evaluation challenges that have occurred.

These challenges have both affected how we analyze and interpret claims data. First, the anticipated control state implemented policies during the post-period that no longer make it a suitable comparator for some of our analyses. Second, the claims data used in the evaluation have significant quality issues, including duplications, billing/coding errors, and other limitations. The evaluation team is working closely with the data suppliers to identify and correct these errors in order to provide the most rigorous results possible. This interim report highlights results that we believe are accurate. Analyses that were based on lower quality data are included in Appendix C: Treatment-Related Outcomes, and readers are urged to view them with appropriate caution.

Among the findings we believe are accurate, the evaluation team found that the waiver significantly improved the supply of residential facilities, bed, and peer recovery support specialists (PRSS). PRSS are an especially valuable resource for providers and were reported to help make care transitions more “seamless”, specifically in residential settings. However, connecting patients to residential beds is still subject to barriers, most notably approval from managed care organizations (MCOs).

Additionally, while uptake of individual waiver services rose over time, the observed rise in overall SUD treatment utilization use appears to be part of a larger trend beginning prior to waiver implementation. At the time of this report, we cannot claim that the waiver was responsible for these increases, even though they continued during the waiver period. In addition, it appears that quality of SUD treatment (e.g. engagement) may have worsened during the waiver period. However, this is also due to broader declines in care quality that began prior to the waiver’s implementation.

Poor data quality has increased the time we will need to fully describe the impact of the waiver in terms of health care outcomes. In the meantime, the evaluation team and the State are working together to address these data quality issues. We strongly recommend that the State consider data quality improvements as a major cornerstone of its waiver extension plan.

A. General Background Information about the Demonstration

This report communicates interim findings from OHA's evaluation of the 1115 Substance Use Disorder (SUD) Medicaid Waiver, as of November 2021. A summative report will be issued in February 2023. The measures outlined in this report were approved by the Center for Medicaid Services (CMS) on May 29th, 2020.

The WV Bureau of Medical Services (BMS) received approval for a 5-year (from January 2018 to December 2022) section 1115 waiver demonstration entitled "Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders" on October 6, 2017 (henceforth referred to as the "waiver"). Including the pre-waiver implementation period, this evaluation will analyze data from January 2016 through December 2022.

This demonstration was developed to address the state's SUD epidemic. West Virginia has the highest age-adjusted rate of drug overdose deaths in the country (52.8 deaths per 100,000 residents in 2019)^[1], almost 2.5 times the national average.^[2] Between 2012 and 2019, the death count due to drug overdoses increased 55.9%.^[3] Additionally, 51 of every 1,000 births in the state involve babies born with Neonatal Abstinence Syndrome (NAS) resulting from substance use among pregnant women.^[4] As of June 2021, the WV Medicaid program provides health coverage to more than 596,000 residents with over 80% of members served through the state's managed care delivery system.^[5] More than one-third of WV's population is covered by Medicaid at some point during the year.

Against this backdrop, the waiver aimed to meet the following objectives stated in the approved special terms and conditions:

- Improve quality of care and population health outcomes for Medicaid enrollees with SUD;
- Increase enrollee access to and utilization of appropriate SUD treatment services based on the American Society of Addiction Medicine (ASAM) Criteria or comparable, nationally, recognized SUD program standards based on evidence-based clinical treatment guidelines;
- Decrease medically inappropriate and avoidable utilization of high-cost emergency department and hospital services by enrollees with SUD; and
- Improve care coordination and care transitions for Medicaid enrollees with SUD.

The waiver approach centers upon three reimbursement mechanisms designed to address gaps in the SUD care continuum and were thought to be cost-neutral. The waiver also established standards of care for SUD services that incorporate industry standard benchmarks from the ASAM criteria for patient assessment and placement.

The three main treatment options expanded through Medicaid are peer recovery support services, adult residential treatment, and methadone treatment.

1. **Peer Recovery Support Services (PRSS):** These services are designed and delivered by individuals in recovery from SUD, who provide counseling support to help prevent relapse and promote recovery. Services are provided by appropriately trained staff employed by Licensed Behavioral Health Centers. Peer recovery coaches must be certified through a WV Department

of Health and Human Resources approved training program. This service became officially available for Medicaid reimbursement beginning on July 1st, 2018.

2. **Residential Treatment Services:** These services are available to adult Medicaid beneficiaries with a SUD diagnosis who are residents in facilities that meet the definition of an Institution for Mental Disease (IMD). Facilities must be enrolled as Medicaid providers and must deliver care consistent with ASAM Levels 3.1, 3.3, 3.5 and/or 3.7, as assessed by BMS staff. These services can be provided in settings of any size. The average length of stay for individuals receiving these services must be 30 days or less. Covered services include withdrawal management, addiction pharmacotherapy, drug screening, motivational enhancement, counseling, clinical monitoring, and recover support services. This service was implemented on July 1st, 2018.
3. **Methadone Treatment:** This service bundle benefit includes physician-supervised daily opioid agonist medication, counseling services provided to maintain multidimensional stability for Medicaid beneficiaries with OUD, as well as associated lab services. This service can be provided by BMS-licensed Opioid Treatment Programs (OTPs, methadone clinics) in accordance with an individualized service plan determined by a licensed physician or prescriber. Covered services include use of opioid agonist pharmacotherapy (methadone), drug screening, linkage to psychological and medical consultation, cognitive or behavioral therapy, and referral for infectious disease screening. This service was implemented on January 14th, 2018.

This demonstration was designed to impact West Virginia residents with SUD who are enrolled in Medicaid. In particular, the policy targets those who need services meeting ASAM levels of care 3.1-3.7, and those who can benefit from peer support services and/or medication for opioid use disorders (MOUD).

The structure of the waiver demonstration was significantly altered in 2019 with the transition to managed care. BMS initiated this change in alignment with a broader WV Medicaid programmatic shift to stronger reliance on MCOs for service delivery. The objective of managed care service delivery is to improve care coordination for those enrolled via improved administrative functionality, and as a result to increase access to services and to improve member health outcomes. Additionally, improved care coordination helps support efficient economic operations. The State contracts with multiple MCO organizations; currently, approximately 80% of WV members receive services via managed care. On July 1, 2019, adult residential services and peer recovery support services were carved in to MCO contracts, making the organizations responsible for providing necessary authorizations and for paying claims for these services. Although methadone is not carved in under the MCOs, in the MCO contracts for SUD services BMS did include that MCOs will be responsible for assisting a member during the admission and discharge transition processes for Opioid Treatment Program services. The 1115 Evaluation Design was altered to address these changes to the waiver program. The updated design highlighted how the evaluation planned to incorporate managed care into cost analyses conducted, using actual amounts paid to providers for each encounter in addition to FFS payments (where appropriate) to calculate costs. CMS approved the Final Evaluation Design, inclusive of these changes, on September 27, 2019.

As discussed in more detail later in this report, through creating the Interim Evaluation Report the evaluating team has discovered differences in treatment-related outcomes over time depending on

whether an individual received services via FFS versus MCO. Recognizing this, the evaluators have broken down several of the data trends reported on by FFS and MCO to show the difference between the two. The analysis revealing these differences further break down the MCO trend into individual trends for each of the three MCOs so that comparison among each of the MCOs and FFS is accessible. Recognizing these discrepancies revealed by the data, the waiver evaluation team is currently considering future analytic options for separating outcomes into FFS versus MCO to assess changes in the impact of the waiver by payer.

Another major operational change to the waiver program was the amendment, with federal authorization, to allow Children with Serious Emotional Disorder Section 1915(c) Waiver (CSEDW) members a lock-in period for continuous enrollment with a single MCO in Mountain Health Promise (MHP), the Specialized Managed Care Plan for Children and Youth. This amendment was approved on December 12, 2019, and in 2020 CSEDW automatic enrollment was integrated under the 1115 waiver. This programmatic system enrollment change was made in order to provide specialized and coordinated care to CSEDW members in the most seamless and cost-effective way possible. Given that this change was operational and specific to program coordination among the State’s waivers, no CSEDW automatic enrollment- specific changes were implemented as part of the Evaluation Design.

Finally, the Special Terms and Conditions (STCs) for the 1115 waiver were edited and updated twice during the effective demonstration period, with updates made in both April and December of 2019. The first set of changes added flexibilities that SUD providers can use for determining assessment criteria, updating the original condition that providers should use the ASAM criteria to allow for assessment based on ASAM criteria or another nationally recognized and approved set of SUD criteria based on evidence-based treatment guidelines. The STCs finalized in December 2019 were updated to incorporate STCs specific to the inclusion of the CSEDW member automatic enrollment in accordance with the demonstration amendment approved by CMS on December 12, 2019. Each of these updates to the STCs were made to clarify and update terms and conditions in order to reflect how the State was currently operating the waiver demonstration.

B. Evaluation Questions & Hypotheses

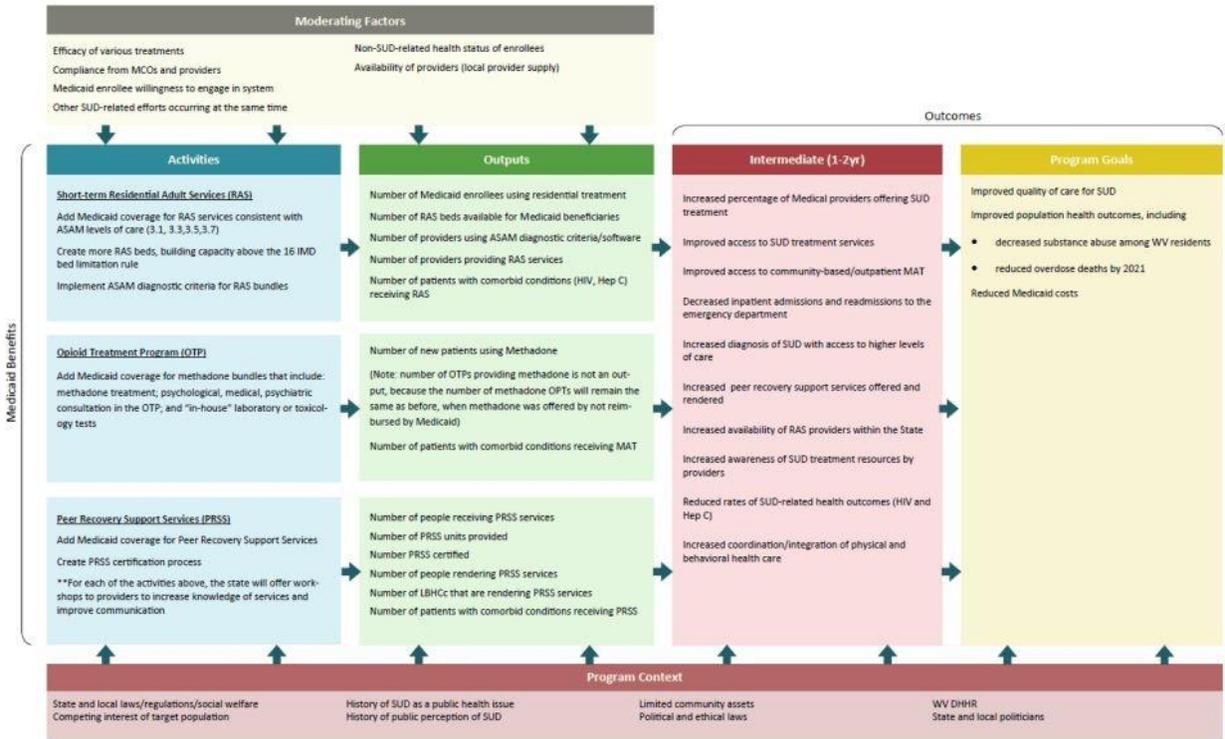
To measure the performance of the demonstration, the state’s goals were translated into quantifiable targets for improvement. Figure C- 1, the demonstration logic model, explains the c behind the demonstration features and intended outcomes. Table 1 lists the evaluation questions and hypotheses. For a full list of the original evaluation measures, including a table providing the most recent set of updates made to the measures, please see Appendix A: Evaluation Measures Table.

Table 1 Evaluation Questions & Hypotheses

| Evaluation Question (EQ) | Evaluation Hypothesis (EH) |
|--------------------------|----------------------------|
|--------------------------|----------------------------|

| | |
|--|---|
| 1.1: What is the impact of the demonstration on quality of care for Medicaid enrollees? | 1.1.1: The demonstration will improve the quality of SUD services delivered to Medicaid enrollees. 1.1.2: The demonstration will increase provider knowledge of appropriate SUD treatment options. |
| 1.2: What is the impact of the demonstration on population health outcomes among Medicaid enrollees? | 1.2.1: The demonstration will decrease morbidity and among Medicaid enrollees and their children. |
| 2.1: What is the impact of the demonstration on access to SUD treatment among Medicaid enrollees? | 2.1.1: The demonstration will increase the supply of residential, MAT, and PRSS care available for Medicaid enrollees. |
| 2.2: What is the impact of the demonstration on use of SUD treatment among Medicaid enrollees? | 2.2.1: The demonstration will increase the use of residential, MAT, and PRSS care available by Medicaid enrollees. |
| 3.1: What is the impact of the demonstration on emergency department (ED) utilization by Medicaid enrollees with SUD? | 3.1.1: The demonstration will decrease the rate of ED use and the percentage of ED visits that are non-emergent among Medicaid enrollees with SUD. |
| 3.2: What is the impact of the demonstration on inpatient hospital use by Medicaid enrollees with SUD? | 3.2.1: The demonstration will decrease hospital admissions among Medicaid enrollees with SUD. |
| 4.1: What is the impact of the demonstration on the integration of physical and behavioral health care among Medicaid enrollees with SUD and comorbid conditions? | 4.1.1: The demonstration will increase the rate of Medicaid enrollees with SUD-related physical health conditions who are also receiving behavioral care. |
| 4.2: What is the impact of the demonstration on care transitions among Medicaid enrollees with SUD? | 4.2.1: The demonstration will improve communication among providers who transition patients to other providers. |

Figure C-1 Demonstration Logic Model



C. Methodology

For many of the outcomes, the planned evaluation will be an assessment of pre/post data with a comparison group. A unique feature of the evaluation for WV's waiver is that we secured data from a comparator state (State A, which did not implement an 1115 Waiver over the course of the study period) to act as a control group. This allows us to conduct *difference-in-differences models* for several of our measures. The difference-in-differences technique is an accepted way to mimic an experimental research design, in the absence of the ability to implement a true experimental design. For the measures where State A data is insufficient or inappropriate for use as a control, we instead will conduct difference-in-differences, matched-control, or interrupted time series analyses, using only WV data.

Our analytic sample included all individuals age 18-64, enrolled in WV or State A Medicaid for at least one month throughout the study period. Individuals who were dually eligible for Medicare were excluded.

The demonstration project began implementation in January 2018 and is scheduled to run through 2022. These years represent the post-treatment period for the evaluation. In most cases, the pre-treatment period begins in 2016.

To operationalize our measures, we began with the measure sets suggested by CMS. In the cases where a CMS recommended measure set did not exist for our outcome, we either identified or are continuing to look for measure specifications from other nationally recognized data stewards (e.g. National Quality Forum). The denominators for certain measures – as defined by the data stewards – in Appendix A:

Evaluation Measures Table specify the population of interest as “all Medicaid beneficiaries.” However, we have limited the denominator for each of these measures to include only Medicaid beneficiaries with SUD. Claims with a diagnosis code (any diagnosis on the claim) listed under one the following HEDIS 2019 Value Sets denotes a SUD diagnosis: (1) Alcohol Abuse and Dependence, (2) Opioid Abuse and Dependence, and (3) Other Drug Abuse and Dependence, as well as claims for drug overdoses.

The primary data source for this evaluation is administrative Medicaid claims data, from both WV and (depending on appropriateness) the comparator State A. The limited claims data set currently includes all eligibility, authorization, pharmaceutical, facility, and professional claims, as well as provider-level reference data from January 2009 to through February 2020. A second data source is the WV DHHR Vital Statistics mortality database that includes death certificate data for all decedents in WV. These data include both date of death, as well as underlying and contributing cause of death codes. The third data source is the WV Birth Score Program, which collects information on NAS for every birth in the state; these data are being used to assess the impact of the Waiver on NAS morbidity. Finally, the team collected primary, qualitative data to assess outcomes that are unobtainable from other sources.

Because a simple pre-post analysis of WV data would be subject to bias from non-waiver changes also occurring in the state, the evaluation team instead compared the pre-post changes in WV outcomes to the pre-post changes in State A’s outcomes, over the same time frame. Whether the evaluation team can continue with this approach remains to be seen, as the team is in ongoing talks with the comparator state to determine its appropriateness as a comparator. This approach mitigates the effects of extraneous (non-waiver) factors and selection bias^[1]. We follow the preferred difference-in-differences model outlined in the SUD Evaluation Guidance:

$$\text{Outcome} = \beta_0 + \beta_1 \cdot \text{TIME} + \beta_2 \cdot \text{POST} + \beta_3 \cdot (\text{TIME} \cdot \text{POST}) + B_i \cdot \text{CONTROLS} + \varepsilon$$

where:

TIME is a count variable that starts with the first month of pre-demonstration period data and ends with the last month of post-demonstration period data.

POST is the indicator variable that equals 1 if the month occurred on or after demonstration start date.

CONTROLS are covariates, such as age, gender, race, dual Medicare-Medicaid enrollment, and month.

Though costs will be analyzed within the same difference-in-differences framework described in the previous section, there are intricacies to analyzing costs that require additional explanation. Our plan for analyzing costs was heavily informed by the SUD Evaluation Design guidance provided by CMS (as part of the draft SMI/SED and SUD guidance). We are using net MCO payments, in addition to FFS payments (where appropriate) to calculate costs. Per CMS recommendations, we have also conducted a granular cost analysis using the following equation:

$$\text{Total costs} = \text{inpatient} + \text{non-ED outpatient} + \text{ED outpatient} + \text{prescription} + \text{long-term care}$$

This approach identifies cost drivers for the target population by splitting out costs associated with different types of care using claims data. As suggested by CMS, we separated ED-related outpatient

costs from other outpatient costs, given that ED services are particularly high-cost, and represent an important opportunity for cost savings that could be achieved with better access to SUD services.

We did not require minimum enrollment durations for beneficiaries to be included in the analysis. Beneficiaries are included in the analysis during the first month in which a relevant SUD diagnosis or treatment claim was observed, and for up to 11 additional months that did not include a relevant diagnosis or treatment claim. Once an individual has period of 1 year with no relevant diagnosis or treatment claims, that beneficiary will be excluded from further analyses, unless and until they have a subsequent relevant diagnosis and/or treatment claim. This ensures our analysis represents the costs of serving individuals in the target population with active treatment needs. All cost outcome measures are expressed in terms of the recommended dollars per member per month.

So far, we have calculated and trended monthly spending for the three main waiver services offered. We also plotted the means compiled in the tables below to show trends visually and verify that month-to-month variation is within expectations and does not indicate an underlying data error. As needed, we conducted quarterly spending analyses to smooth out monthly variation in costs.

Still in progress are the regression models for costs. Because some person-months have \$0 healthcare spending, and other months have very large values, we are conducting two-part regression models. In particular, we are conducting a model that accounts for whether they are any costs in the person-month (logit model) and then another model that accounts for the level of costs conditional on having non-zero costs (generalized linear model [GLM]). We will run separate models for each of the outcomes described in the equation above, including total costs. We will control for covariates including age, race, gender, dual eligibility status, and physical or behavior health comorbidities.

The final component of our analysis is qualitative and intended to yield information that is not otherwise attainable from administrative data sources. Due to significant concerns over nonresponse bias from employing traditional survey research methods, communication among providers and provider knowledge has been assessed via focus groups.

A purposive sample of providers was guided by two broad, general questions per current phenomenological research recommendations. These two broad general questions are: “What have you experienced in terms of the phenomenon (i.e., communication among providers and provider knowledge)”; and, “What contexts or situations have typically influenced or affected your experiences of the phenomenon”? A semi-structured interview guide was developed around these two questions (see Appendix B: Interview Instrument). Per current recommendations, we planned to conduct interviews with groups of 3 to 5 providers with a maximum sample size of 25 annually over the three-year period between 2020 and 2022. Providers were to be purposefully selected each year from the list of Medicaid substance use disorder providers maintained by the state. In the first year of interviews, a maximum variation approach was employed with a goal of annually selecting providers that represent all 4 geographic regions of the state (Ohio River Valley, Allegheny Plateau, Allegheny Highlands, Potomac Section). In the second year of interviews, our team also employed a maximum variation approach and selected providers that ensured representation across ASAM levels 3.1, 3.5, and 3.7. The first 3.3 level

facility available to WV Medicaid enrollees (located in Ohio) did not open until April 2021; therefore, we did not purposefully select from this level of care.

Our sampling strategy and interview goals changed slightly in 2021, as our ongoing analyses indicated two areas for further exploration: rising HIV/HCV rates in the state around the same time the waiver was implemented, and general state-wide enthusiasm for peer recovery support specialists. To better understand the reasons for rising HIV/HCV rates and determine whether the waiver was truly correlated with this trend, we conducted two additional focus groups with a total of seven individuals who are subject matter experts in the field. To learn more about experiences specific to peer recovery support specialists in the state, we conducted one additional focus group with a total of three individuals in this role. This additional focus group data is not included in this report, as we limited our reported results to the measures outlined in the original evaluation plan.

In line with traditional data collection and translational protocols, interviews were audio recorded and transcribed by an external professional transcriber. A twofold coding process was employed using the NVIVO® software subjected to line-by-line coding with a goal of identifying a parsimonious set of themes. Consensus with a second researcher was sought per current qualitative research recommendations. As needed, discrepancies were resolved by a third party. Respondent quotes that captured the essence of each theme were selected as the primary data outcomes.

D. Methodological Limitations

As our evaluation has progressed, we've encountered several major limitations. First, changes occurred in the SUD landscape of our intended control group (State A) after initial approval of our evaluation plan. We have noted that there are several measures for which the comparator state and WV outcomes do not appear to meet the parallel trends assumption (i.e., that trends in both states would have remained the same, had the WV waiver not taken place). If we were to compare outcomes between WV and State A, the difference-in-differences approach would yield a biased result. Due to these changes, the evaluation team is still assessing whether and for what measures the State A data can be best used for this analysis. Therefore, State A data are not included in this report.

A second limitation that has become apparent throughout the evaluation period is the poor quality of the WV Medicaid data available to the evaluation team. For example, the evaluation team discovered that the death records used in the mortality analysis measures have double-counted some individuals' deaths. As another example, methadone treatment is billed in weekly bundles, which does not allow us to observe how many or where (e.g., in clinic or via take-home) doses were taken. Providers often mis-code services when billing, which in turn would yield inaccurate results from our models. We are working with the state to remedy these problems, or to find work arounds that maintain the rigor of our analyses.

Finally, the COVID-19 pandemic has implications for our study. It has become evident that the pandemic directly contributed to a rise in opioid and other drug use, as well as related morbidity and mortality. One benefit to our difference-in-differences design is that our comparator state was also subject to the pandemic, and therefore, our results might not be as biased as they would have been without a control group. However, we are internally still discussing how to treat the data collected at the peak of the

pandemic. Our interim solution has been to conduct our analyses with data up to March 2020, truncating it at the point of the WV stay-at-home order.

E. Results

This section of the report reviews evaluation findings as of November 2021. As noted in the methodology section, these findings include data from January 2016 to December 2019, with some exceptions for measures that include data through February 2020. Because the evaluation is ongoing and our team continues to refine measures, not all measures will be populated. A list of measures not included in this report can be found in Section G. In graphs that include vertical dotted lines, the lines at January 2018 or Q1-2018 correspond to the inclusion of methadone reimbursement under Medicaid and the lines at July 2018 or Q3-2018 correspond to the inclusion of RAS and PRSS services. The numbers following “EQ” and “EH” in the graphs’ captions correspond to the evaluation question and evaluation hypothesis as labeled in Table 1.

Preliminary findings have been organized into four main components: the supply of SUD treatment options, utilization of these treatment options, treatment-related morbidity and mortality outcomes, and claims costs for each of the three waiver services.

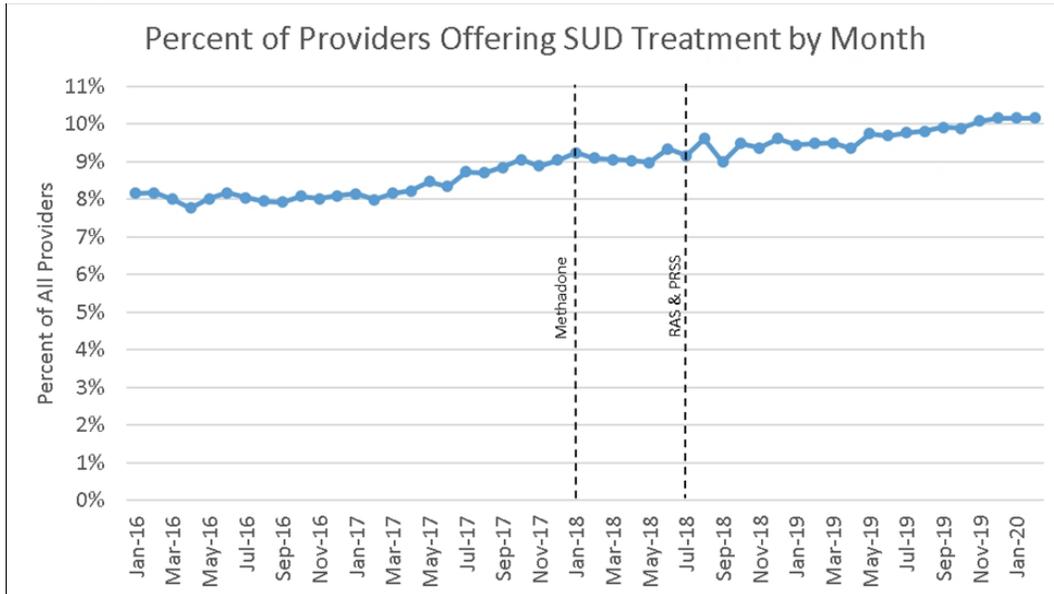
1 Supply of SUD treatment

We hypothesized that the waiver demonstration would increase the supply of residential, MOUD, and PRSS care available for Medicaid enrollees. Since the waiver was implemented, the number of providers, facilities, and beds for SUD treatment in WV did indeed rise. This section reviews the changes in supply of providers treating SUD overall, and reviews availability for each waiver service.

Supply of SUD providers

Due to a lack of methadone coverage under Medicaid in State A, a WV-only descriptive analysis was conducted to determine whether the supply of Medicaid providers delivering SUD treatment services changed significantly during the measurement period. This analysis was conducted by identifying providers in the claims data that provided SUD treatment to at least one person. From January 2016 to February 2020, the percentage of Medicaid providers offering these services increased by about two percentage points, with the increase beginning around March 2017, prior to the waiver’s start.

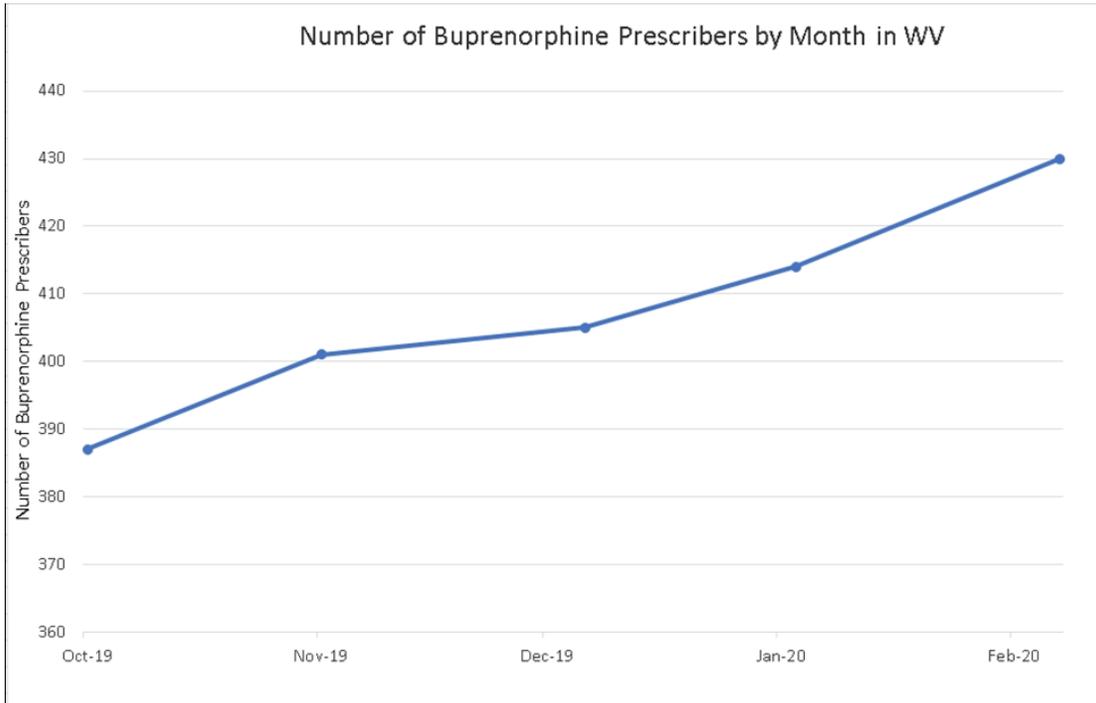
Figure F-1 Percent of Providers Offering SUD Treatment by Month (EQ 2.1, EH 2.1.1)



Buprenorphine prescriber availability

Even though buprenorphine was covered prior to the waiver, DHHR was interested in determining whether the waiver also improved the supply of providers prescribing buprenorphine, as providers may be more likely to begin offering other types of SUD treatment in conjunction with waiver services. Providers that meet certain criteria are eligible to prescribe buprenorphine to patients with OUD via a prescribing waiver administered by Substance Abuse and Mental Health Services Administration (SAMHSA). Information for these providers is available through WV DHHR starting October 2019. Between then and February 2020, the number of buprenorphine prescribers increased 11% (43 providers). Note that buprenorphine prescribers (identified as any provider who had at least one claim for buprenorphine connected to their provider ID) are included prior to October 2019 in Figure F-1 (above). However, the graph below shows the number of prescribers on the buprenorphine prescribing waiver list, regardless of whether they actually prescribed buprenorphine.

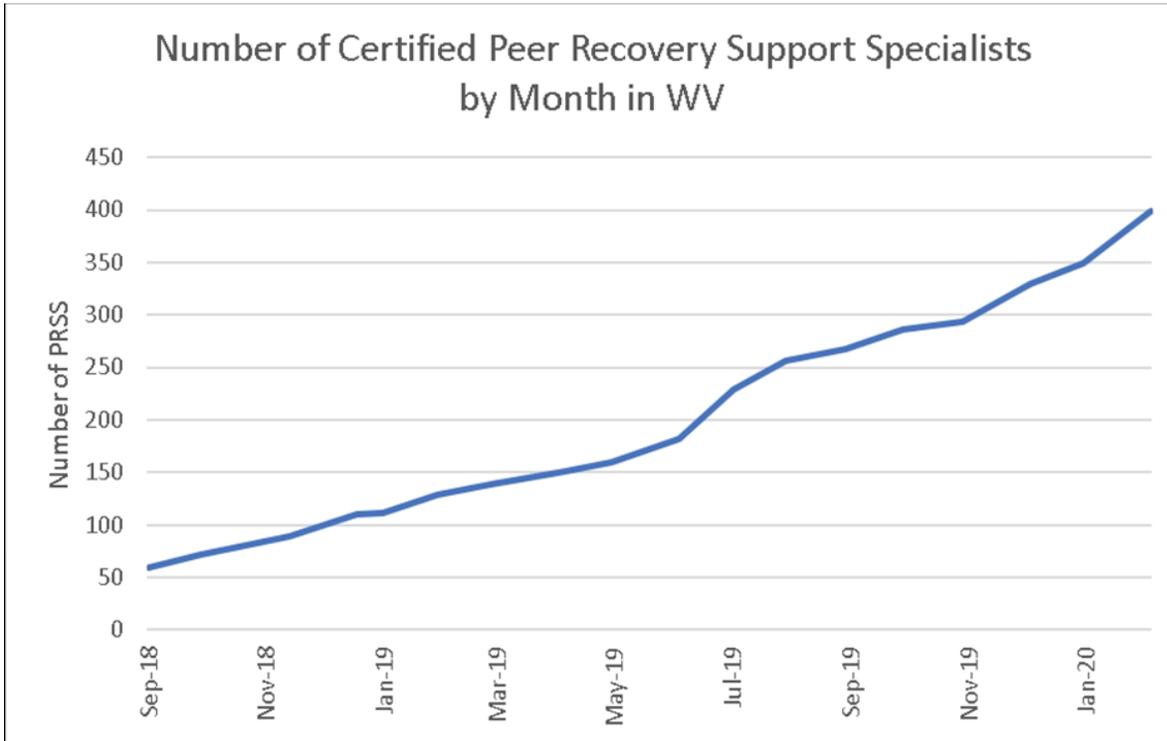
Figure F-2 Number of Buprenorphine Prescribers by Month in WV (EQ 2.1, EH 2.1.1)



Peer recovery support specialist availability

While peer recovery coaches existed prior to the waiver, state-certified peer recovery support specialists were newly reimbursed via the waiver beginning July 2018. WVU has access to provider data starting September 2018, at which time 59 certified PRSS were employed in WV. Between then and February 2020, that number increased to 399 PRSS.

Figure F-3 Number of Certified Peer Recovery Support Specialists by Month in WV (EQ 2.1, EH 2.1.1)



Supply of SUD residential treatment facilities and beds

SUD residential treatment facilities and the total number of residential beds in WV have also increased since the waiver implementation. While two months of data are missing (July and September 2018), the number of treatment facilities has increased from 19 in October 2018 to 55 in February 2020 (an increase of 36 facilities). The number of residential treatment beds has also increased, from 145 in August 2018 to 739 in February 2020 (an increase of 594 beds). Across all three waiver components, the demonstration has considerably increased the supply of both services and providers in the state. Note that RAS bed data included a source not available for facilities; thus, the bed data is more complete.

Figure F-4 Supply of Residential Treatment Facilities (EQ 2.1, EH 2.1.1)

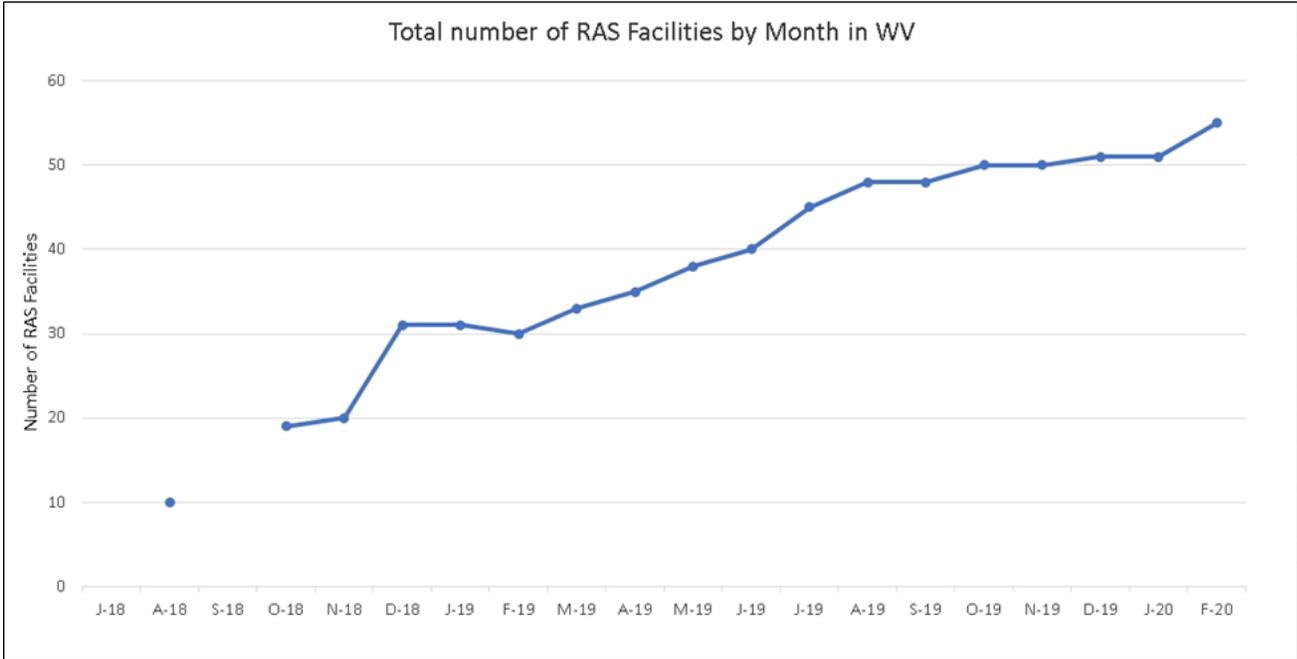
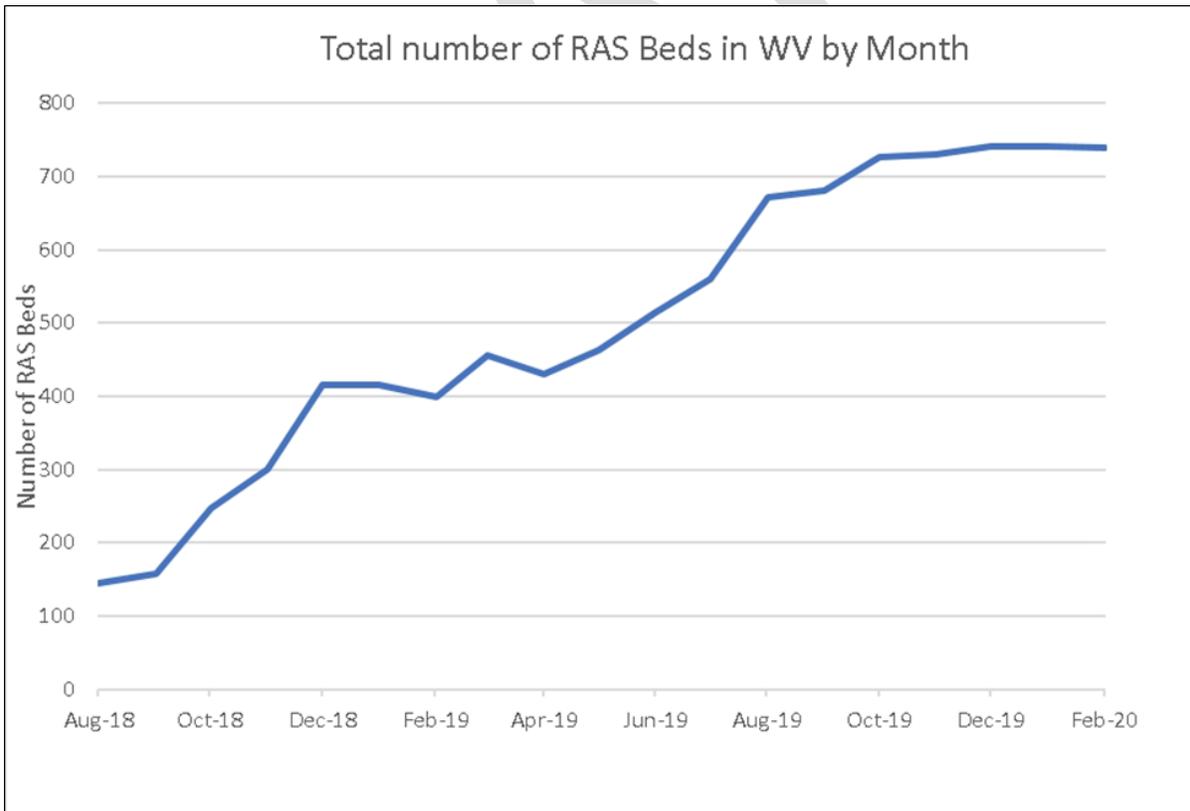


Figure F-5 Supply of Residential Treatment Beds (EQ 2.1, EH 2.1.1)



RAS Focus Group Findings

As described in the Methodology section, OHA conducted focus groups among RAS staff members over two years- 2020 and 2021. In the first year, the evaluation team conducted six focus groups across six different RAS facilities, with a total of 22 staff members participating. In the second year, the evaluation team conducted seven focus groups across six different RAS facilities, with a total of 23 individuals participating.

To provide more context on the provision of residential adult services, focus group data were analyzed to determine the degree to which these providers demonstrated changes in ability to correctly identify the expanded treatment mechanisms as a result of state-run trainings ((EQ 1.1, EH 1.1.2). At the beginning of each focus group, we asked participants how familiar they were with the waiver. Once we received their answers, we then explained any parts of the waiver they were not able to identify. Notably, the themes that emerged from the focus groups were largely the same between 2020 and 2021.

Among participating focus groups in Fall 2020, knowledge of the waiver was limited. Four participants reported generally having knowledge of the waiver and able to name all three components. Six participants were unsure exactly what services were provided by the waiver. One respondent summed up their facility's knowledge by saying "I think we're all kind of fairly clueless on it, it seems." Note that some facilities may not provide all the services covered by the waiver, which would result in less knowledge about all services provided through the waiver. In addition, some facilities were aware they could provide services and bill through Medicaid but were just unaware the waiver was the reason why.

A similar finding emerged during the focus groups held in Fall 2021. Overall, most participants had little to no knowledge of the waiver and any of its components. Forty-four statements were made regarding a lack of waiver knowledge, while only nine statements mentioned information about the purpose of the waiver and one or more components. However, some participants were unable to provide waiver knowledge due to their role beginning or facility opening during or after waiver implementation.

Based on these findings, we recommend that the state discuss if they feel awareness of the waiver is important. If they do feel that awareness of the waiver among providers is important, additional education and training could help fill this knowledge gap. In addition, one respondent explained that more education about methadone would help them better utilize this waiver service:

"I think maybe some more education would be awesome. [...] Even having worked in substance abuse for such a long amount of time, I was not familiarized with methadone. I had to do my own little bit of research and ask questions from the other staff. I also think not just for facilities in general, but I think also maybe other providers. Providing education that would maybe help ease those conversations about other recovery pathways."

Other barriers related to MOUD in general came up during focus groups, as well. In the 2021 focus groups, five statements were made about how facilities not accepting patients who receive MOUD inhibits their recovery and limits treatment options, while fifteen statements cited provider stigma and beliefs surrounding MOUD as another barrier. A few providers mentioned that they had some initial biases towards certain types of MOUD (notably, methadone) when they first entered their role:

“I’ll just be honest, I think initially before I came into this role, I think I struggled with some stigma and some of my own personal biases towards people on methadone.”

Additionally, some providers said that they still encounter stigma such as this from others in the field:

“So five years ago I’d say there’s a massive stigma with methadone. I still think there’s a massive stigma with methadone.”

“I think people think if anything, it’s a harm. It’s another substance that they’re abusing, and that frankly just isn’t true.”

However, providers with patients who were able to continue treatment while receiving MOUD expressed positive opinions of MOUD and shared their patients’ success with it.

Other participants stated that barriers related to MOUD sometimes affect care transitions. In particular, providers noted difficulty transitioning patients to clinics that provide MOUD such as suboxone during both the 2020 and 2021 focus groups. The stigma around methadone use for treatment was also identified as a barrier in transitioning patients to other providers.

Focus group data were also analyzed to determine the degree to which RAS treatment providers expressed communication difficulties with other providers (EQ 4.2, EH 4.2.1). In 2020, fourteen participants stated that communication has improved among providers since the waiver implementation. Further, eleven participants specifically noted that transitions through different levels of care were made easier and twelve participants noted that the billing process as improved. In particular, peer recovery support specialists were identified as a part of the waiver that has facilitated easier communication and transitions among providers:

“As a therapist, I don’t always have time, either, to make all those phone calls and to do all that because I’ve got another person in crisis waiting outside. So I can get PRSS to say, “Hey, work with them. Call. See if we can get a bed. See what we can get going. Let’s get this rolling.” So that’s [a] ... I don’t know any other term but seamless, way that we can do things and it flows because we have this connection to multiple agencies now.”

This finding remained the same between 2020 and 2021. Across all focus groups, participants expressed overwhelming support for peer recovery support services. In 2021, thirty-eight statements relayed that peers are an essential component of treatment and the importance of their lived experiences was emphasized.

“We wouldn’t be able to be open without them.”

“They are really able to meet people where they’re at. Sometimes people show a resistance to trusting people that haven’t been there themselves. So it really helps to bridge that divide.”

However, some barriers were identified related to communication among providers, especially related to communication between facilities and insurance providers. Overall, 21 participants in 2020 noted issues

with treatment ending due to coverage constraints and six participants expressed frustration with authorization requirements. These frustrations are illustrated in the following quotes:

“Just regarding back to communication when guys are getting denied and were up for a peer-to-peer review and they're deciding on whether or not to continue again. I've literally had a reviewer ask me, "Is this gentleman suicidal?" And when I say no, he says, "Well that's a shame." And I've had a reviewer say, "Well is this person on Suboxone?" And I say, "No." And then we are asked why and I say it's because it was his drug of choice, and he said, "Well, I can't continue funding, if he's not taking Suboxone and Antabuse. And Antabuse is on a national low.”

“It's frustrating. We have found that it's continuing to actually get more difficult. Even just here in the last month we've had a change with another provider that would cover the full 28 days of our program. They're sending it to a doctor review after 14 days, and that doctor is declining services, continued services. We have another provider we get about 8 to 11 days of coverage, sometimes less than that depending on what's going on with the patient upon admission.”

“Well, now they're talking about how they can come to a 3.5 program for seven days, and then they're good to go to transitional living. The transitional living is not treatment. That is just a roof over your head. Transitional [living] is needed. It is. But if I'm sending someone there after having just five days of therapy, these consumers don't trust us to open up in group until at least 14 days, give or take, and that's with us have a peer recovery support specialist whose goal and job is to bridge that gap between the clinician and the consumer. Then we send them off to a transitional home after seven days, and that's just setting them up for failure.”

In 2021, thirty-nine statements were made explaining that facilities did not experience any general difficulties related to provider communication and patient transition. Fifteen statements mentioned some type of difficulty, but these were unique to each facility. Furthermore, six statements expressed an increase in communication and transition since the waiver implementation:

“... it raised awareness and yeah, and really started the conversation of what's the next step.”

However, a similar theme relating to communication between facilities and insurance providers emerged. In fact, insurance difficulties were related to communication, care transitions, and treatment quality in seventy separate statements. Participants regularly expressed that they were not able to have the full length of treatment covered for their patients and authorization was especially difficult to obtain for those who had previous treatment experience:

“Before the SUD waiver, everyone had 28 days. And then now, like I said, we have an idea of how many days based upon which MCO and we're very transparent with the patients on that because they have to know they have to move in a rapid rate.”

Additionally, participants often experienced insurance pushing for patients to be in a lower level of care, and authorization was difficult to obtain if patients needed to be in a higher level of care.

“We live in a state of confusion and then that’s where they kind of get pushed down, pushed out quicker. And that’s where kind of Participant 2 spoke on of somebody having to be ready to be in sober living, to get a job, and attend those outpatient services after eight days.”

Understandably, difficulties due to COVID-19 were mentioned by many participants across both years. Focus group participants in 2020 identified related issues with transitioning patients between levels of care, reduced bed availability, difficulties transitioning to telehealth, and increased relapse and overdose risk among patients. In the 2021 focus groups, participants noted that testing and isolation requirements were negatively impacting patients’ treatment experiences and willingness to enter treatment. Several factors contributed to the increase in relapse and overdose rates, such as stimulus checks being used to purchase substances, boredom, and loss of a job or loved one. Telehealth difficulties continued to be an issue in 2021. Participants often said that telehealth led to a loss of connection, both literally and metaphorically:

“And our population access to internet or cell phone, computers can be an issue as well.”

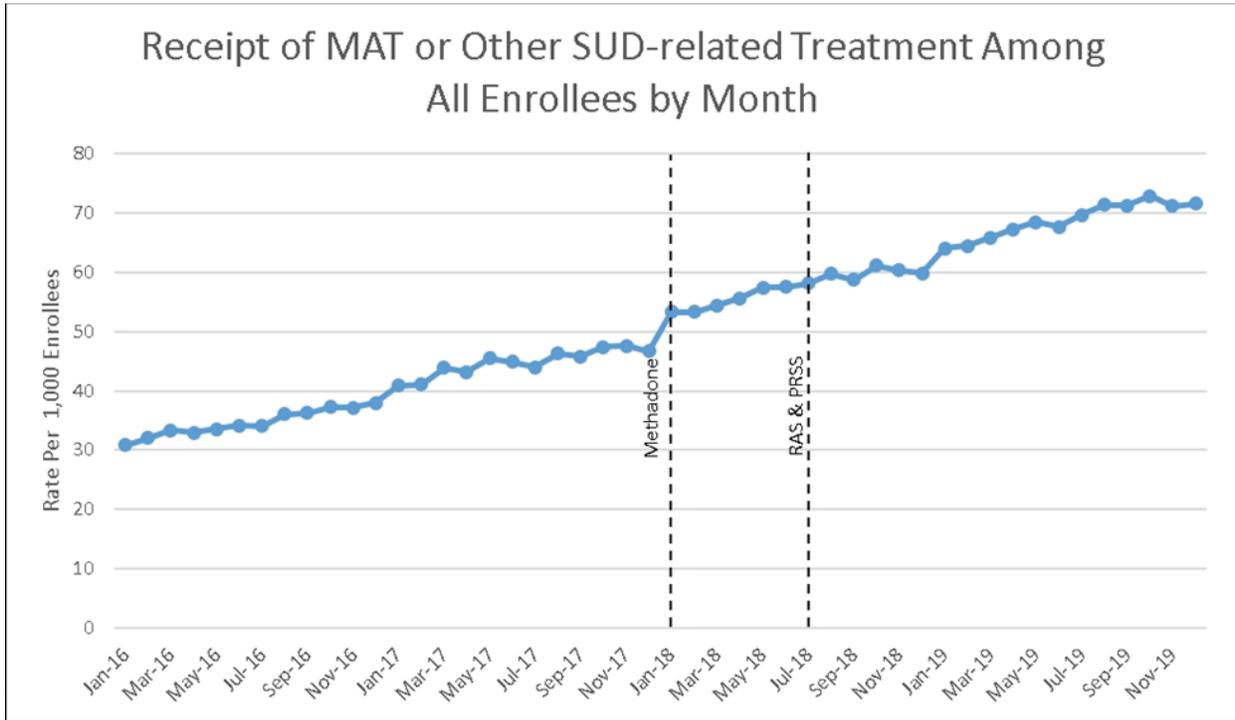
“I think it would create a barrier for anybody. But I know these guys, since it’s inpatient, it becomes a home which when you take away our accessible resources and our sources of beneficial communication, I think it’s natural for them to have some sort of resistance to you.”

“But I think what really lacks is intimacy and connection, which for me, as a therapist, those things are really important. So if I’m not able to connect on that level, it creates a massive barrier to change.”

2 Utilization of treatment

Use of the waiver services has increased since the waiver’s implementation. In Figure F- 6, the trend line shows an increase in the rate of enrollees who received MAT (buprenorphine, naltrexone, methadone, acamprosate, and disulfiram) or had qualifying facility or professional claims with a SUD diagnosis and SUD-related treatment starting before waiver implementation and continuing post-waiver implementation, reaching a rate of just over 70 per 1,000 enrollees by December 2019. The following measures investigate how the waiver has impacted initiation, engagement, and continuation of treatment; the utilization of waiver-covered services; and changes in emergency department visits over time.

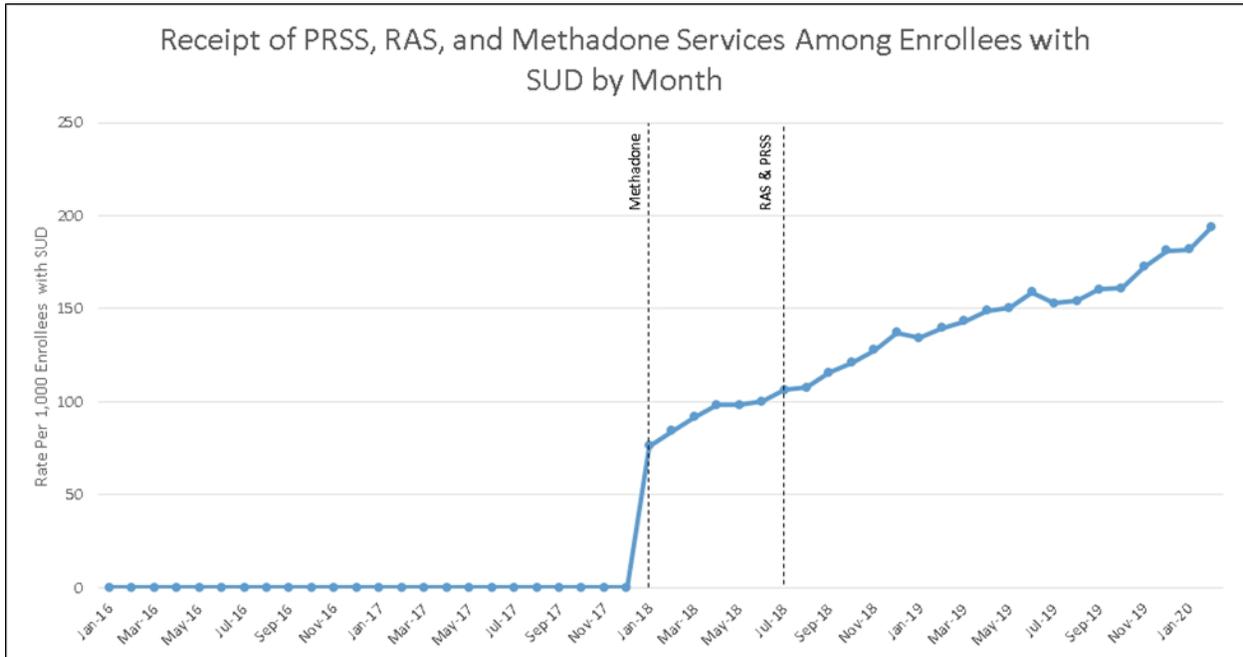
Figure F-6 Receipt of MAT or Other SUD-related Treatment Among All Enrollees by Month (EQ 1.2, EH 1.2.1)



Rate of beneficiaries with a SUD diagnosis who used SUD services per month

At the onset of methadone coverage in January 2018, about 76 per 1,000 enrollees with SUD were receiving a waiver-covered service. As of February 2020, about 194 per 1,000 enrollees with SUD were receiving a service covered by the waiver each month.

Figure F-7 Receipt of PRSS, RAS, and Methadone Services Among Enrollees with SUD by Month (EQ 1.1, EH 1.1.1)



Residential, Methadone, and PRSS Services Used

Analyzed as individual services, utilization of all three waiver-covered treatments (residential adult services, methadone, and PRSS support) has increased since the start of each related part of the waiver (MOUD in January 2018 and PRSS and RAS in July 2018). Residential treatment service use has increased to a rate of about 50 per 1,000 enrollees with SUD since its onset. By the end of 2019, methadone utilization was up to about 140 per 1,000 enrollees with OUD. Finally, peer recovery support services continued to rise in WV through 2019.

Figure F-8 Receipt of Residential Treatment Services Among Enrollees with SUD Diagnosis by Quarter (EQ 2.2, EH 2.2.1)

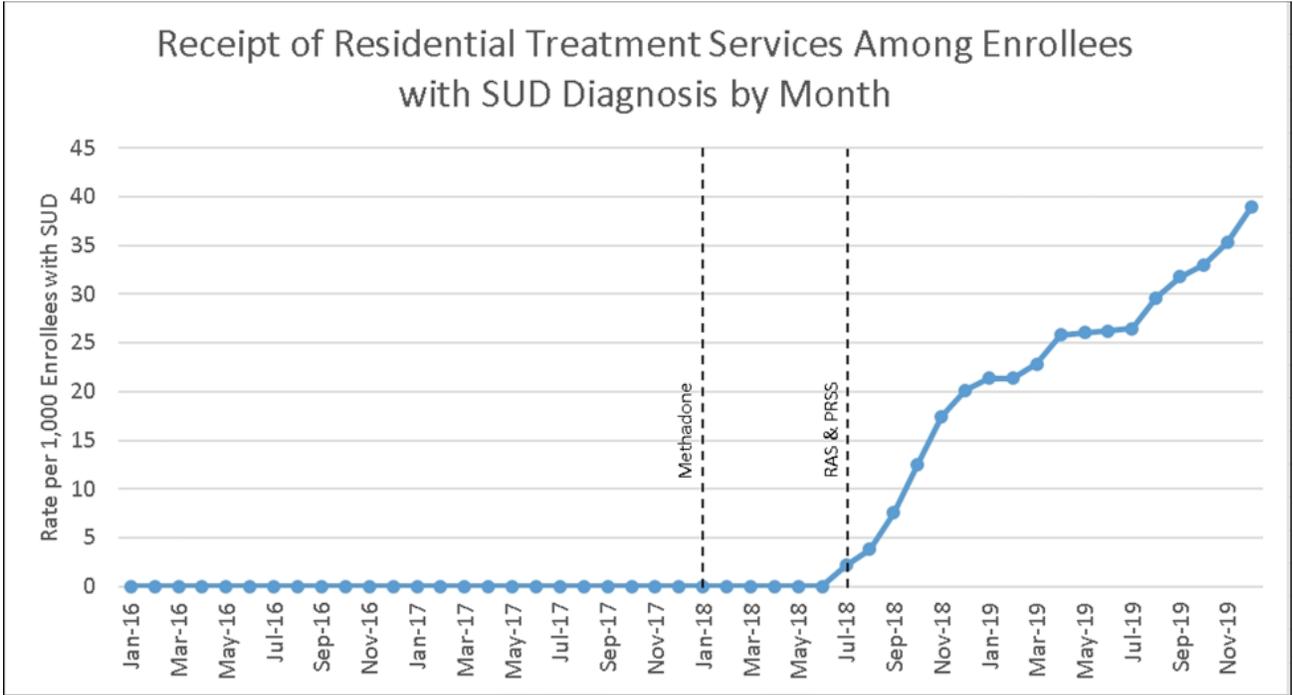


Figure F-9 Receipt of Methadone Among Enrollees with OUD Diagnosis by Month (EQ 2.2, EH 2.2.1)

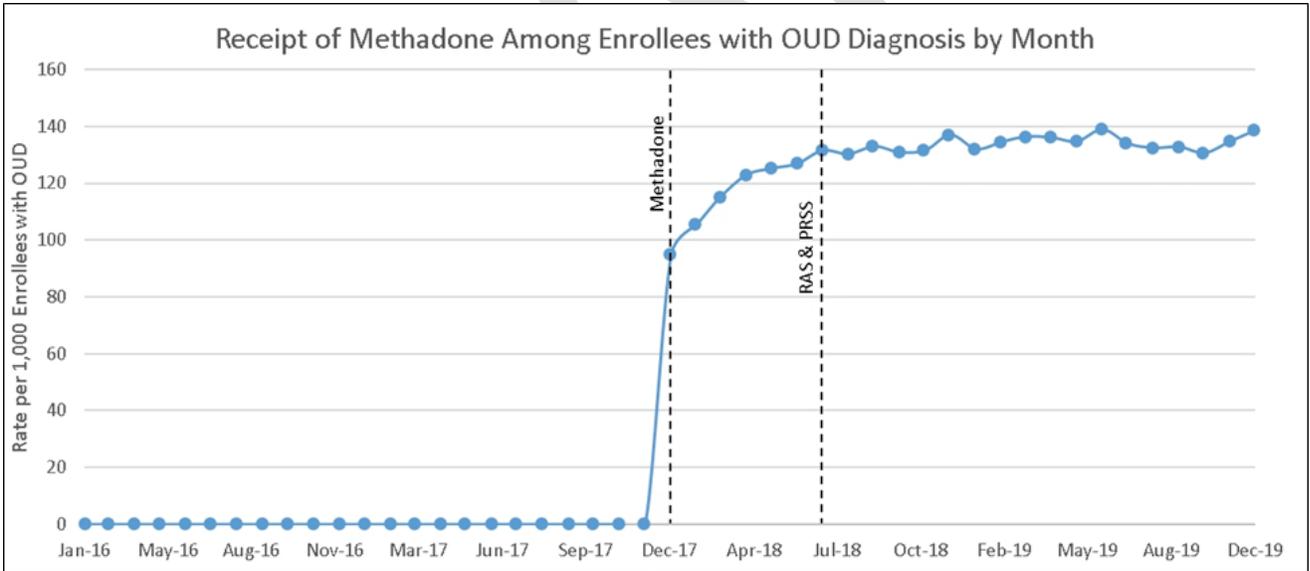
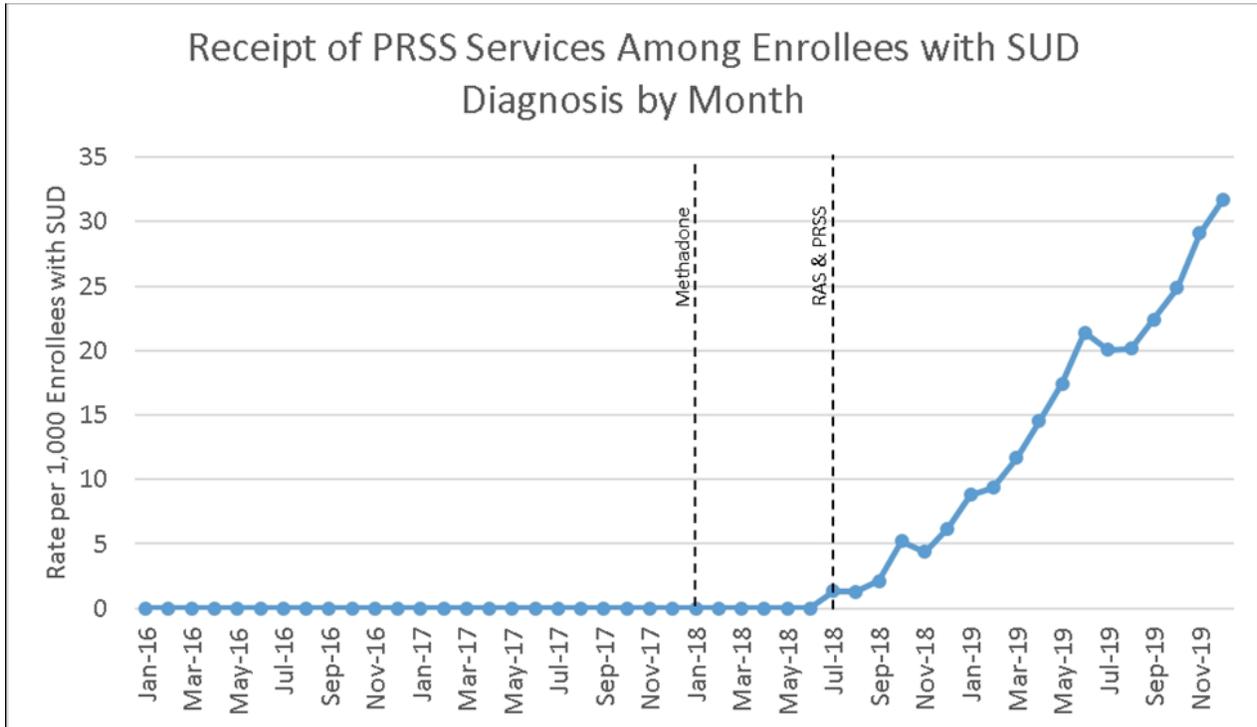


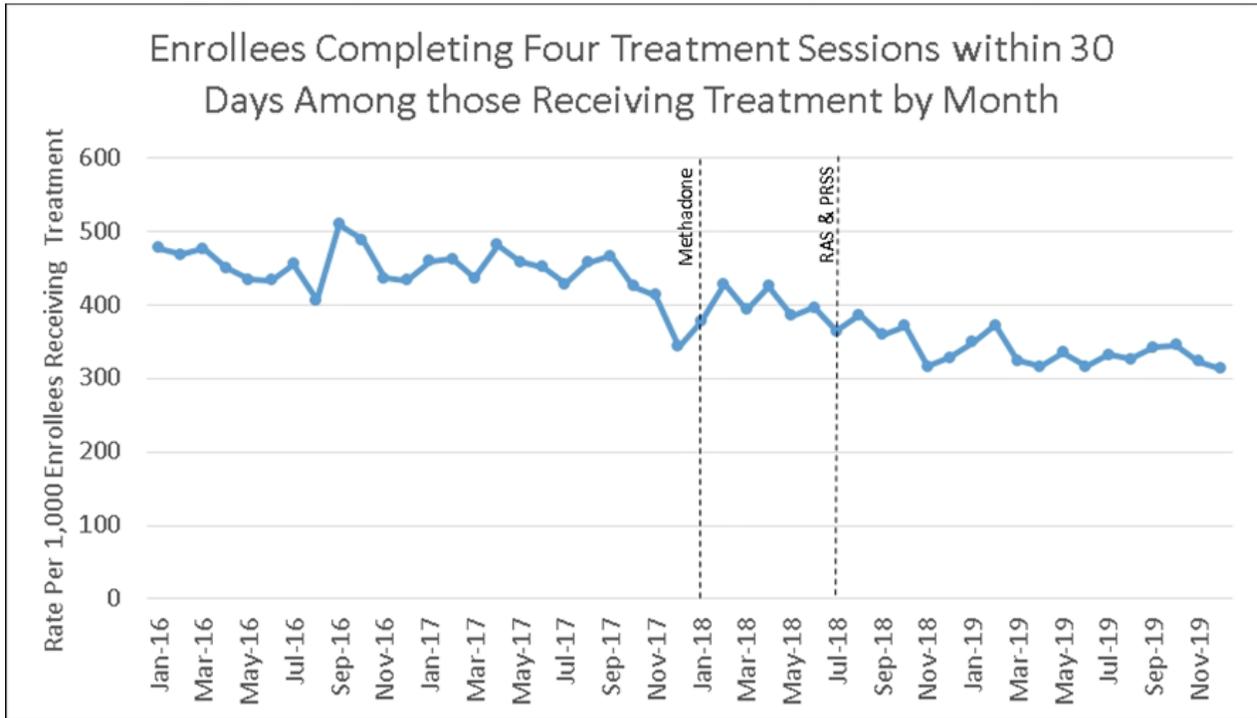
Figure F-10 Receipt of PRSS Services Among Enrollees with SUD Diagnosis by Month (EQ 2.2, EH 2.2.1)



Rate of continuation of treatment

The number of enrollees who completed a fourth treatment session within the first 30 days of treatment in WV fell as compared with the beginning of the pre-implementation period (January 2016). It appears that this decrease was happening before the waiver was implemented.

Figure F-11 Enrollees Completing Four Treatment Sessions within 30 Days Among those Receiving Treatment by Month (EQ 1.1, EH 1.1.1)



Initiation and engagement of alcohol and other drug (AOD) dependence treatment

For these measures, we used definitions created by the Medicaid Outcomes Distributed Research Network (MODRN); we note this because these measures are reported at the yearly level. They assess the waiver’s impact on the number of enrollees both starting and engaging in treatment for AOD. Engagement is defined as having two or more additional AOD services within 34 days of the initial treatment visit.

The number of Medicaid enrollees with AOD that initiated AOD treatment in WV increased by about five percentage points since the onset of the waiver. The number of enrollees with AOD who initiated and engaged in AOD treatment in WV also increased by about five percentage points during this time period.

Figure F-12 Percent of Medicaid Enrollees with AOD who Initiated AOD Treatment by Year (EQ 1,1, EH 1.1.1)

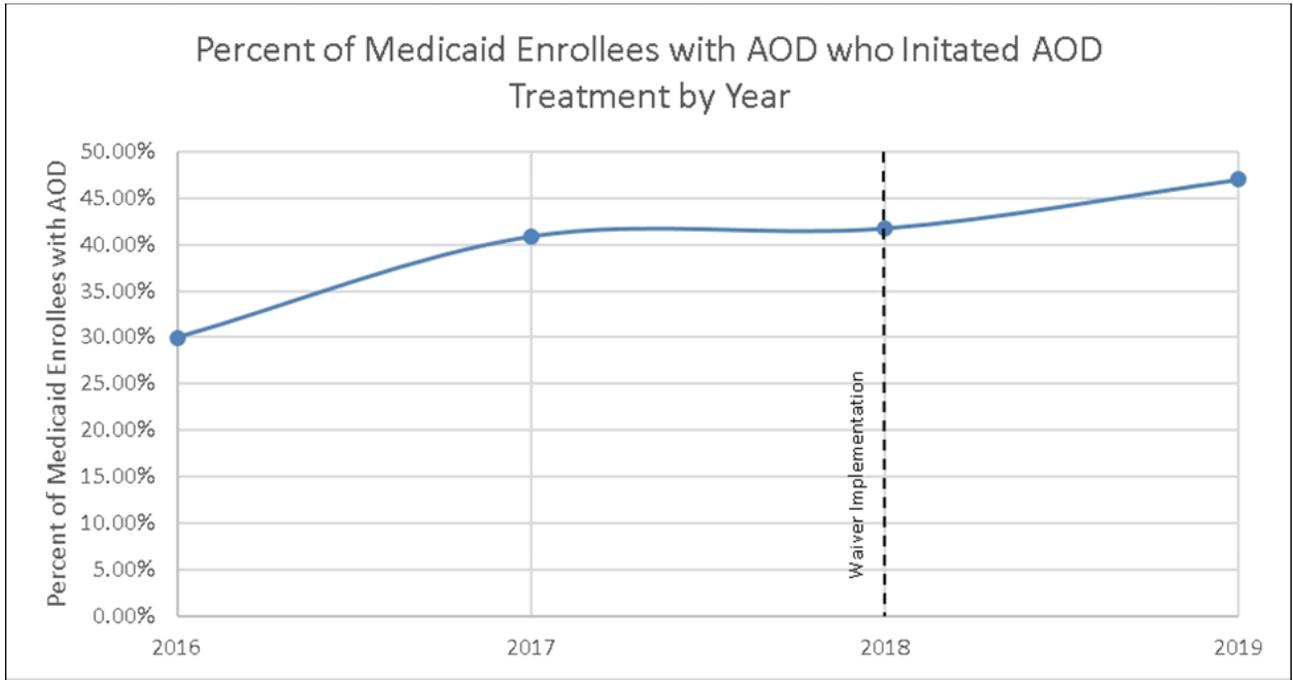
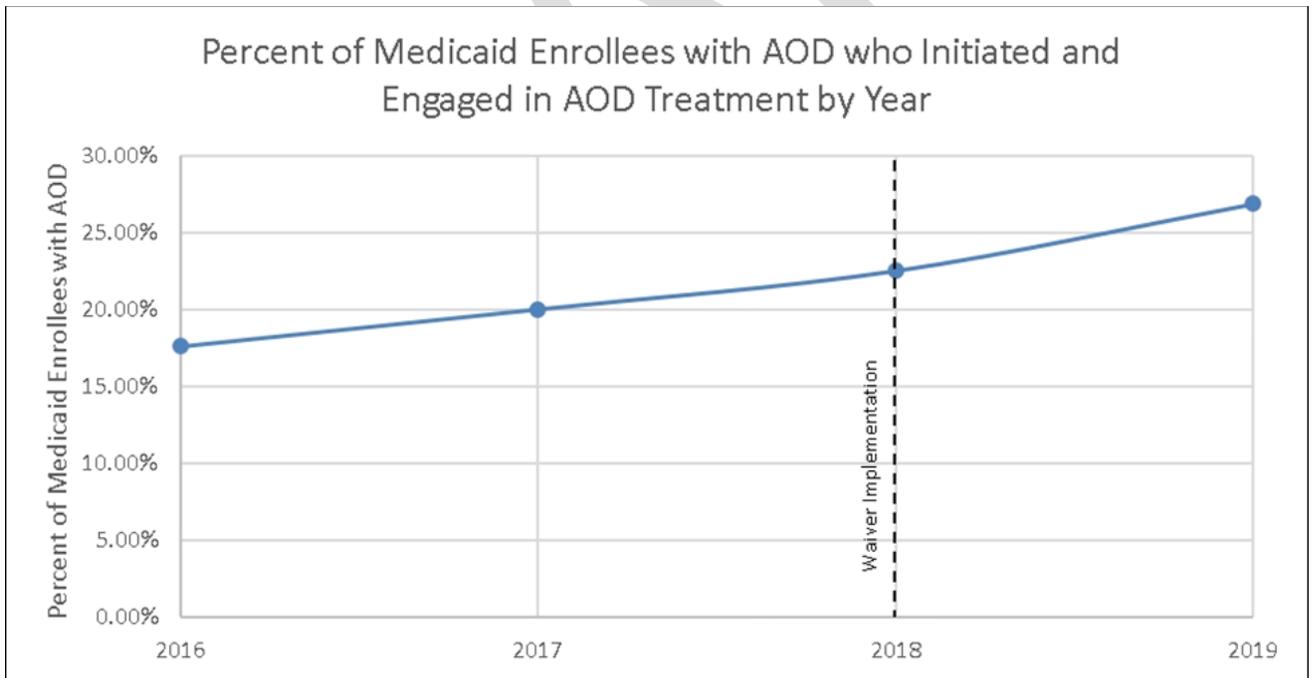


Figure F-13 Percent of Medicaid Enrollees with AOD who Initiated and Engaged in AOD Treatment by Year (EQ 1.1, EH 1.1.1)

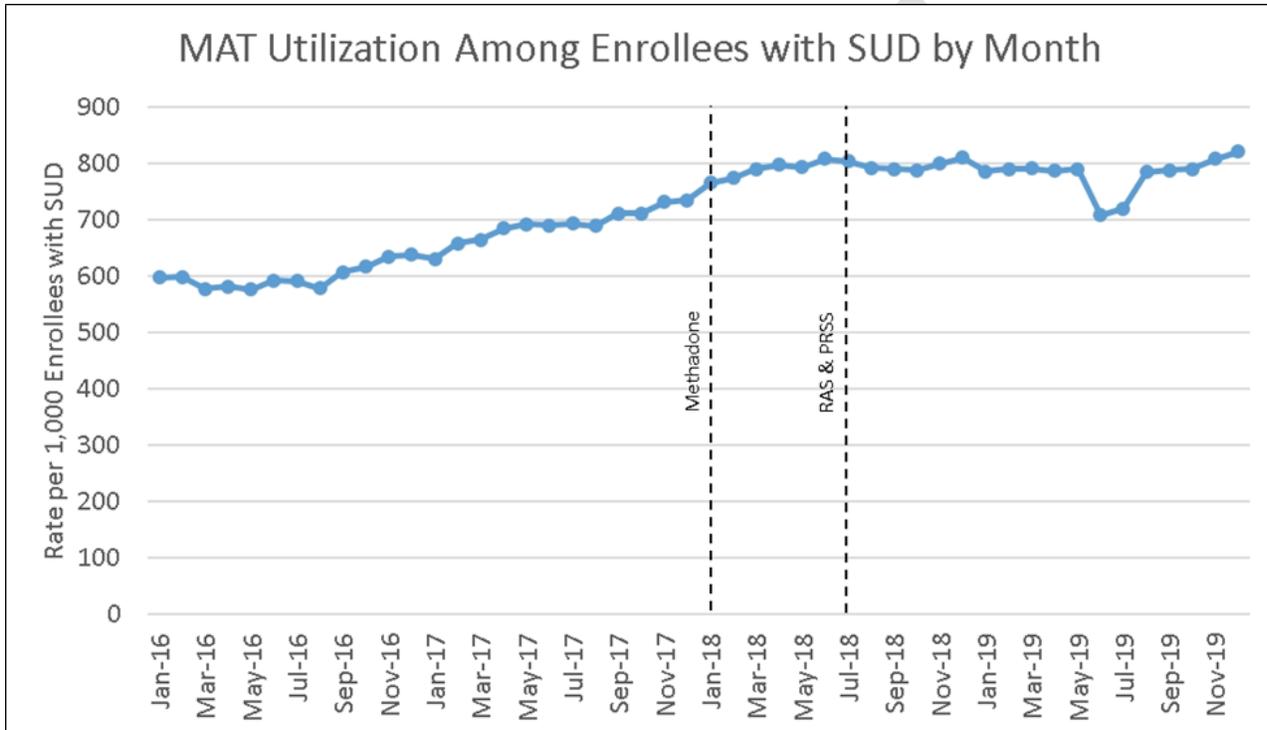


Medication for Opioid Use Disorder Utilization

Medicaid claims data were analyzed to determine the number of unique beneficiaries who had a claim for MAT services (buprenorphine, naltrexone, methadone, acamprosate, and disulfiram) during the

measurement period. MOUD utilization increased by 7% between the onset of the waiver service (January 2018) and December 2019, from a rate of 765 per 1,000 enrollees with SUD to 820 per 1,000 enrollees with SUD. MOUD use increased during the waiver period; however, this increase was part of an upward trend that began two years to the waiver’s start, and therefore may not be attributable to the waiver alone.

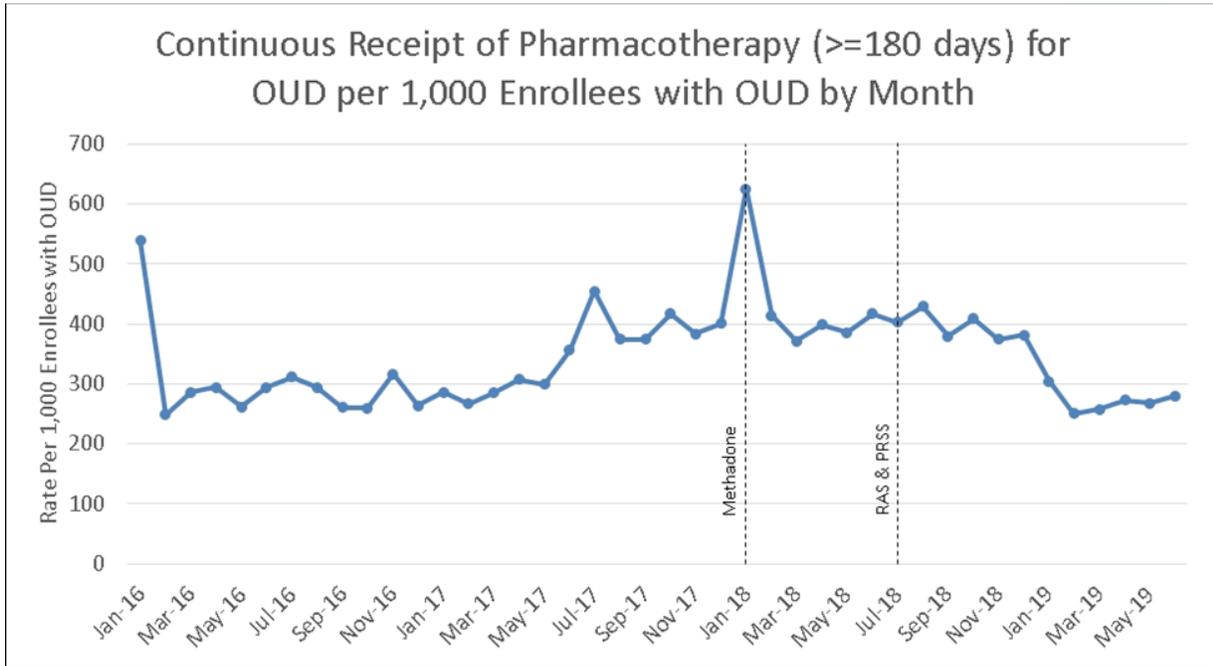
Figure F-14 MAT Utilization Among Enrollees with SUD by Month (EQ 1.1, EH 1.1.1)



Continuity of pharmacotherapy for OUD

This measure omits data from July 2019 through December 2019 to account for the 180-day measurement period to determine continuity of pharmacotherapy. Despite a large initial spike at the waiver’s introduction, continuous receipt of pharmacotherapy (a measure of treatment quality) rates decreased from 400 per 1,000 enrollees with SUD in December 2017 (the month prior to methadone coverage under the waiver) to 279 per 1,000 enrollees with OUD in June 2019.

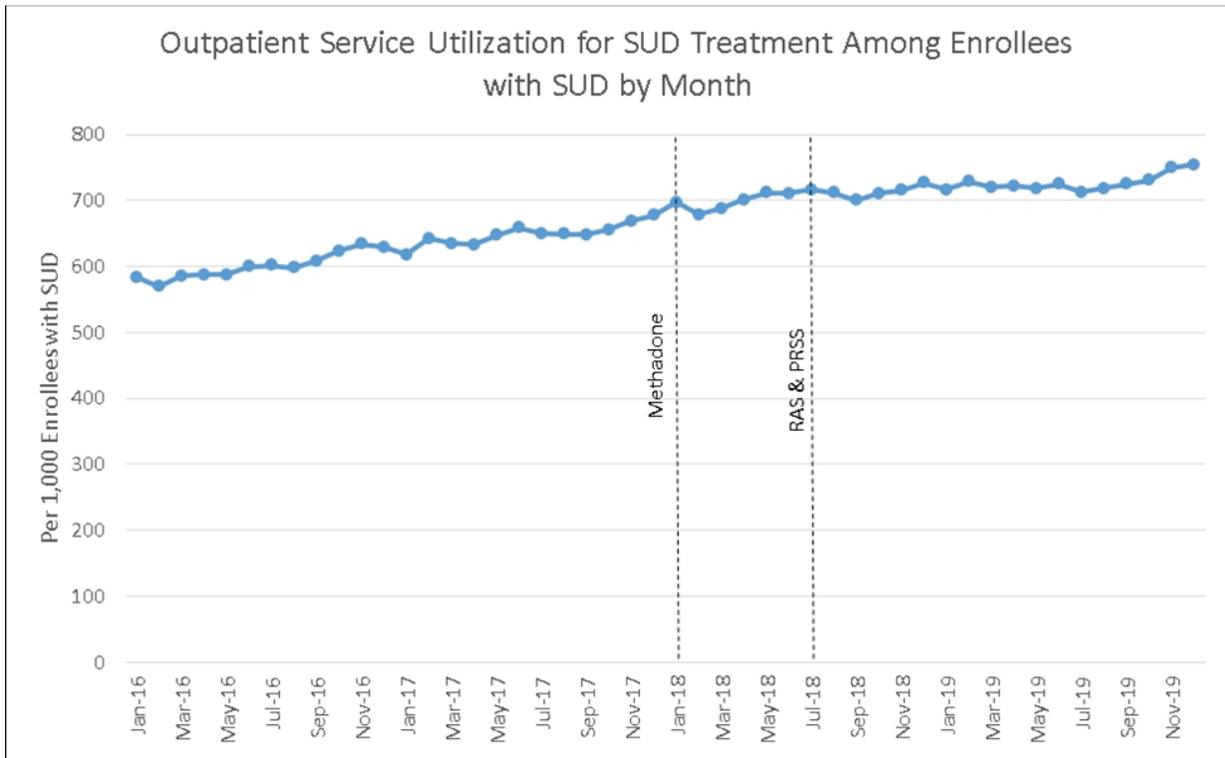
Figure F-15 Continuous Receipt of Pharmacotherapy Among Enrollees with OUD (EQ 1.1, EH 1.1.1)



Outpatient services for SUD treatment

The trend line for outpatient service utilization for SUD treatment increased starting at the beginning of the pre-waiver implementation period and continued to increase post-waiver implementation. Since January 2018, the rate of outpatient service utilization for SUD treatment among enrollees with SUD has increased by 57 per 1,000 enrollees with SUD.

Figure F-16 Outpatient Service Utilization for SUD Treatment Among Enrollees with SUD by Month (EQ 2.2, EH 2.2.1)

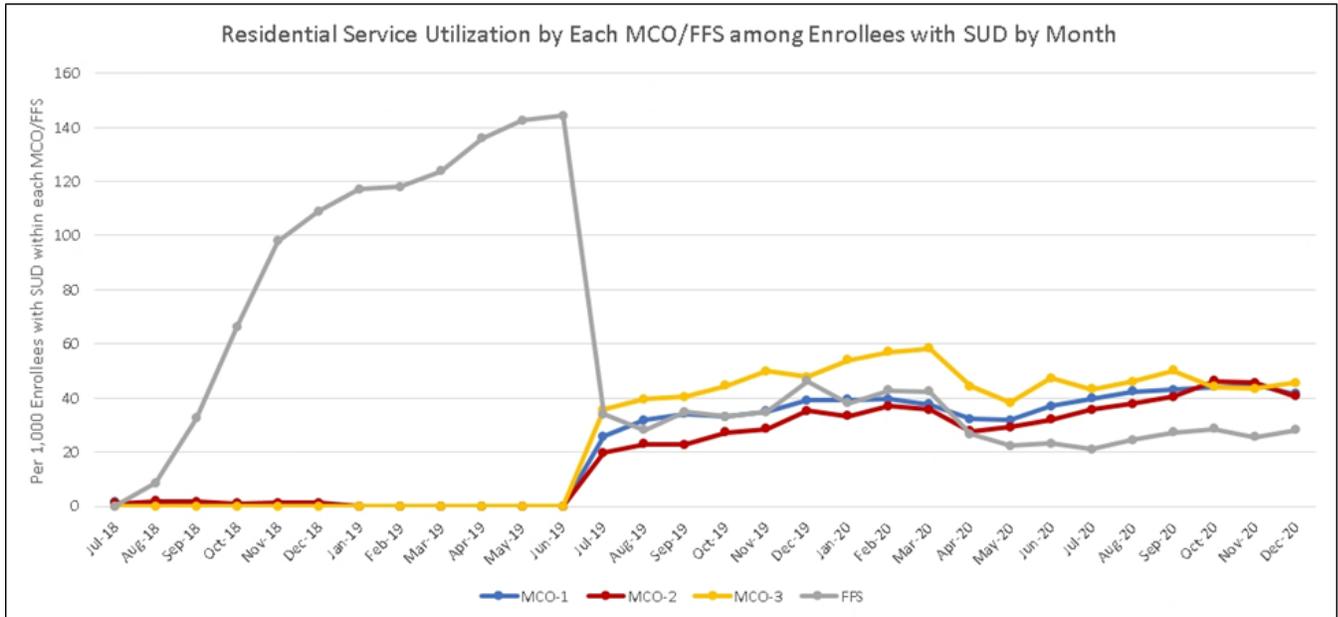


3 Treatment-related outcomes

The treatment-related outcomes measures specified in the evaluation plan can be found in Appendix C: Treatment-Related Outcomes. These measures were derived using data that we have since found are of poor quality, or which require further investigation (for example, stratifying by MCO). Therefore, we ask readers to interpret them with appropriate caution. In this section, we present results from four of our data quality checks, which illustrate some of these data concerns.

As shown in Figure F- 17, nearly all residential service claims were billed as fee-for-service prior to June 2019, at which point these services were carved in to MCO coverage for those with Medicaid plans administered by MCOs. This policy change coincides with several unexpected outcomes that we had been seeing in our results, including a sharp increase in inpatient stays among enrollees with SUD (see Figure J- 5 and Figure J- 6 in Appendix C: Treatment-Related Outcomes).

Figure F-17 RAS Utilization by Each MCO/FFS



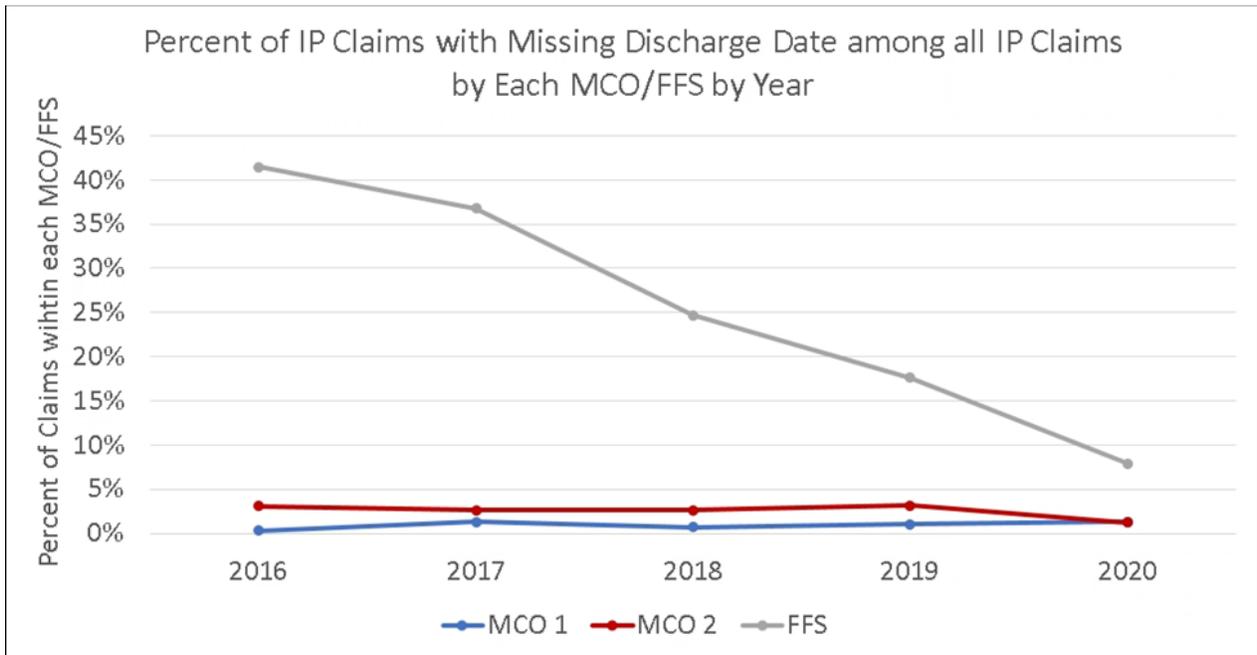
Investigating this further, our team stratified RAS claims by connected Place of Service Codes to determine whether there is overlap between our RAS measure definition and other measure definitions. Table 2 documents significant miscoding of this variable in the 2020 Medicaid claims data. For example, over 7% of RAS claims were coded as taking place in an office setting, while over 7% more were coded as taking place in a psychiatric residential treatment center. A small number of claims were also miscoded as taking place in an inpatient setting. These codes have been used incorrectly, thus necessitating the evaluation team to undertake more creative approaches for RAS utilization measurement.

Table 2 Frequency of POS Codes in Residential Adult Services Claims, 2020

| Claim Type | | Place of Service Code | | | | | | | | | | Total |
|---------------------|-----------|-----------------------|---|-------------|----------------|--------------------------|-------------------------------------|-------------------------------------|---|---|--------------|---------|
| | | Telehealth (2) | Indian Health Services Free-standing Facility (5) | Office (11) | Inpatient (21) | Outpatient Hospital (22) | Inpatient Psychiatric Facility (51) | Community Mental Health Center (53) | Residential Substance Abuse Facility (55) | Psychiatric Residential Treatment Center (56) | Missing (99) | |
| Facility Claims | Frequency | - | - | - | 568 | - | - | - | - | - | - | 568 |
| | Percent | 0.00% | 0.00% | 0.00% | 100.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 100% |
| Professional Claims | Frequency | 507 | 4 | 8,487 | - | 14 | 1 | 24,536 | 77,342 | 9,193 | 53 | 120,137 |
| | Percent | 0.42% | 0.00% | 7.06% | 0.00% | 0.01% | 0.00% | 20.42% | 64.38% | 7.65% | 0.04% | 100% |
| Total | Frequency | 507 | 4 | 8,487 | 568 | 14 | 1 | 24,536 | 77,342 | 9,193 | 53 | 120,705 |

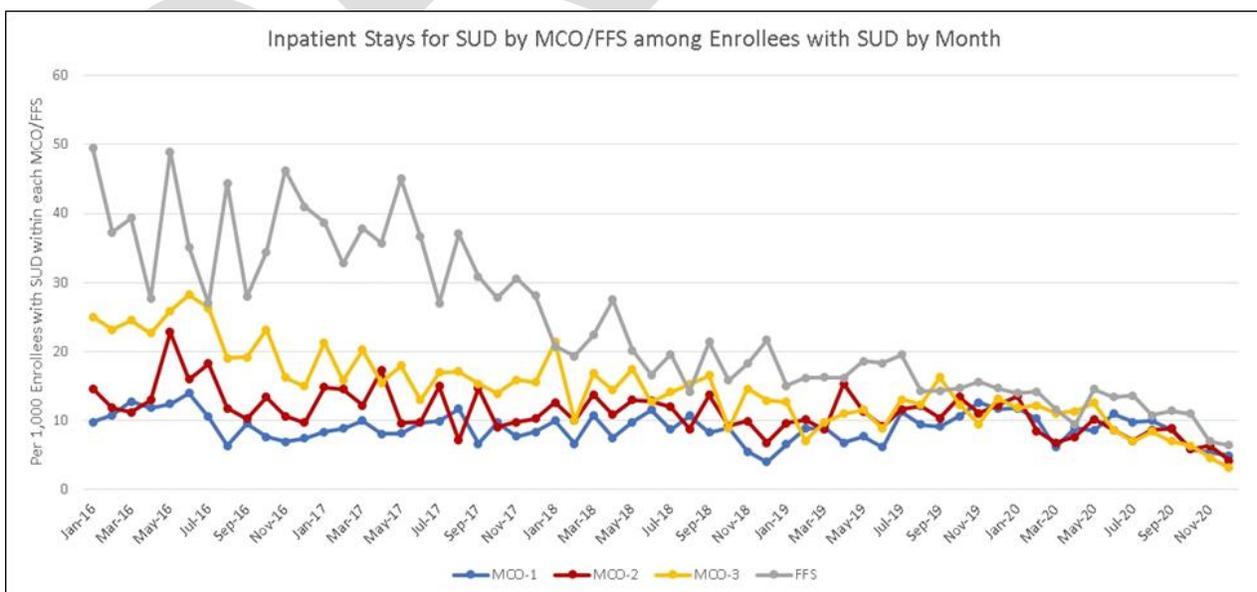
Further, in Figure F-18, we document the substantial (though improving) rate of missing data in some of our sources. For example, we find that a large percentage of inpatient claims are missing a discharge date, which has implications for outcomes related to inpatient hospitalization and length of stay. It appears that the majority of problematic claims can be attributed to FFS inpatient stays. Note that MCO-3 is not included in this table because they do not have any missing discharge date fields.

Figure F-18 Percent of Inpatient Claims with Missing Discharge Date



The evaluation team has also discovered differences in treatment-related outcomes over time by FFS versus MCO, as illustrated in Figure F- 19. The graph shows that inpatient stays for SUD among those who have FFS-administered Medicaid increased substantially starting at the end of 2018 and continuing throughout 2019. By analyzing this outcome with FFS and MCO claims combined, we are obscuring important individual trends by payer that warrant additional investigation. Therefore, the evaluation team is currently considering options for separating our outcomes into FFS versus MCO to assess changes in the impact of the waiver by payer types.

Figure F-19 Inpatient Stays for SUD by MCO/FFS



4 Cost Analysis

The figures below provide quarterly costs for each of the waiver components- methadone, PRSS, and RAS services. These do not include administrative costs, as the WVU team is awaiting FMAP information required to calculate these costs. Instead, these are claim costs for each service. Total costs for all three services have increased from \$1,217,370 in Q1-2018 (representing only methadone claims) to \$15,860,025 in Q4-2020, which corresponds with large increases in unique enrollees receiving treatment. For example, unique enrollees receiving PRSS services grew from 43 in Q3-2018 to 2,388 in Q4-2020. Methadone utilization nearly doubled between Q1-2018 and Q4-2020, and enrollees receiving RAS treatment increased from 50 to 1,533 in that same time period.

Figure F-20 PRSS Recipients and Cost Per Quarter

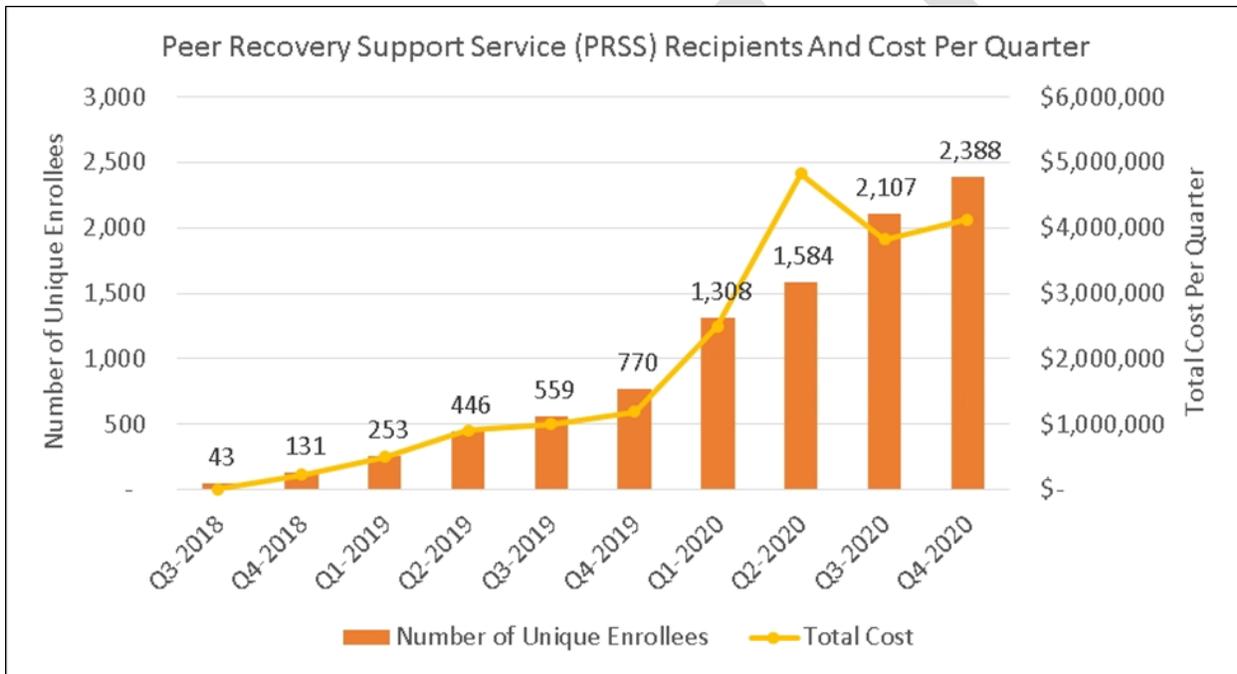


Figure F-21 Methadone Recipients and Cost Per Quarter

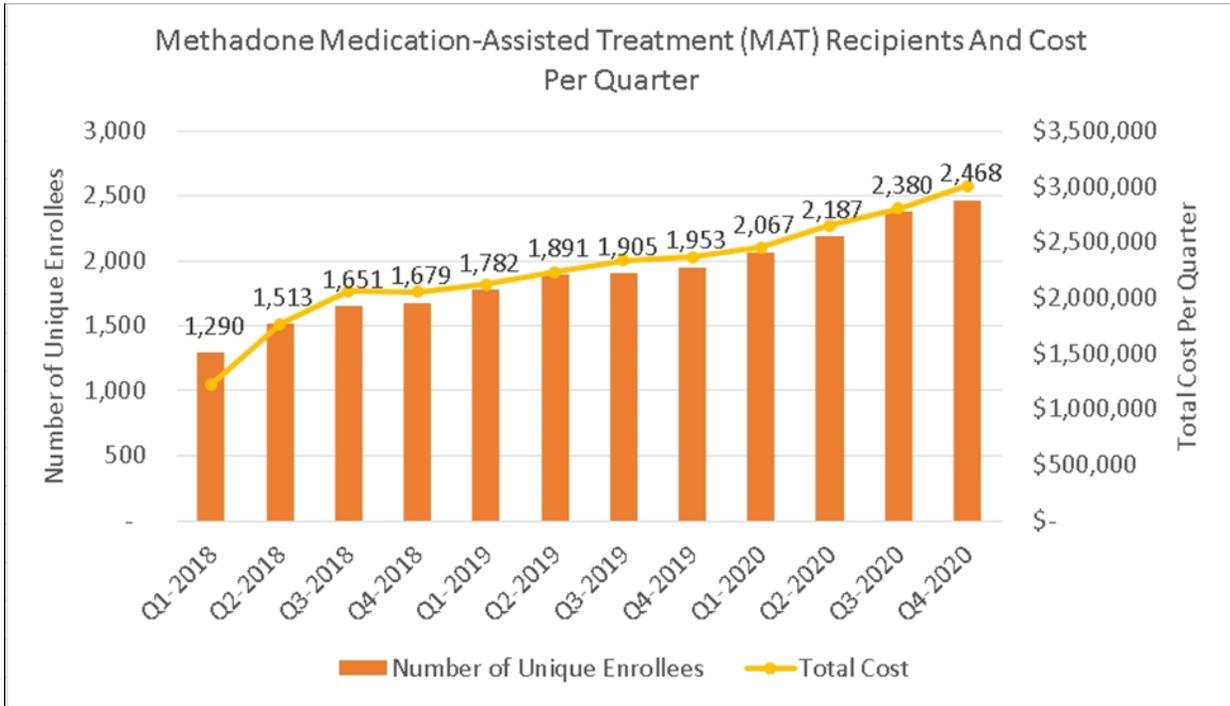
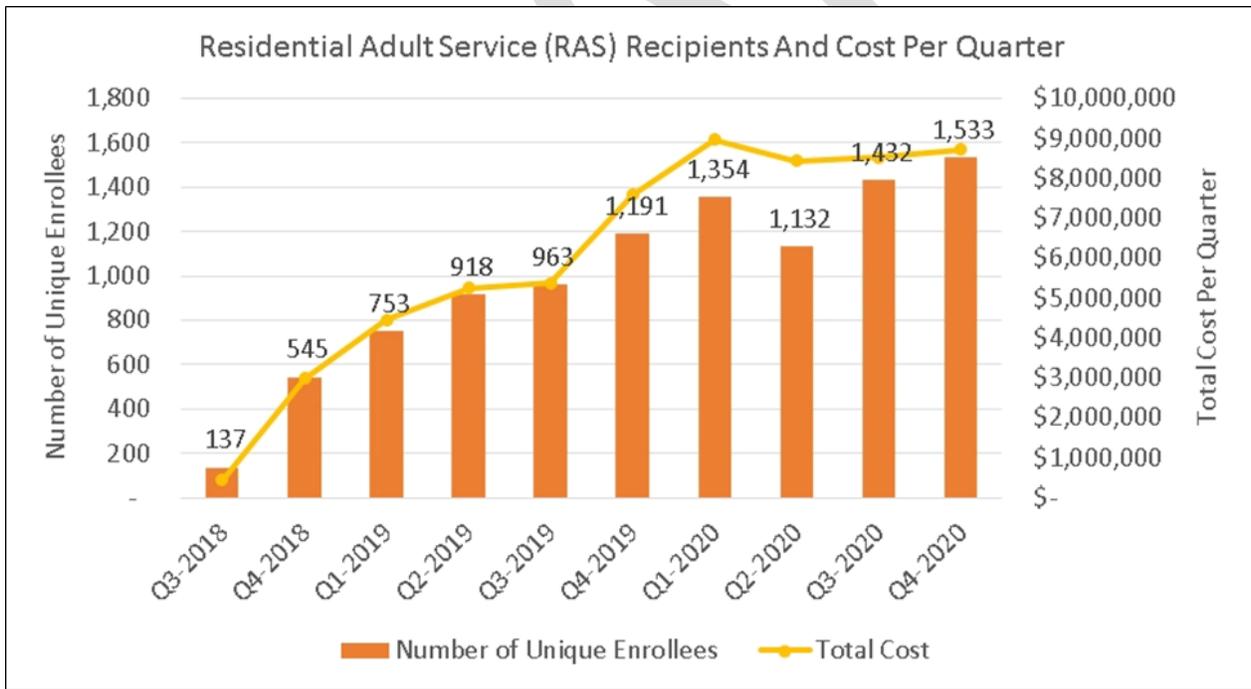


Figure F-22 RAS Recipients and Cost Per Quarter



5 Changes to evaluation plan for extension

Currently, BMS is applying for an extension of these waiver services and expanding to include additional services. The new waiver application is intended to:

- Continue existing waiver services to collect additional data on outcomes.
- Engage high-risk individuals in vulnerable settings.
 - Expand peer support to more settings (e.g., emergency departments [EDs]).
 - Provide continuity of care for justice-involved individuals with SUD.
 - Offer involuntary secure withdrawal management and stabilization (SWMS) for individuals deemed a danger to themselves or others—or other eligibility criteria to be determined in state code—by a designated crisis responder.
 - Support a more holistic and integrated approach to treatment, education, and outreach for HIV/HCV in relation to substance use.
- Address SDOH to cultivate self-reliance and support continued recovery through recovery housing offering clinical-level treatment services to SUD members, supported housing, and supported employment.
- Offer contingency management, through the Treatment of Users with Stimulant Use Disorder (TRUST) comprehensive outpatient model, as an additional evidence-based practice for individuals with stimulant use disorder.
- Provide multidisciplinary Quick Response Teams that are in contact with an individual 24-72 hours after an overdose event or SUD related emergency.
- Reimburse short-term (i.e., average length of stay no longer than 30 days), medically necessary residential and inpatient treatment services within settings that qualify as IMDs for Medicaid-eligible adults with serious mental illness (SMI).
- Expansion of allowable length of stays in IMDs at the ASAM 3.7 level of care for individuals with SUD and co-occurring complex medical conditions for up to 60 days.

Upon approval of this waiver extension application, the WVU team plans to expand the measures currently used to evaluate the current waiver in order to capture changes related to new services under the extension. Table 2 outlines these measures and WVU’s proposed methods for evaluating each one. These plans should be considered a draft and not final.

Table 3 Proposed Evaluation Plan for Waiver Extension

| Waiver Extension Service/New Demonstration Goal | Change to Evaluation Plan | Proposed Measurement Method |
|---|---|--|
| Decrease utilization of high-cost ED and hospital services with SUD and/or SMI. | This demonstration goal will replace Demonstration Goal 3: “Decrease emergency department and hospital services by enrollees with SUD.” | Use the same measurement method as the replaced demonstration goal. |
| Reimburse short-term residential and inpatient treatment services for adults with SMI at IMDs | Include SMI in Demonstration Goal 4: “Improve care coordination and care transitions for Medicaid enrollees with SUD <i>and/or SMI.</i> ” | In addition to HCV and HIV, additional physical health conditions consistent with SMI will be examined separately. |

| | | |
|---|---|--|
| Provide Medicaid coverage to eligible individuals incarcerated in state prisons starting 30 days prior to release | Measure non-emergent ED utilization post-incarceration. Measure number of individuals reinstated in Medicaid within 30 days of incarceration release. | Contingent upon WV DHHR implementing a way to track previously-incarcerated enrollees in claims data, these measures can be completed using Medicaid claims data. |
| Provide integrated access treatment, education, and outreach for HIV/HCV in relation to substance use. | Measure number of individuals receiving HIV/HCV education. | Use CPT codes to flag HIV/HCV testing encounters. Contingent upon data quality issues being addressed, code modifiers can be used to flag educational encounters among these visits. |
| Provide supported housing and supported employment to enrollees with SUD. | Measure number and rate of enrollees with SUD receiving supported housing and/or supported employment. | Use HCPCS codes for supported housing (H0043, H0044) and supported employment (H2023) to analyze changes in utilization. |
| Implement the TRUST comprehensive outpatient model for contingency management | Measure the number and rate of enrollees with SUD that have utilized contingency management services. | Contingent on Medicaid claims data changes, this measure can be completed using Medicaid claims data. |
| Provide multidisciplinary Quick Response Teams | Measure the number and rate of enrollees with SUD that are contacted by a QRT within 72 hours of a SUD-related emergency. | Contingent on Medicaid claims data changes, this measure can be completed using Medicaid claims data. |
| Expand allowable length of stays in IMDs at the ASAM 3.7 level of care for individuals with SUD and co-occurring complex medical conditions for up to 60 days | Include separate measure for length of RAS stays among ASAM level 3.7. | Number and rate of ASAM level 3.7 visits exceeding 30 days. |

F. Conclusions

Based on the data described in this report, the evaluation team concludes at this point the following about the waiver:

- The waiver significantly improved the supply of residential facilities, bed, and peer specialists. In particular, PRSS have served as a valuable resource for providers,

especially in helping make care transitions more “seamless.” Connecting patients to residential beds is still subject to barriers, including MCO approval.

- While uptake of the individual waiver services rose over time, the observed rise in overall SUD treatment use appears to be part of a larger trend of increased SUD utilization. At the time of this report, we cannot claim that the waiver was responsible for these increases, even though they occurred during the waiver period. It appears that quality of SUD treatment (e.g. engagement) may have worsened during the waiver period, though for several of our outcomes, this is also due to broader declines in care quality.
- Poor data quality has increased the time we will need to fully describe the impact of the waiver in terms of health care outcomes. In the meantime, the evaluation team and the State are working together to improve data quality in order to provide the most rigorous evaluation possible. We strongly recommend that the State consider data quality improvements as a major cornerstone of its waiver extension plan.
- Costs of delivering the waiver services rose as expected with the introduction of the waiver; we did not conduct any cost effectiveness analysis as part of the evaluation.

In addition, results for the following measures have not yet been finalized, due to ongoing data improvements. These measures will be included in the final report:

- Rate of Continuation of Treatment (EQ 1.1, EH 1.1.1)
- HIV morbidity (EQ 1.2, EH 1.2.1)
- Hepatitis C morbidity (EQ 1.2, EH 1.2.1)
- Access to preventive / ambulatory health services for adult Medicaid beneficiaries with SUD (EQ 1.2, EH 1.2.1)
- Treatment initiation and engagement for enrollees with SUD and HCV comorbidities (EQ 4.1, EH 4.1.1)
- Treatment initiation and engagement for enrollees with SUD and HCV comorbidities (EQ 4.1, EH 4.1.1)

Though the program made important progress toward some identified demonstration objectives, BMS was not able to fully achieve the goals set forth in the 1115 waiver due to the onset of the COVID-19 public health emergency, which began midway through the demonstration period. BMS and involved provider agencies faced a notable workforce shortage prior to the start of the COVID-19 pandemic, a problem made significantly worse over the past several years by the circumstances the pandemic created. The workforce available to provide waiver services has been notably and negatively impacted due both to lives lost to COVID-19 and to providers leaving the healthcare field at significant rates due to COVID-19 reasons. In light of the serious, unforeseen implications of the COVID-19 pandemic during the demonstration period, BMS does not feel that the 1115 waiver was or could be executed in a complete, correct manner as was intended when the waiver was implemented.

G. Interpretations, Policy Implications, and Interactions with Other State Initiatives

West Virginia recognizes both the successes and areas for continued improvement that emerge from the data presented in this report. The existing 1115 SUD Waiver has established a continuum of care for individuals diagnosed with SUD from which the State can expand upon and build from in the coming years. Importantly, the 1115 waiver is one component of broader efforts, both existing and planned, in the State's efforts to support individuals with SUD diagnoses.

The 1115 waiver coordinates with WV's State Plan services for SUD treatment, building on the services that existed prior to the waiver implementation in order to create a continuum of care for members in need of treatment services and support at differing levels of care. As discussed in detail above, the waiver interrelates with the 1915c CSED waiver by covering automatic enrollment of CSEDW participants in MHP.

In addition to aspects of the BMS structure for this work, the waiver fits into a broader WV strategy for addressing SUD response planning as one of several mechanisms by which the State is working to serve and help WV Medicaid members with SUD diagnoses. The waiver operates in tandem with the State's Ryan Brown-funded treatment programs and with several initiatives resulting from SAMHSA grants, such as the State Opioid Response (SOR) grant and the Block Grant.

The SOR grant, which the State received in 2019 to support its opioid response efforts, expands the availability of MAT and evidence-based services that identify and engage individuals in treatment and provide supports to help keep them in treatment and long-term recovery, as well as expands access to prevention services. The SAMHSA Block Grant provides WV funding to plan, implement, and evaluate activities that prevent and treat substance abuse and promote public health.

Finally, WV operates a Drug Free Moms and Babies (DFMB) pilot program, an integrated comprehensive medical and behavioral health program for pregnant and postpartum women with substance use disorder, which has been operational for several years. A State Pilot Grant Program for Treatment for Pregnant and Postpartum Women (PPW-PLT) SAMHSA awarded to the State in 2021 has allowed WV to expand the program, as well as establish a State Project Director position within DHHR's Bureau for Behavioral Health to coordinate an effective State continuum of care specifically supporting women's behavioral healthcare. The DFMB program requires the presence of a peer supporting women in the program, tying this program's operations to the 1115 waiver.

At the time of this report, WV is developing a State Plan Amendment (SPA) to expand the DFMB program. BMS is also developing a SPA relating to the implementation of a Medicaid-run and funded mobile crisis intervention services program for individuals with a suspected substance use or behavioral health emergency. This work is currently in the planning phase, conducted with funding from a CMS American Rescue Plan (ARP) grant award the State received in 2021. The Medicaid mobile crisis program has a planned effective date of January 1, 2023. The State is also in the process of further evolving the Centers of Excellence (COE) for substance abuse and addiction treatment program and is developing a SPA for this program.

Each of these programs directly connects to and reinforces the SUD waiver's services and programmatic goals. Detailed information about the breadth of what WV is doing to address SUD and how the 1115 waiver is braided as part of a broader State effort can be found in the State's [Substance Use Response Plan](#).

In consideration of how this report's findings can inform future policy considerations and developments for both the State and at a national level, the following implications from the report are of note:

- The activities of the waiver to this point emphasize the importance of having connected information sources.

When providers at facilities across the care continuum have more information readily accessible, they are able to offer members better care coordination and therefore better quality of care. An example from this drawn from waiver activities thus far is Methadone availability in clinics; when clinics and providers at these facilities have all information connected, they are able to access both the information and supplies needed to provide optimal quality of care.

- Inclusion of PRSS as a component of the waiver demonstration had a resounding positive impact on waiver members, as indicated by both quantitative and anecdotal interview data highlighted in this report.

West Virginia is leveraging this success in seeking to expand PRSS to new settings with the 1115 waiver renewal. At a wider level, there should be a concerted and coordinated effort to work to expand the accessibility and types of peer support available to individuals with SUD or who are experiencing a behavioral health crisis. This could include diversifying settings in which individuals providing peer support operate, as well as aligning peer support certification processes.

- Standardization of the PRSS experience and certification requirements would benefit states as they continue to develop and expand PRSS programs in various substance use and behavioral health settings.

This policy consideration stems from West Virginia's experience with PRSS during the waiver period to this point. Lessons learned from the implementation of PRSS under the waiver are discussed in Section I. Given the overwhelming positive impact the inclusion of PRSS has had, it is in WV's (and presumably other states') interest to help ensure optimal execution of service delivery and standards.

- Within SUD treatment service care continuums, there is continued need for concentrated efforts improving care coordination of SUD treatment services.

The data described in this report highlights that the waiver significantly improved availability of services, such as those provided in residential facilities. Barriers to treatment have arisen more in areas' engagement and coordination than on availability, and in some cases, there remains a disconnection between levels of care. Smooth transitions between levels of care can continually be improved upon. West Virginia and other states can consider these challenges and continue to develop waiver and other treatment programs that make connections to care and care coordination a priority.

It should again be noted that the COVID-19 public health emergency, which began in the middle of this waiver demonstration period, significantly affected both the individual members served by the waiver, the State, and evaluation team's ability to obtain quality data to accurately assess the impact the demonstration has had. At both a State and national level, the COVID-19 PHE has illuminated the need for intentional and specific long-range planning in preparation for the next time such an event occurs.

BMS will make more policy-driven decisions based on more complete data provided by coming years of the waiver, beyond the years which have occurred at the time of this Interim Report. Once a full demonstration period, and as a result a full data cycle, has been completed, BMS will consider and leverage what has happened during this five-year period to inform policy target areas and drive policy decisions in future years of the waiver and the State's broader substance use response planning.

H. Lessons Learned & Recommendations

BMS is committed to learning from the results of the 1115 demonstration to date to inform both the remainder of this demonstration period and the waiver extension and values the chance to collaboratively inform other Medicaid programs and interested stakeholders of lessons learned to build collective knowledge and advance the broader Medicaid mission. Key learnings and their implications for the future are discussed in detail here.

As evidenced by the data presented in this report, BMS saw notable success in providing increased access to SUD treatment services under the waiver program. A central goal of the demonstration was to increase access to and utilization of appropriate treatment services in accordance with ASAM or other nationally recognized criteria. The waiver program to date has made positive changes in terms of access to care, which is the first critical juncture in achieving this goal. The results of this evaluation highlight the way in which changes, and successes are incremental. The step-based success model stands to remind Medicaid policymakers, advocates, and other stakeholders that successful strategies are those which can be planned and executed incrementally. While BMS did not fully recognize this overarching goal in every aspect of the waiver, the program made important changes that inform and provide the basis for opportunities to continue making forward progress on the second half of this goal, increasing utilization of services available.

A central and critical lesson learned from the process of conducting the Interim Evaluation Report is that BMS has faced data quality challenges, which then consequentially impacted the evaluators' ability to accurately and fully evaluate demonstration activities. Poor data quality in certain cases impacted the evaluation team's ability to synthesize data to provide results, and for all results negatively impacted levels of confidence in the findings generated. BMS recognizes the challenges that poor data quality has created and remains committed to data quality improvement. Going forward, data quality improvement efforts will continue to use of national quality measures, aligning with CMS' NCQA, the American Medical Association[®] (AMA) Physician Consortium for Performance Improvement[®] (PCPI) and other nationally recognized standards.

In full understanding of the importance evaluation activities have for the program and the spirit of the 1115 waiver, BMS will continually develop and adhere to data improvement efforts for this demonstration. One targeted branch of these efforts that BMS hypothesizes will help ensure improving data quality is increasing collaboration and communication activities with entities connected to waiver service delivery. Several of the data quality issues the evaluating team encountered when analyzing data for the Interim Evaluation Report were rooted in providers misunderstanding billing procedures and therefore billing claims incorrectly. This led to a lack of clarity as to which data represented a given evaluation measure, and which data was incorrectly integrated. BMS will enhance provider communication and education on billing procedures and codes to help ensure that all providers are aware of how to properly bill for services provided. As a result, future evaluations will not have to contend with determining whether data is correctly or incorrectly included in a particular data set.

In addition, BMS will more often conduct outreach as necessary throughout the waiver period if BMS recognizes data that seems out of alignment with quality standards. As detailed in the BMS provider manual, the agency may outreach to members and providers as appropriate based on findings within the data from the measures, claims data reviews, inquiries from other providers, inquiries from members, suggestions from the MCOs, the External Quality Review vendor, and initiatives from the BMS senior management. This ongoing outreach will help ensure data quality is a topic of ongoing discussions between BMS, providers, and members, and will better inform data improvement efforts in real time so that adjustments can be made throughout the waiver period rather than only because of formal evaluations.

Recognizing the centrality of monitoring and evaluation activities to the 1115 waiver model, West Virginia recommends that other states implement similar structures and procedures to continually assess data quality. Consistent awareness of the data being gathered on a given program will lead to more accurate data, which in turn contribute to more accurate and comprehensive evaluations from which states can learn from and use to improve both program outcomes and data quality efforts.

As mentioned in Section H, BMS has learned from the evaluation data that care transitions between levels of care remains an area for continuous improvement. The waiver has helped in this area, as some providers acknowledged they felt the waiver improved communication and overall coordination. Still, other data points to disconnects in care transition. With this in mind, BMS will continue to prioritize care coordination and smooth transitions along the treatment continuum of care as core objectives of the existing and renewed demonstration.

Additionally, the preliminary years of the waiver have illuminated that PRSS delivery would benefit from a standardized certification for peer providers. BMS is currently undertaking a peer certification process to resolve educational and ethical issues encountered during the years of the waiver to date. Beginning October 1, 2022, the BMS will require the West Virginia Certification Board for Addiction & Prevention Professionals (WVCBAPP) Peer Recovery certification as credentials for all existing and new PRSS to be reimbursed for PRSS services. BMS will terminate its own certification process on September 30, 2022, and only those individuals possessing the WVCBAPP's Peer Recovery certification on October 1, 2022, will be eligible for reimbursement. BMS is providing this two-year period to assist those individuals having a BMS certification to transition to the WVCBAPP certification.

Finally, as has been mentioned several times throughout this report, the impact that the COVID-19 public health emergency has had on the waiver program and resulting impacts on enrolled members cannot be understated. As was the case for states across the country, BMS, providers, and all who work in healthcare alike pivoted to prioritize COVID-19 prevention and mitigation efforts. This emergent, dominant priority was necessary to keep people alive and safe facing the public health crisis. As a result of the focus and allocation of resources the COVID-19 response has required, degrees of attention and prioritization the 1115 waiver and other Medicaid programs held prior to the public health emergency were allocated to COVID-19 response.

The COVID-19 pandemic fundamentally changed the lives of too many Americans and has uprooted or collapsed many aspects of the healthcare system through its multiyear duration. Aside from the destruction it has caused and gaps in the system it has revealed, the pandemic also holds important lessons that Medicaid and the healthcare system at large can and should critically consider. The pandemic has revealed the general lack of and need for long-term planning for future public health emergencies; the current public health emergency is not the last the country will face, and there is an outstanding need to be better prepared for the next. Long-term planning should occur on both the micro level (such as ensuring healthcare facilities are well equipped with personal protective equipment) and the macro, national level (such as policies dictating funding streams to draw from when an emergency response requires it).

Attachments

[Appendix A: Evaluation Measures Table](#)

Table 4 Evaluation Design Table

| Logic Model Component | Measure Description | Steward | Numerator | Denominator | Data Source | Analytic Approach |
|---|---|---|---|---|-----------------|---------------------------|
| Demonstration Goal 1: Improve quality of care and population health outcomes for Medicaid enrollees with SUD. | | | | | | |
| Evaluation Question 1.1: What is the impact of the demonstration on quality of care for Medicaid enrollees? | | | | | | |
| Evaluation Hypothesis 1.1.1: The demonstration will improve the quality of SUD services delivered to Medicaid enrollees. | | | | | | |
| Intermediate Outcome | Initiation of alcohol and other drug (AOD) dependence treatment | 2019 Medicaid Adult Core Set, NQF #0004 | <p>Initiation: Count of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.</p> <p>If the Index Episode was an inpatient discharge (or an ED/observation visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the beneficiary is compliant.</p> <p>If the Index Episode was not an inpatient discharge, the beneficiary must initiate the treatment on the start date of the Index Episode or in the 13 days after the Index Episode (14 total days). Any of the following code combinations meet criteria for initiation:</p> <ul style="list-style-type: none"> An acute or nonacute inpatient admission with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions: <p>1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).</p> | <p>Beneficiaries who were diagnosed with a new episode of alcohol or drug dependency during the first 10 and ¼ months (January 1 – November 14) of the measurement year</p> <ul style="list-style-type: none"> The total AOD abuse or dependence rate is not a sum of the diagnosis cohorts. Count beneficiaries in the total denominator rate if they had at least one alcohol, opioid, or other drug abuse or dependence diagnosis during the measurement period. <p>Report beneficiaries with multiple diagnoses on the Index Episode claim only once for the total rate for the denominator.</p> <ul style="list-style-type: none"> Exclude beneficiaries from the denominator for both rates (initiation of AOD treatment and engagement of AOD treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year. Beneficiaries in hospice are excluded from the eligible population. | Medicaid Claims | Difference-in-differences |

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| Logic Model Component | Measure Description | Steward | Numerator | Denominator | Data Source | Analytic Approach |
|-----------------------|---------------------|---------|---|-------------|-------------|-------------------|
| | | | <p>2. Identify the admission date for the stay.</p> <ul style="list-style-type: none"> • IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set) • Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set with or without a telehealth modifier (Telehealth Modifier Value Set) • IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set with or without a telehealth modifier (Telehealth Modifier Value Set)A telephone visit (Telephone Visits Value Set) with a diagnosis | | | |

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| Logic Model Component | Measure Description | Steward | Numerator | Denominator | Data Source | Analytic Approach |
|-----------------------|---------------------------------|---|--|--|-----------------|---------------------------|
| | | | <p>matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set</p> <ul style="list-style-type: none"> • An online assessment (Online Assessments Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • If the Index Episode was for a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set) a medication treatment dispensing event (Medication Treatment for Alcohol Abuse or Dependence Medications List, see link to Medication List Directory in Guidance for Reporting above) or medication treatment during a visit (AOD Medication Treatment Value Set) • If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) a medication treatment dispensing event (Medication Treatment for Opioid Abuse or Dependence Medications List, see link to Medication List Directory in Guidance for Reporting above) or medication treatment during a visit (AOD Medication Treatment Value Set) | | | |
| Intermediate Outcome | Engagement of alcohol and other | 2019 Medicaid Adult Core Set, NOF #0004 | Engagement: Count of beneficiaries who initiated treatment and who had two or | Beneficiaries who were diagnosed with a new episode of alcohol or drug | Medicaid Claims | Difference-in-differences |

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| Logic Model Component | Measure Description | Steward | Numerator | Denominator | Data Source | Analytic Approach |
|-----------------------|---------------------------|---------|---|--|-------------|-------------------|
| | drug dependence treatment | | <p>more additional AOD services or medication treatment within 34 days of the initiation visit.</p> <p>Step 1. Identify all beneficiaries compliant for the initiation of AOD Treatment numerator. For beneficiaries who initiated treatment via an inpatient admission, the 34-day period for the two engagement visits begins the day after discharge.</p> <p>Step 2. Identify beneficiaries whose initiation of AOD treatment was a medication treatment event (AOD Medication Treatment Value Set; Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence Medications List).</p> <p>These beneficiaries are numerator compliant if they have two or more engagement events where only one can be an engagement medication treatment event.</p> <p>Step 3. Identify the remaining beneficiaries whose initiation of AOD treatment was not a medication treatment event (beneficiaries not identified in step 2). These beneficiaries are numerator compliant if they meet either of the following:</p> <ul style="list-style-type: none"> • At least two engagement visits • At least one engagement medication treatment event <p>Two engagement visits can be on the same date of service but they must be with different providers in order to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets</p> | <p>dependency during the first 10 and ½ months (January 1 – November 14) of the measurement year</p> <ul style="list-style-type: none"> • The total AOD abuse or dependence rate is not a sum of the diagnosis cohorts. Count beneficiaries in the total denominator rate if they had at least one alcohol, opioid, or other drug abuse or dependence diagnosis during the measurement period. <p>Report beneficiaries with multiple diagnoses on the Index Episode claim only once for the total rate for the denominator.</p> <ul style="list-style-type: none"> • Exclude beneficiaries from the denominator for both rates (initiation of AOD treatment and engagement of AOD treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year. • Beneficiaries in hospice are excluded from the eligible population. | | |

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| Logic Model Component | Measure Description | Steward | Numerator | Denominator | Data Source | Analytic Approach |
|-----------------------|---------------------|---------|---|-------------|-------------|-------------------|
| | | | <p>criteria (there is no requirement that they be with different providers).</p> <p>Any of the following meet criteria for an engagement visit:</p> <ul style="list-style-type: none"> • An acute or nonacute inpatient admission with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions: <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay. • IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set) • Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • IET Visits Group 1 Value Set with IET POS Group 1 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid | | | |



| Logic Model Component | Measure Description | Steward | Numerator | Denominator | Data Source | Analytic Approach |
|-----------------------|---------------------|---------|--|-------------|-------------|-------------------|
| | | | <p>Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set)</p> <ul style="list-style-type: none"> • IET Visits Group 2 Value Set with IET POS Group 2 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set) • A telephone visit (Telephone Visits Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An online assessment (Online Assessments Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set <p>Either of the following meets criteria for an engagement medication treatment event:• If the IESD diagnosis was a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), one or more medication treatment dispensing events or medication treatment during a visit (AOD Medication Treatment Value Set),</p> | | | |

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| Logic Model Component | Measure Description | Steward | Numerator | Denominator | Data Source | Analytic Approach |
|-----------------------|-----------------------------------|---|---|--|-----------------|---------------------------|
| | | | <p>beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Alcohol Abuse and Dependence Treatment.</p> <ul style="list-style-type: none"> If the IESD diagnosis was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), one or more medication dispensing events (Medication Treatment for Opioid Abuse or Dependence Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Opioid Abuse and Dependence Treatment. | | | |
| Intermediate Outcome | Medication Assisted Treatment use | Mathematica Policy Research Technical Specifications for Monitoring Metrics | <p>The number of unique beneficiaries (de-duplicated total) who have a claim for a MAT dispensing event for SUD during the measurement period</p> <p>Step 1. Identify claims with a code from the following HEDIS 2018 medications lists:</p> <ul style="list-style-type: none"> MAT for Alcohol Abuse or Dependence Medications List MAT for Opioid Abuse or Dependence Medications List <p>Step 2. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Step 1.</p> | All Medicaid beneficiaries with SUD, enrolled for any amount of time during the measurement period | Medicaid claims | Difference-in-differences |

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|--|---|--------------|--|---|------------------|---|
| | Continuity of pharmacotherapy for OUD | NQF #3175 | Number of participants who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days | Individuals who had a diagnosis of OUD and at least one claim for an OUD medication | Claims data | Difference-in-differences |
| | Percentage of beneficiaries with an SUD diagnosis (including beneficiaries with an OUD diagnosis) who used SUD services per month | None | Number of enrollees who receive a service during the measurement period by service type | Number of enrollees | Claims data | Descriptive statistics, Difference-in-differences |
| | Time to treatment | NBHQF Goal 1 | Sum of (date of clinical assessment- date of 1 st contact) | Number of clinical assessments | Claims data | Descriptive statistics, difference-in-differences |
| | Rate of continuation of treatment | NBHQF Goal 1 | Sum of (date of first treatment service-date of clinical assessment) | Number of enrollees receiving treatment | Claims data | Descriptive statistics, difference-in-differences |
| | Length of engagement in treatment | NBHQF Goal 1 | Number of clients completing 4 th treatment session within 30 days | Number of enrollees receiving treatment | Claims data | Descriptive statistics, difference-in-differences |
| Evaluation Hypothesis 1.1.2: The demonstration will increase provider knowledge of appropriate SUD treatment options. | | | | | | |
| Activities | Provider knowledge | | Degree to which focus group members (providers) demonstrate changes in ability to correctly | | Focus group data | |

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| Logic Model Component | Measure Description | Steward | Numerator | Denominator | Data Source | Analytic Approach |
|--|--|--|---|---|---|---|
| | | | Identify the expanded treatment mechanisms as a result of state-run trainings | | | |
| Evaluation Question 1.2: What is the impact of the demonstration on population health outcomes among Medicaid enrollees? | | | | | | |
| Evaluation Hypothesis 1.2.1: The demonstration will decrease morbidity and mortality among Medicaid enrollees and their children. | | | | | | |
| Program Goal | Mortality rate among beneficiaries with SUD | | Number of all-cause deaths among beneficiaries diagnosed with SUD during the measurement period | All Medicaid beneficiaries with SUD, enrolled for any amount of time during the measurement period | Medicaid claims data supplemented with Death certificate data | Difference-in-differences Interrupted time series for death certificate data |
| Program Goal | Drug-related mortality (due to any drug and also due to opioids alone) | Mathematica Policy Research Technical Specifications for Monitoring Metrics | <p>Number of drug poisoning deaths during the measurement period.</p> <p>As recommended by Mathematica, we will report the cause of overdose death as specifically as possible using underlying and contributing cause of death codes where available (for example, prescription vs. illicit opioid)</p> <p>Identify beneficiaries with the following ICD-10 underlying cause of death codes:</p> <ul style="list-style-type: none"> • X40 – X44 (unintentional drug poisonings) • X60-X64 (suicidal drug poisonings) • X85 (homicide drug poisoning) • Y10-Y14 (drug poisoning of undetermined intent) <p>Opioid-related drug overdoses can be reported separately as follows: Among all drug poisoning deaths identify those with the following ICD-10 contributing cause of death codes::</p> <ul style="list-style-type: none"> • T40.1 (heroin) • T40.2 (natural and semisynthetic opioids) • T40.3 (methadone) | All Medicaid beneficiaries with SUD, enrolled for at least one month (30 consecutive days) during the measurement period. Number of beneficiaries/1000 | Medicaid claims data, supplemented with vital statistics mortality data, which contain underlying and contributing cause of death codes. Prior to 2018 these data only include underlying cause of death codes. For all deaths occurring after 1/1/18, these data include both underlying and contributing cause of death codes | Difference-in-differences Interrupted time series for death certificate data |

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| Logic Model Component | Measure Description | Steward | Numerator | Denominator | Data Source | Analytic Approach |
|-----------------------|---|--|--|--|------------------------|----------------------------------|
| Program Goal | <p>Medicaid Beneficiaries with SUD Diagnosis (monthly and annually)</p> <p>[Note: this is to measure SUD morbidity, not treatment rates.]</p> | <p>Mathematica Policy Research Technical Specifications for Monitoring Metrics</p> | <p>• T40.4 (synthetic opioids other than methadone)"</p> <p>The number of unique beneficiaries (de-duplicated total) enrolled in the measurement period who receive MAT or have qualifying facility, or professional claims with a SUD diagnosis and a SUD-related treatment during the measurement period and/or in the 11 months before the measurement period</p> <p>Step 1. Identify claims for MAT, defined in one of the following HEDIS 2018 IET value sets or medications lists:</p> <ul style="list-style-type: none"> • Medication Assisted Treatment Value Set • MAT for Alcohol Abuse or Dependence Medications List • MAT for Opioid Abuse or Dependence Medications List <p>Step 2. Identify claims with a diagnosis code (any diagnosis on the claim) listed under one of the following HEDIS 2018 Value Sets:</p> <ul style="list-style-type: none"> • Alcohol Abuse and Dependence • Opioid Abuse and Dependence • Other Drug Abuse and Dependence <p>In addition to a diagnosis code above, the claim must also have a procedure code from any of the following HEDIS 2018 IET value set for identifying SUD treatment:</p> <ul style="list-style-type: none"> • IET Stand Alone Visits • IET Visits Group 1 with IET POS Group 1 • IET Visits Group 2 with IET POS Group 2 • Detoxification • ED | <p>All Medicaid beneficiaries, enrolled for any amount of time during the measurement period</p> | <p>Medicaid claims</p> | <p>Difference-in-differences</p> |



| Logic Model Component | Measure Description | Steward | Numerator | Denominator | Data Source | Analytic Approach |
|-----------------------|---|---------|--|---|--|---|
| | | | <ul style="list-style-type: none"> Inpatient Stay Telephone Visits Online Assessments <p>Step 3. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Step 1 or Step 2.</p> | | | |
| Program Goal | Neonatal abstinence syndrome morbidity | | Number of infants meeting NAS criteria, born to Medicaid enrollees during measurement period | Infants born to Medicaid enrollees during the measurement period | Medicaid claims WV Birth Score Data | Difference-in-differences |
| Program Goal | HIV morbidity | | Number of Medicaid enrollees with a diagnosis of HIV during the measurement period | All Medicaid beneficiaries enrolled for any amount of time during the measurement period [We are looking at the whole Medicaid population as a denominator, because transmission is not limited to needles.] | Medicaid claims | Difference-in-differences |
| Program Goal | Hepatitis C morbidity | | Number of Medicaid enrollees with a diagnosis of Hepatitis C during the measurement period | All Medicaid beneficiaries enrolled for any amount of time during the measurement period [We are looking at the whole Medicaid population as a denominator, because transmission is not limited to needles.] | Medicaid claims | Difference-in-differences |
| | Access to preventive / ambulatory health services for adult Medicaid beneficiaries with SUD | NCQA | Number of beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period | Number of beneficiaries with an SUD diagnosis | Claims data | Descriptive statistics, difference-in-differences |

| | | | | | | |
|--|-----------------------------|------|---|--|-------------|---|
| | Plan All-cause readmissions | None | At least one acute unplanned readmission for any diagnosis within 30 days of the date of discharge from the index hospital stay, that is on or between the second day of the measurement year and the end of the measurement year | Medicaid beneficiaries age 18 and older with a discharge from an acute inpatient stay (index hospital stay) on or between January 1 and December 1 of the measurement year | Claims data | Descriptive statistics, difference-in-differences |
|--|-----------------------------|------|---|--|-------------|---|

Demonstration Goal 2: Increase enrollee access to and use of appropriate SUD treatment services based on the ASAM Criteria..

Evaluation Question 2.1: What is the impact of the demonstration on access to SUD treatment among Medicaid enrollees?

Evaluation Hypothesis 2.1.1: The demonstration will increase the supply of residential, MAT, and PRSS care available for Medicaid enrollees.

| | | | | | | |
|--------|--|-----|---|--|---|-------------------------|
| Output | Supply of SUD providers | N/A | Providers who were enrolled in Medicaid and delivered SUD treatment services during the measurement period. This will be calculated as the count of distinct providers who either prescribed MAT or delivered behavioral health treatment services with a primary diagnosis of SUD listed on the professional claim | Total number of providers enrolled with Medicaid during the measurement period | Medicaid claims and provider enrollment data | Interrupted time series |
| Output | Supply of SUD residential treatment facilities | N/A | Number of residential SUD treatment facilities that have been credentialed to deliver services consistent with ASAM Levels 3.1, 3.5, and/or 3.7 | | Monthly internal reports submitted to the Bureau for Medical Services | Interrupted time series |
| Output | Supply of SUD residential treatment beds | N/A | Number of residential SUD treatment beds that have been certified as delivering care consistent with ASAM Levels 3.1, 3.5, and/or 3.7 | | Monthly internal reports submitted to the Bureau for Medical Services | Interrupted time series |

| Logic Model Component | Measure Description | Steward | Numerator | Denominator | Data Source | Analytic Approach |
|---|---|--|---|--|--|---------------------------|
| Intermediate Outcome | Buprenorphine prescriber availability | | The total number of Medicaid enrolled providers who have a DEA x-license and have also been approved by BMS to prescribe buprenorphine | N/A | BMS approved buprenorphine prescriber list | Interrupted time series |
| Output | Peer recovery support specialist availability | | Percentage of peer recovery coaches that are certified through a West Virginia Department of Health and Human Resources-approved training program that provides peer support providers with a basic set of competencies necessary to perform the peer support function. | | Monthly internal reports submitted to BMS | Interrupted time series |
| Evaluation Question 2.2: What is the impact of the demonstration on use of SUD treatment among Medicaid enrollees? | | | | | | |
| Evaluation Hypothesis 2.2.1: The demonstration will increase the use of residential, MAT, and PRSS care available by Medicaid enrollees. | | | | | | |
| Intermediate Outcome | Outpatient services for SUD treatment | Measure Set/Endorsement: Mathematica Policy Research Technical Specifications for Monitoring Metrics | <p>The number of unique beneficiaries (de-duplicated total) with a service or pharmacy claim for outpatient services for SUD (such as outpatient counseling or motivational enhancement therapies, step-down care, and monitoring for stable patients) during the measurement period</p> <p>Step 1. Identify claims with a diagnosis code (any diagnosis on the claim) listed under one of the following HEDIS 2018 Value Sets:</p> <ul style="list-style-type: none"> Alcohol Abuse and Dependence Opioid Abuse and Dependence Other Drug Abuse and Dependence <p>Step 2. Retain claims with a procedure code from any of the following IAD HEDIS 2018 Value Sets:</p> <ul style="list-style-type: none"> IAD Stand-Alone Outpatient Value Set Observation Value Set BH Visit Setting Unspecified Value Set with a corresponding | All Medicaid beneficiaries with SUD, enrolled for any amount of time during the measurement period | | Difference-in-differences |



| Logic Model Component | Measure Description | Steward | Numerator | Denominator | Data Source | Analytic Approach |
|-----------------------|--|---------|--|--|-----------------|---------------------------|
| | | | <p>code from Outpatient POS Value Set</p> <ul style="list-style-type: none"> BH Visit Setting Unspecified Value Set with a corresponding code from POS 53 Value Set <p>o States should ensure that the visit was in an outpatient setting including any of the above services billed with a code from the Telehealth Modifier Value Set.</p> <p>Step 3. Exclude any claims with a code in the Detoxification HEDIS 2018 Value Set.</p> <p>Step 4. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Steps 1, 2 and 3.</p> | | | |
| Intermediate Outcome | Residential services for SUD treatment | N/A | <p>The total number of unique beneficiaries (de-duplicated total) who receive residential treatment services consistent with ASAM Levels 3.1, 3.5, and/or 3.7</p> <p>Step 1. Identify claims for residential treatment using CPT codes:</p> <ul style="list-style-type: none"> H2036 U1 HF : ASAM Level 3.1 residential services H2036 U5 HF : ASAM Level 3.5 residential services H2036 U7 HF : ASAM Level 3.7 residential services <p>Step 2. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Steps 1.</p> | All Medicaid beneficiaries with SUD, enrolled for any amount of time during the measurement period | Medicaid Claims | Difference-in-differences |

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| Logic Model Component | Measure Description | Steward | Numerator | Denominator | Data Source | Analytic Approach |
|---|---|--|---|---|-----------------|---------------------------|
| Intermediate Outcome | Methadone use among beneficiaries with OUD (Adapted from "Use of pharmacotherapy for opioid use disorder (OUD)") | NQF #3400 (Steward: CMS) | Beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered a methadone prescription for the disorder during the measure year. | Number of Medicaid beneficiaries with at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year. | Medicaid claims | Difference-in-differences |
| Output | Peer recovery support specialist use | | Number of Medicaid enrollees with SUD diagnosis (appropriate for peer recovery treatment) receiving peer recovery treatment | Number of Medicaid enrollees with SUD diagnosis (appropriate for peer recovery treatment) | Medicaid Claims | Time series |
| Demonstration Goal 3: Decrease emergency department and hospital services by enrollees with SUD. | | | | | | |
| Evaluation Question 3.1: What is the impact of the demonstration on emergency department (ED) utilization by Medicaid enrollees with SUD? | | | | | | |
| Evaluation Hypothesis 3.1.1: The demonstration will decrease the rate of ED use and the percentage of ED visits that are non-emergent among Medicaid enrollees with SUD. | | | | | | |
| Intermediate Outcome | All-cause ED use among beneficiaries with SUD | Adapted from Mathematica Policy Research Technical Specifications for Monitoring Metrics, Metric #23 | Number of ED visits among during the measurement period Step 1. Identify all claims for ED visits during the measurement period. Count each visit to an ED once, regardless of the intensity or duration of the visit. Step 2. Identify the date of service for each visit identified in Step 1. Retain only visits with dates of service that fall within the measurement period. Count multiple ED visits on the same date of service as one visit. | All Medicaid beneficiaries with SUD, enrolled for any amount of time during the measurement period | Medicaid claims | Difference-in-differences |
| Intermediate Outcome | ED Utilization for SUD per 1,000 Medicaid Beneficiaries with SUD | Measure Set/Endorsement: Mathematica Policy Research Technical Specifications for Monitoring Metrics | The number of ED visits for SUD during the measurement period Step 1. Identify all claims for ED visits during the measurement period using the HEDIS 2018 ED Value Set. Count each visit to an ED once, regardless of the intensity or duration of the visit. | All Medicaid beneficiaries with SUD, enrolled for at least one month (30 consecutive days) during the measurement period. | Medicaid claims | Difference-in-differences |



| Logic Model Component | Measure Description | Steward | Numerator | Denominator | Data Source | Analytic Approach |
|---|--|--|--|---|-----------------|---------------------------|
| | | | <p>Step 2. Identify the date of service for each visit identified in Step 1. Retain only visits with dates of service that fall within the measurement period. Count multiple ED visits on the same date of service as one visit.</p> <p>Step 3. Identify the subset of claims with a diagnosis code (any diagnosis on the claim) listed under one of the following HEDIS 2018 Value Sets:</p> <ul style="list-style-type: none"> • Alcohol Abuse and Dependence • Opioid Abuse and Dependence • Other Drug Abuse and Dependence <p>Step 4. Calculate the number of visits using all visits identified in Steps 1, 2 and 3.</p> | | | |
| Intermediate Outcome | Non-SUD non-emergent ED use | NYU ED Algorithm | <p>Percentage of ED visits classified as non-emergent using the NYU ED Algorithm. The algorithm reports a percentage of total visits.</p> <p>Note: Because all drug and alcohol visits are carved out from the algorithm, we are only able to measure non-drug related ED visits.</p> | Because the algorithm reports a percentage of total visits, we do not include a denominator here. Instead, we highlight our population of interest, on whose claims we will run the algorithm: All Medicaid beneficiaries with SUD, enrolled for any amount of time during the measurement period | Medicaid claims | Difference-in-differences |
| Intermediate Outcome | Emergency department visits for SUD-related diagnoses and specifically for OUD | None (from page B.8 from CMS SMI/SED and SUD evaluation design guidance, Appendix B) | The number of ED visits for SUD during the measurement period | Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period | Medicaid claims | Difference-in-differences |
| Evaluation Question 3.2: What is the impact of the demonstration on inpatient hospital use by Medicaid enrollees with SUD? | | | | | | |



| Evaluation Hypothesis 3.2.1: The demonstration will decrease hospital admissions among Medicaid enrollees with SUD. | | | | | | |
|---|--|---|---|--|------------------|------------------------------------|
| Intermediate Outcome | Inpatient stays for SUD (and specifically for OUD) | Mathematica Policy Research Technical Specifications for Monitoring Metrics | Number of beneficiaries with an inpatient admission for SUD (and specifically for OUD) | Total number of beneficiaries/1,000 member months | | Difference-in-differences |
| Demonstration Goal 4: Improve care coordination and care transitions for Medicaid enrollees with SUD | | | | | | |
| Evaluation Question 4.1: What is the impact of the demonstration on the integration of physical and behavioral health care among Medicaid enrollees with SUD and comorbid conditions? | | | | | | |
| Evaluation Hypothesis 4.1.1: The demonstration will increase the rate of Medicaid enrollees with SUD-related physical health conditions who are also receiving behavioral care. | | | | | | |
| Output | Separate analyses for each of the following measures, as defined above: Medication Assisted Treatment Initiation of Alcohol and Other Drug Treatment Engagement of Alcohol and Other Drug Treatment | See above | See above | Medicaid enrollees with SUD diagnosis and comorbid hepatitis C | Medicaid Claims | Difference-in-differences analysis |
| Output | Separate analyses for each of the following measures, as defined above: Medication Assisted Treatment Initiation of Alcohol and Other Drug Treatment | See above | See above | Medicaid enrollees with SUD diagnosis and comorbid HIV | Medicaid Claims | Difference-in-differences analysis |
| Logic Model Component | Measure Description | Steward | Numerator | Denominator | Data Source | Analytic Approach |
| | Engagement of Alcohol and Other Drug Treatment | | | | | |
| Evaluation Question 4.2: What is the impact of the demonstration on care transitions among Medicaid enrollees with SUD? | | | | | | |
| Evaluation Hypothesis 4.2.1: The demonstration will improve communication among providers who transition patients to other providers. | | | | | | |
| Activities | Communication among providers | | Degree to which focus group members (providers) express in levels of communication difficulties with other providers. | | Focus group data | |

Table 5 Changes to Evaluation Plan Measures Table as of November 2021

| Measure(s) | Original Definition/Analysis | Current Definition/Analysis |
|---|---|---|
| All measures that include definition for SUD, OUD, or AUD | Only included codes from HEDIS value set. | Also includes overdose codes related to each substance. |

| | | |
|---|---|---|
| Percent of beneficiaries with SUD diagnosis who used SUD services per month | Denominator was total number of enrollees. Numerator in WV vs. State A comparison included methadone. | Denominator is now number of enrollees with SUD. Numerator in WV vs. State A comparison no longer includes methadone (not covered by State A Medicaid). |
| Time to treatment | -- | Removed from measures table because the date of first contact was not available in the claims data. |
| Mortality rate among beneficiaries with SUD | Difference-in-differences between WV and State A. | In-state difference-in-differences of all-cause mortality rate among those with SUD diagnosis and all-cause mortality rate among those without a SUD diagnosis. |
| Drug-related mortality | Difference-in-differences between WV and State A. | In-state difference-in-differences of drug-related and non-drug-related mortality rates, as well as and opioid and other drug mortality rates. |
| Outpatient services for SUD treatment | Did not include procedure codes for methadone, buprenorphine, naltrexone, and PRSS in the numerator. | Includes procedure codes for methadone, buprenorphine, naltrexone, and PRSS in the numerator. |
| Residential services for SUD treatment | Numerator used the H2036 code with the following modifiers to identify claims : <ul style="list-style-type: none"> • U1 HF : ASAM Level 3.1 residential services • U5 HF : ASAM Level 3.5 residential services • U7 HF : ASAM Level 3.7 residential services | Numerator uses the H2036 code without modifiers because the modifiers inaccurate in the claims data. |
| Inpatient stays for SUD (and | One measure defined as number of beneficiaries with an inpatient admission for SUD | Three separate measures, defined as: |

| | | |
|------------------------------|---|---|
| <p>specifically for OUD)</p> | <p>(and specifically for OUD) over the total number of beneficiaries/1,000 member months.</p> | <ul style="list-style-type: none"> • Number of all-cause inpatient stays over the number of beneficiaries with SUD. • Number of SUD-related inpatient stays over the number of beneficiaries with SUD. • Number of OUD-related inpatient stays over the number of beneficiarie with OUD. |
|------------------------------|---|---|

Appendix B: Interview Instrument

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Medicaid 1115 SUD Waiver Evaluation Provider Interview Guide

Introductory Script

"Thank you again for taking the time to discuss the impact of the Medicaid 1115 substance use disorder (SUD) waiver demonstration on care transitions among Medicaid enrollees with SUD. Over the next hour I will be asking you a series of questions about your experience with transitioning your Medicaid patients with substance use disorder to other providers. Everything we discuss will remain confidential, and I will not identify you or your facility by name in any publications that may result from this qualitative research evaluation. As a reminder, participation in this study is entirely voluntary and you can choose to stop at any time without penalty. This research study has been reviewed and acknowledged by the WVU Institutional Review Board."

"Would you like to begin the interview?"

If NO: "I understand. Thank you again for letting me visit today. Have a nice day."

If YES: "Great! To help me remember everything we discuss, I would like to audio record our interview, which will be transcribed and analyzed. Would it be okay if I audio recorded our interview today?"

If NO: "I understand. Would it be okay if I wrote some notes during our interview?"

If YES: "Great! Let's get started. I'm going to turn the audio recorder on now." [Turn on audio recorder]

Guiding Questions

1. Can you tell me a little bit about the 1115 substance use disorder (SUD) waiver the state has implemented? [Probe for knowledge of waiver specifics (i.e., expanded treatment beds, peer recovery coaches, methadone clinics)]
2. Can you tell me a little bit about your experience with communication among providers about the care of Medicaid patients with substance use disorder? [Probe for difficulties or challenges (i.e., knowledge of eligibility criteria and/or available facilities, lack of direct referral process, time taken to complete the referral/**any changes from before 1115 waiver implementation**/facilitators (i.e., EHR systems or IT solutions)/ 42 CFR Part 2)
3. To help me better understand the context, can you tell me a little bit about situations that have typically influenced or affected your experiences with transitioning patients to other providers after the 1115 waiver implementation? [Probe for communication difficulties/**changes (positive and negative) from the 1115 waiver implementation**; relapse temptations or challenges among PRSS]
4. Can you tell me a little bit about how the COVID 19 pandemic has affected SUD treatment? [Probe for lessons learned; bed restrictions from 1115 waiver disaster emergency declaration; telehealth implementation to facilitate provider communication, specific platforms used, length of sessions, retention rates, difficulties encountered, impact on care communication, etc.]
5. Can you talk a little bit about the impact of multiple rural hospital closures on SUD treatment services?

"Thank you sincerely for your time today. Once the data are analyzed, could I speak with you again regarding the results to get your thoughts. Have a nice day." Where do you want your gift cards mailed?

Appendix C: Treatment-Related Outcomes

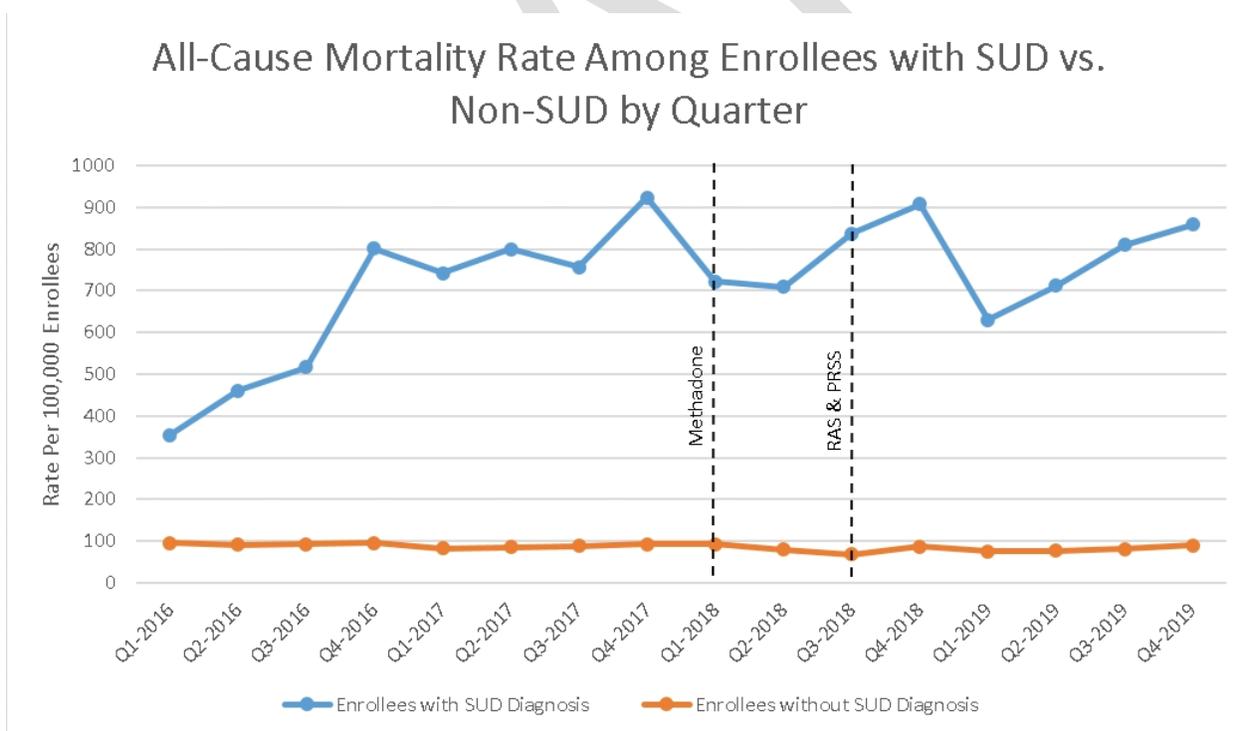
This section includes measures originally outlined in the evaluation plan to assess treatment-related waiver outcomes. As noted in the corresponding report segment, we ask readers to interpret them with appropriate caution due to related data quality issues.

We hypothesized that the waiver demonstration would result in lower morbidity and mortality rates among enrollees with SUD, including lower rates of inpatient hospital stays. Preliminary findings suggest this has not been the case. The following measures investigate morbidity and mortality rates among the SUD population in more detail.

Mortality rate among beneficiaries with and without SUD

The WVU team analyzed the all-cause mortality rate among beneficiaries with SUD and compared it to all-cause mortality among enrollees without SUD in WV. While the mortality rate for enrollees without SUD remained relatively constant throughout the study period, there was more fluctuation in the mortality rate among enrollees with a SUD diagnosis, which could be due to the smaller sample size of the SUD population. We are planning to use enrollees without a SUD diagnosis as a control group for a difference-in-differences analysis in the next iteration of this report.

Figure J1 All-Cause Mortality Rate Among Enrollees with SUD by Quarter (EQ 1.2, EH 1.2.1)

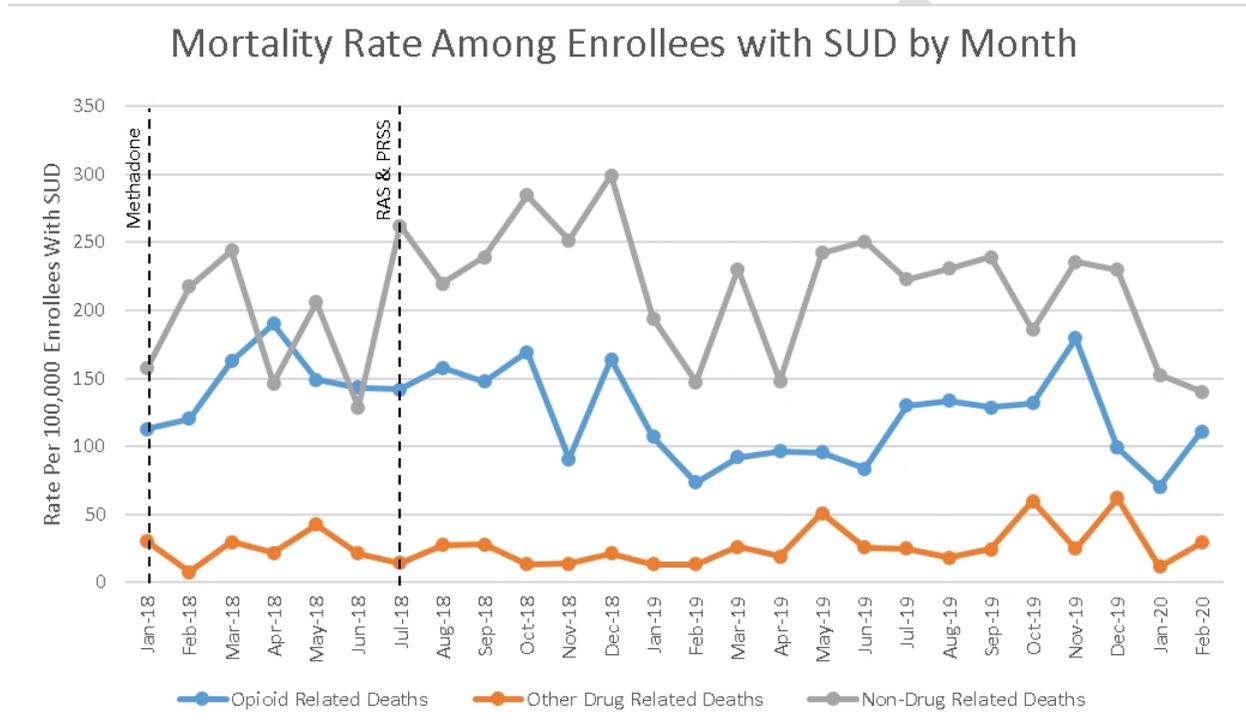


Drug-related mortality (due to any drug/ due to opioids alone)

These measures capture trends from the beginning of the waiver (January 2018) to February 2020. Cause of death data are not available prior to 2018. The blue line in Figure F18 indicates the opioid-

related mortality rate, and the orange line indicates the mortality rate for all other drugs. The opioid-related mortality rate decreases over 2018, with the lowest dip in February 2019 (73.65 deaths per 100,000 enrollees with SUD), but increases again between then and the end of the period of analysis (February 2020), at which point deaths were occurring at a rate of 111 deaths per 100,000 enrollees with SUD.

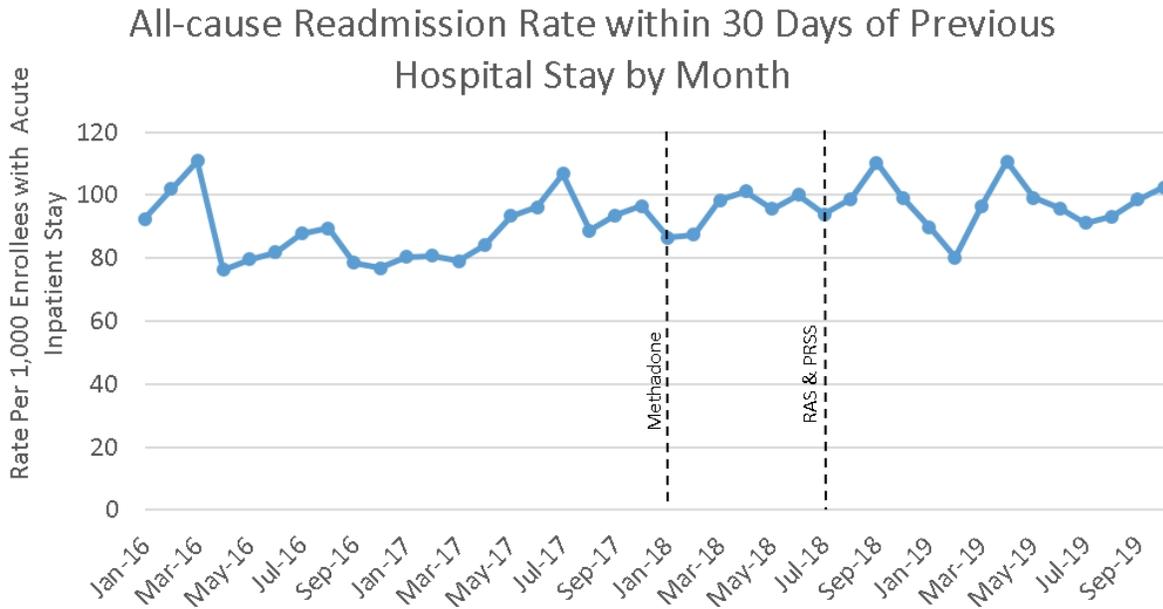
Figure J2 Opioid-Related Mortality Rate Among Enrollees with SUD by Month (EQ 1.2, EH 1.2.1)



Plan all-cause readmissions

This measure omits November and December data for each year because the denominator only includes dates between January 1 and December 1 for each year. The numerator is defined as readmission within 30 days, so we exclude index dates in November to account for the omission of December readmission data. We do not observe a clear trend in readmission rates comparing the pre-waiver period to the post-waiver period in WV.

Figure J3 All-Cause Readmission Rate within 30 Days of Previous Hospital Stay by Month (EQ 1.2, EH 1.2.1)



Inpatient stays for SUD & OUD

Except for a sharp increase in May 2019, inpatient stays appear to have leveled off after the waiver, marking an end to a decline that had been occurring since prior to the waiver implementation.

Figure J4 All Cause Inpatient Stays Among Enrollees with SUD Diagnosis by Month (EQ 3.2, EH 3.2.1)

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All-Cause Inpatient Stays Among Enrollees with SUD Diagnosis by Month

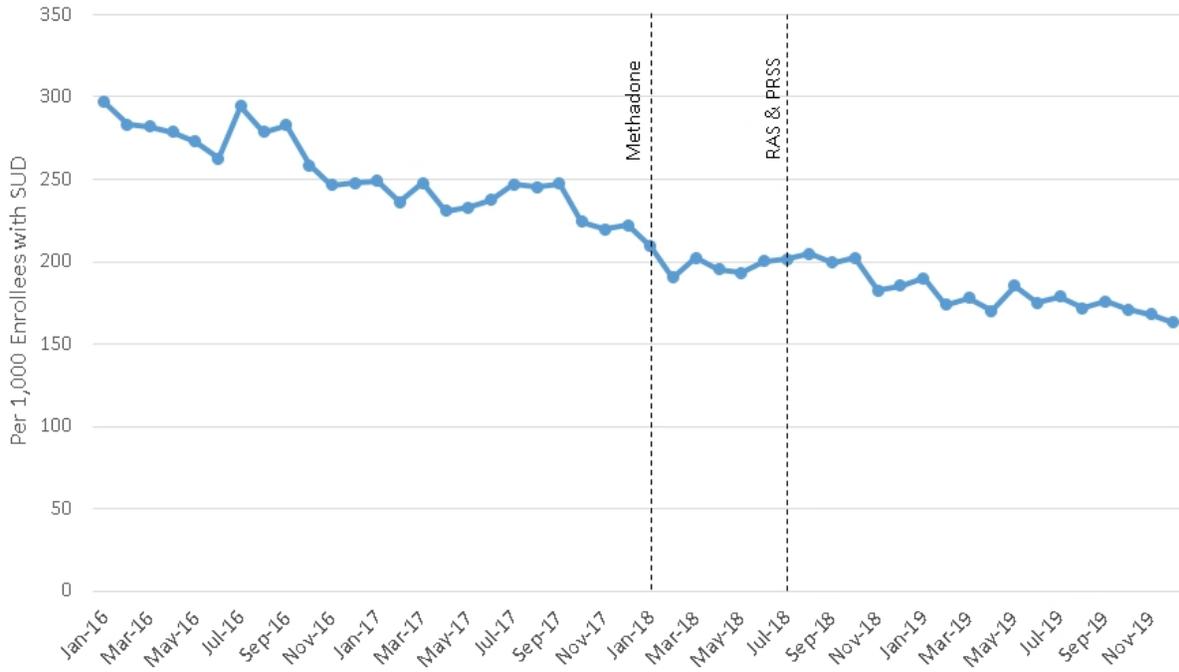


Figure J5 Inpatient Stays for OUD Among Enrollees with OUD Diagnosis by Month (EQ 3.2, EH 3.2.1)

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Inpatient Stays for OUD Among Enrollees with OUD Diagnosis by Month

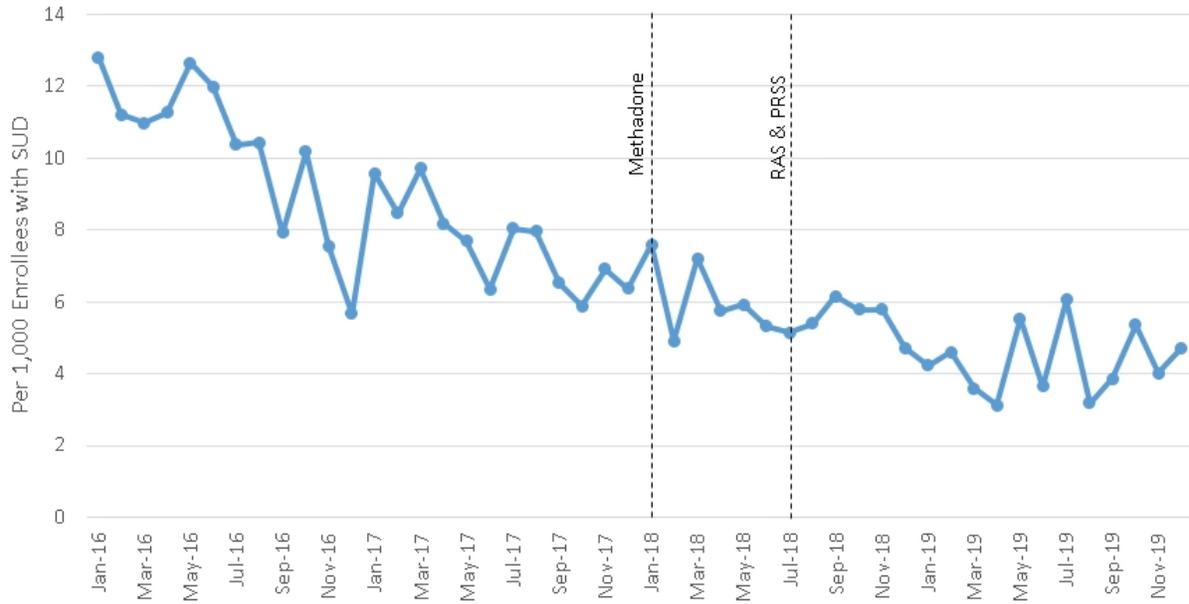
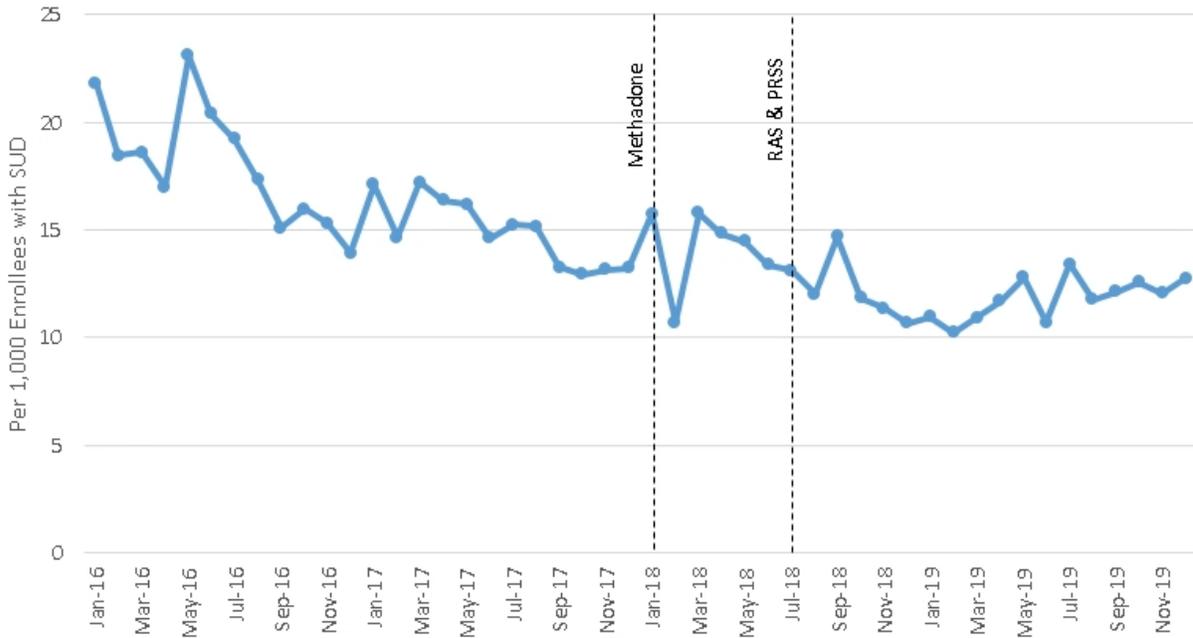


Figure J6 Inpatient Stays for SUD Among Enrollees with SUD Diagnosis by Month (EQ 3.2, EH 3.2.1)

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Inpatient Stays for SUD Among Enrollees with SUD Diagnosis by Month



ED use among beneficiaries with SUD

We hypothesized that the waiver demonstration would decrease the rate of ED use among Medicaid enrollees with SUD. Preliminary data shows that all-cause ED use among beneficiaries with SUD has decreased over time, but only by a rate of about 30 per 1,000 enrollees with SUD from the beginning of the waiver to December 2019. A larger decrease is observed in the pre-waiver implementation period, with the rate decreasing by about 78 per 1,000 enrollees with SUD between January 2016 and the onset of the waiver. It appears that ED utilization for OUD among enrollees with OUD or utilization for SUD among enrollees with SUD leveled out after the onset of the waiver, marking an end to a downward trend that was occurring in the pre period.

Figure J7 All-cause ED Utilization Among Enrollees with SUD Diagnosis by Month (EQ 3.1, EH 3.1.1)

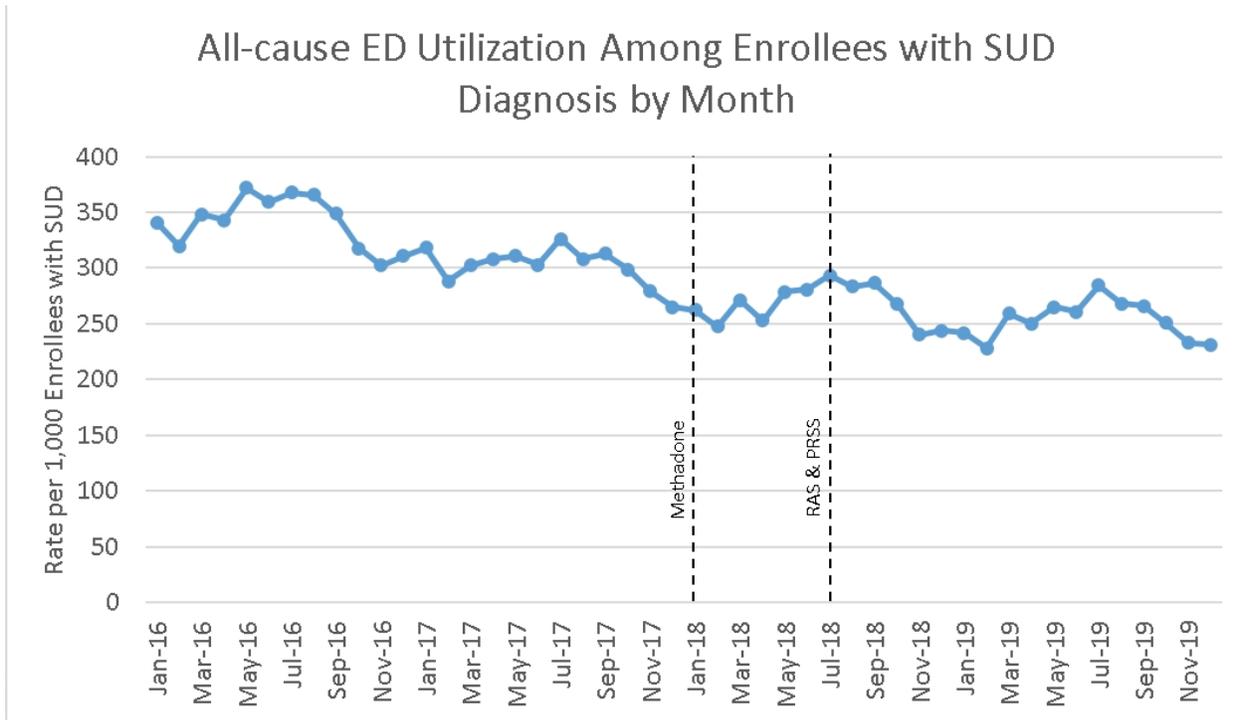


Figure J8 ED Utilization for OUD Among Enrollees with OUD Diagnosis by Month (EQ 3.1, EH 3.1.1)

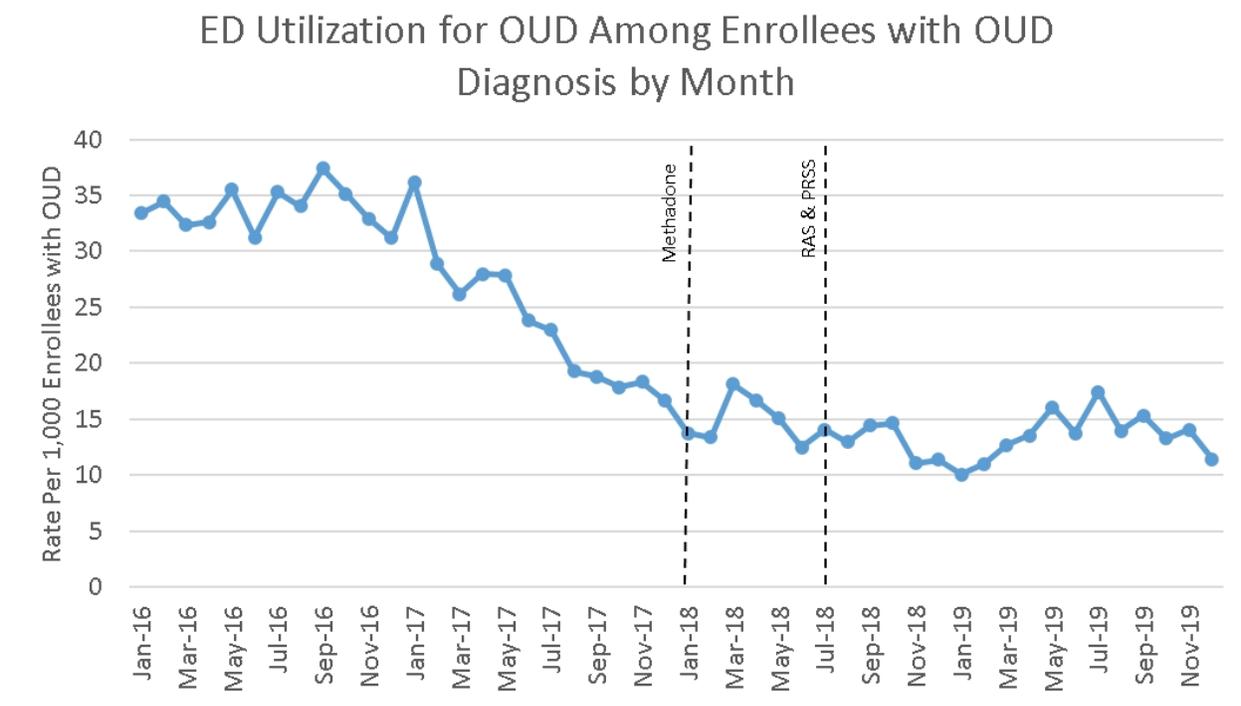
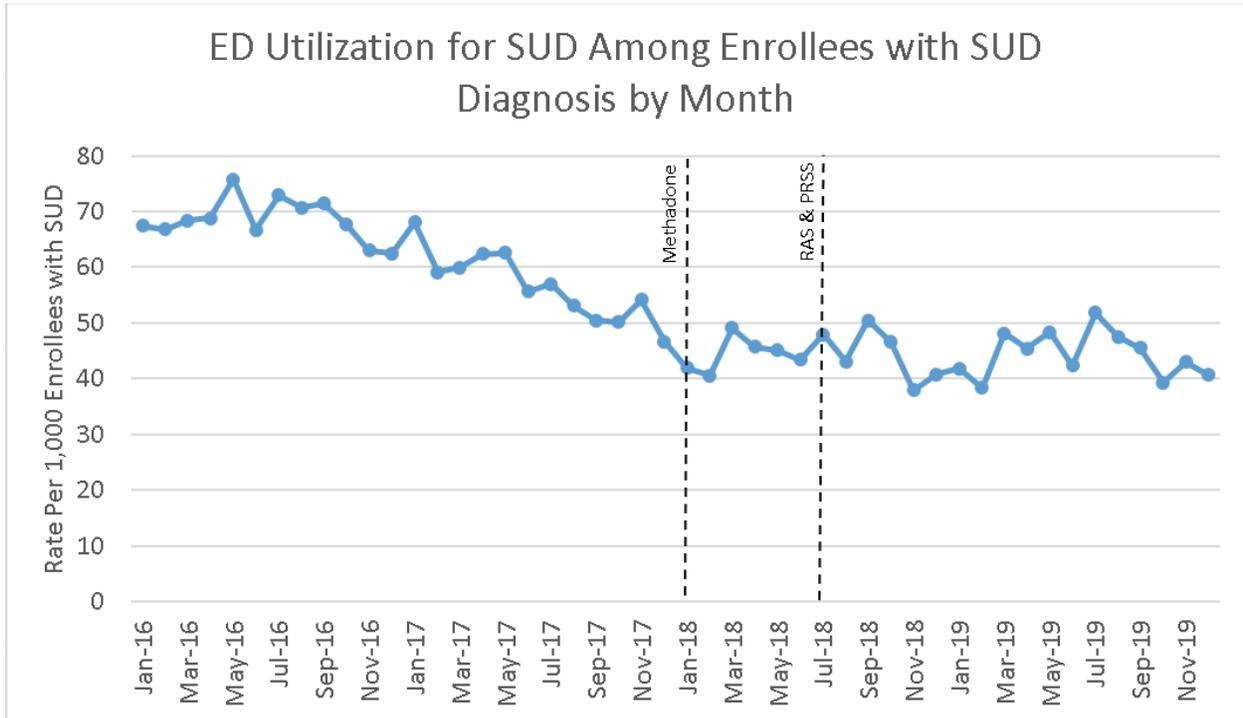


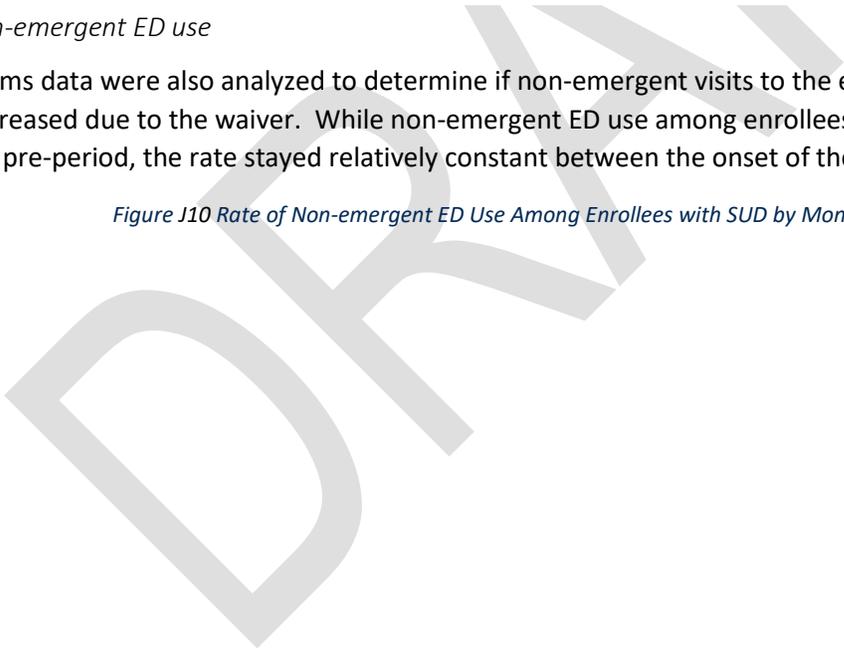
Figure J9 ED Utilization for SUD Among Enrollees with SUD Diagnosis by Month (EQ 3.1, EH 3.1.1)



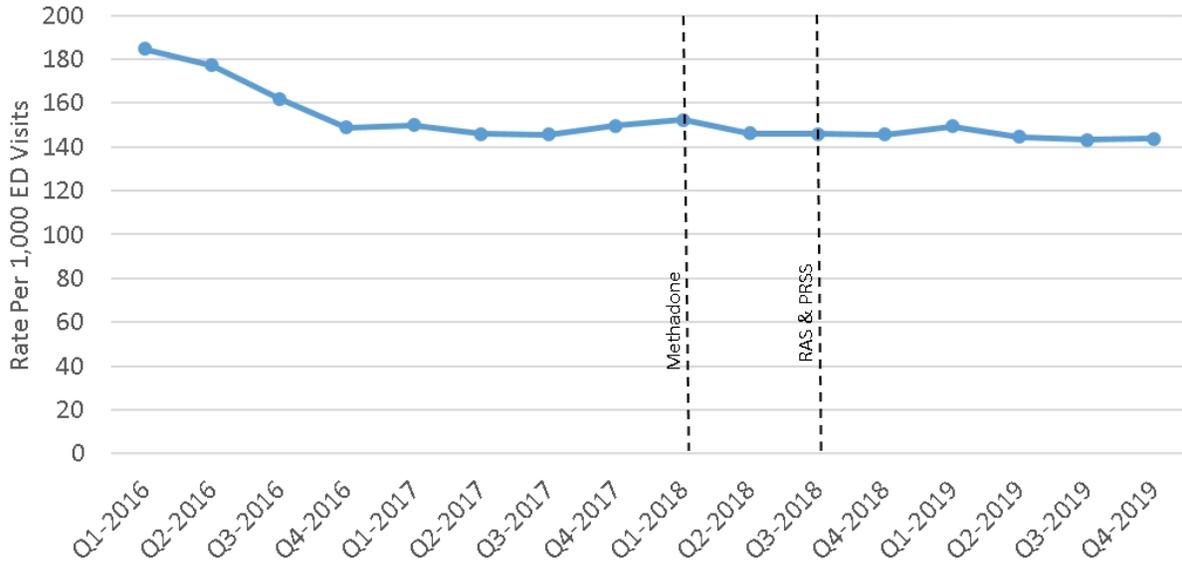
Non-emergent ED use

Claims data were also analyzed to determine if non-emergent visits to the emergency department decreased due to the waiver. While non-emergent ED use among enrollees with SUD decreased during the pre-period, the rate stayed relatively constant between the onset of the waiver and Q4-2019.

Figure J10 Rate of Non-emergent ED Use Among Enrollees with SUD by Month (EQ 3.1, EH 3.1.1)



Rate of Non-emergent ED Use Among Enrollees with SUD by Month



ED Utilization for SUD & OUD among All Enrollees

WVU also investigated changes in ED visits for SUD and OUD among all enrollees, not just those with a related diagnosis. Among this population, the number of ED visits for both OUD and SUD increased post-waiver implementation, though it appears the waiver might have helped postpone the increase in ED visits for OUD, which did not follow the same pattern as the increase in SUD ED visits.

Figure J11 ED Utilization for OUD Among All Enrollees by Month (EQ 3.1, EH 3.1.1)

ED Utilization for OUD Among All Enrollees by Month

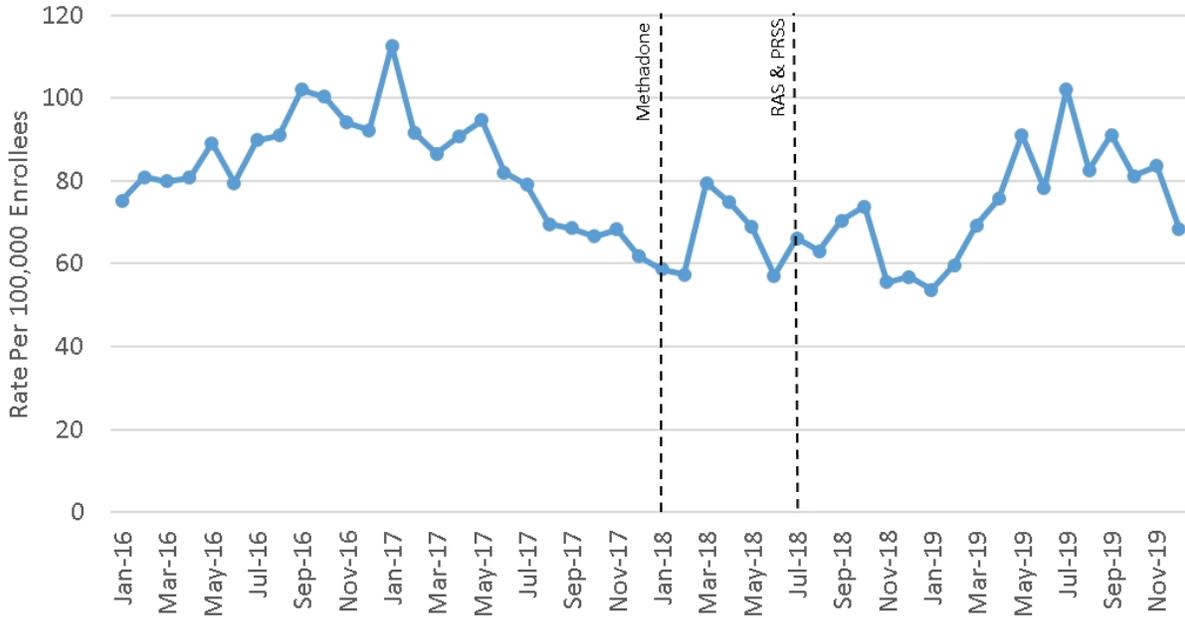
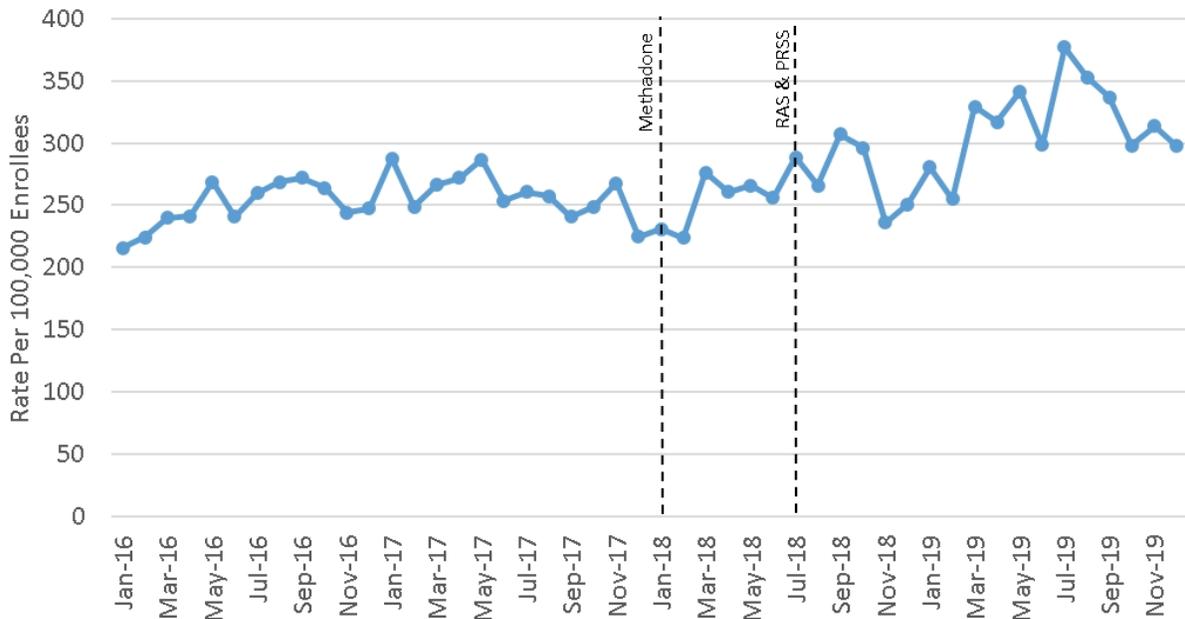


Figure J12 ED Utilization for SUD Among All Enrollees by Month (EQ 3.1, EH 3.1.1)

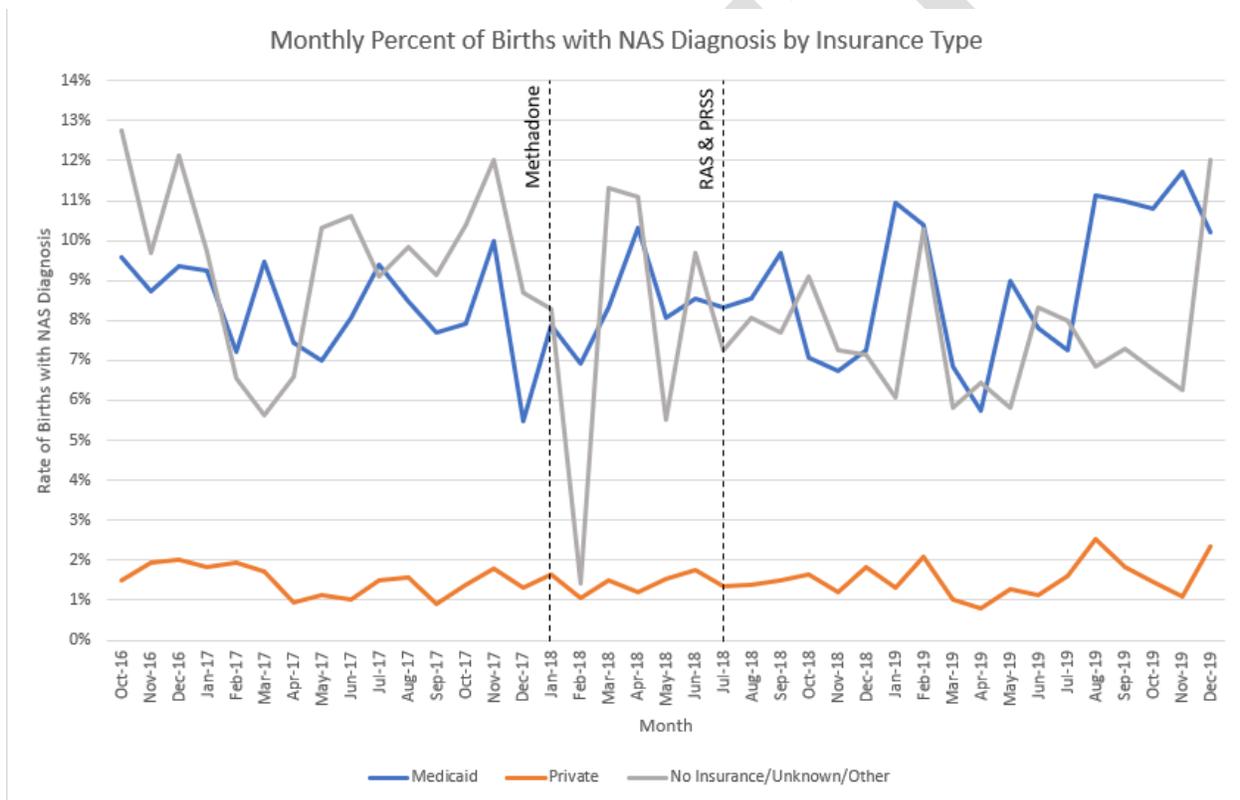
ED Utilization for SUD Among All Enrollees by Month



Neonatal Abstinence Syndrome Rates

In addition to treatment-related outcomes in adults with SUD, we hypothesized the waiver would decrease morbidity rates in the children of these adults, particularly the rate of neonatal abstinence syndrome (NAS). NAS is a group of conditions caused when a newborn withdraws from drugs they are exposed to in the womb. Thus, if SUD treatment rates increase, we would expect lower NAS rates. However, as shown in Figure F29, the waiver does not appear to have lowered the rate of NAS identified post-birth among Medicaid patients. For reference, this graph also includes rates among adults with private insurance and no insurance/unknown status/other insurance. This measure utilizes WV Birth Score data made available through the WV Birth Score Program.

Figure J13 Neonatal Abstinence Syndrome Morbidity (EQ 1.2, EH 1.2.1)



[1] For additional information the difference-in-differences technique, see the following: <https://www.mailman.columbia.edu/research/population-health-methods/difference-difference-estimation>

[1] National Center for Health Statistics, Centers for Disease Control and Prevention (2021). Drug Overdose Mortality by State. https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm

[2] Centers for Disease Control and Prevention. (2021). Drug Overdose Deaths. <https://www.cdc.gov/drugoverdose/deaths/index.html>

[3] National Center for Health Statistics, Centers for Disease Control and Prevention (2021). Drug Overdose Mortality by State.

https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm

[4] Umer, A., Loudin, S., Maxwell, S., et al (2019). Capturing the statewide incidence of neonatal abstinence syndrome in real time: the West Virginia experience. *Pediatric research*, 85(5),607-611.

<https://doi.org/10.1038/s41390-018-0172-z>

[5] WV Department of Health and Human Resources (2021). West Virginia Medicaid Managed Care and Fee for Service Monthly Report 2021.

<https://dhr.wv.gov/bms/Members/Managed%20Care/MCOreports/Documents/Copy%20of%20Managed%20Care%20Monthly%20Enrollment%20Report%20June%202021.pdf>

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Appendix D: Stakeholder Summary from Public Hearings

1.0 Executive Summary

Per the Code of Federal Regulations (CFR) [42 Part 431.408](#) regarding the public notice process for demonstrations, a state must provide at least a 30-day public notice period for demonstration project applications, during which time stakeholders may provide comments on and ask questions about the drafted application. In accordance with this requirement, WV's Bureau for Medical Services (BMS) held the public notice period for the 1115 waiver demonstration renewal from December 1, 2021, through January 3, 2022.

During this period, BMS held two virtual public hearings for stakeholders to learn about and comment on the proposed demonstration project. BMS also concurrently maintained a specific email inbox available for stakeholders to submit questions and comments to. The primary focus of these hearings was to address stakeholder questions and receive stakeholder feedback and insights on the proposed 1115 waiver renewal application.

To gather input broadly, individuals enrolled in or impacted by the existing 1115 Substance Use Disorder (SUD) waiver, representatives from other WV Department of Health & Human Resources (DHHR) agencies, SUD and Serious Mental Illness (SMI) provider groups, the Medical Services Fund Advisory Council (MSFAC), and community organizations were made aware of the public notice period and the two hearings that these stakeholders and the general public were invited to attend.

Stakeholders from varied backgrounds and interest areas participated in the public notice process. In total, there were 56 stakeholders in attendance during the public hearings. At the end of the period, BMS addressed 18 questions and/or comments received between 12/2/2021 and 1/3/2022 and incorporated stakeholder feedback into revisions of the application as was applicable. Materials used at the public hearings and documentation of comments and questions BMS received during the public notice period are included in the appendices of this document.

2.0 Summary of Stakeholder Participation

2.1 Stakeholder Involvement

As outlined in section 1.0 above, an array of stakeholders participated in the public notice process for the 1115 Behavioral Health waiver application. BMS, with assistance from BerryDunn, sent out information blasts at the beginning of the public notice and comment period to help ensure WV stakeholders were aware of the start and end dates of the period, as well as ways to participate in the public comment process.

During this time, the draft 1115 renewal application was posted to the WV BMS website so that stakeholders could access, read, and ask questions about or provide comments on the draft. Input could either be done live during public hearings or via email, phone, or postal mail any time throughout the comment period. Stakeholders participating in the process included individuals currently enrolled in or impacted by the existing 1115 SUD Waiver; provider groups; individual providers; community organizations involved in addressing substance use conditions and/or co-occurring physical, mental, or behavioral health conditions; health plan representatives; and members of the general West Virginian public.

2.2 Public Hearings

Over 60 stakeholders participated in the two public hearings BMS offered, which were each held virtually via Zoom. BMS intentionally conducted the public hearings at different times during their respective days, one in the morning and one in the afternoon, to accommodate varied schedules and include as many stakeholders who wanted to participate in the discussions as possible. There were 33 attendees at the first hearing on December 8, 2021, and 23 attendees at the second hearing on December 16, 2021.

Stakeholder Engagement

During the hearings, BMS and BerryDunn gave a presentation providing background on the existing 1115 SUD waiver and outlined an overview of services included in the proposed renewal and expansion of the waiver. During the presentation portion of the hearings, stakeholders answered two live poll questions about the proposed services and intended outcomes for the proposed waiver renewal. At the end of the presentation, there was time provided for attendees to pose questions about or comment on the information provided regarding the proposed waiver application.

Poll Results

As discussed above, attendees had the opportunity to answer poll questions during the presentation of the proposed application.

The first of these questions asked attendees to rank the top five proposed new waiver services they felt would be most beneficial to members enrolled in the waiver program. Below are the ranked results of services that attendees felt would be most beneficial to members served by this waiver, as indicated by the voluntary poll conducted at each of the two hearings. Aggregated poll results combining data from the two hearings can be found in Table 3.

Table 1: Public Hearing 1 Results: Ranked Proposed Waiver Services

| Rank | Proposed Service | Number of Times Selected | Percentage |
|-----------|---|--------------------------|------------|
| 1 | Recovery Housing | 21 | 15% |
| 2 | Continuity of Care for Justice-Involved Individuals | 18 | 12.9% |
| TIE 3 & 4 | Quick Response Teams (QRTs) | 17 | 12.1% |
| TIE 3 & 4 | Expansion of Residential at American Society of Addiction Medicine (ASAM) 3.7 Level of Care for Medically Complex Individuals | 17 | 12.1 % |
| 5 | Expanded Length of Stay in Institutions for Mental Disease (IMDs) | 16 | 11.4% |

Table 2: Public Hearing 2 Results: Ranked Proposed Waiver Services

| Rank | Proposed Service | Number of Times Selected | Percentage |
|-----------|---|--------------------------|------------|
| 1 | Recovery Housing | 14 | 15.73% |
| 2 | Group Residential Treatment Services | 12 | 13.48% |
| 3 | Supported Housing/Supported Employment | 11 | 12.36% |
| TIE 4 & 5 | QRTs | 10 | 11.23% |
| TIE 4 & 5 | Continuity of Care for Justice-Involved Individuals | 10 | 11.23% |

Table 3: Aggregated Results: Ranked Proposed Waiver Services

| Rank | Proposed Service | Number of Times Selected | Percentage |
|-----------|--|--------------------------|------------|
| 1 | Recovery Housing | 35 | 15.28% |
| 2 | Continuity of Care for Justice-Involved Individuals | 28 | 12.23% |
| TIE 3 & 4 | QRTs | 27 | 11.79% |
| TIE 3 & 4 | Group Residential Treatment Services | 27 | 11.79% |
| TIE 5 & 6 | Expansion of Residential Treatment at ASAM Level 3.7 for Medically Complex | 25 | 10.92% |
| TIE 5 & 6 | Supported Housing/Supported Employment Services | 25 | 10.92% |

The second question asked attendees to choose which of the four outcomes of the proposed waiver they felt was the most important. Below are the aggregated responses to this question, as indicated by the voluntary poll conducted at each of the hearings. Table 6 combines data from both hearings, providing overall results.

Table 4: Public Hearing 1 Results: Outcome Importance

| Outcome of Waiver | Number of Times Selected | Percentage |
|---|--------------------------|------------|
| Improve quality of care | 17 | 40.47% |
| Improve care coordination and transitions | 13 | 30.95% |
| Increase access to and utilization of SUD services | 11 | 26.19% |
| Decrease utilization of high-cost Emergency Department (ED) and hospital services | 1 | 2.38% |

Table 5: Public Hearing 2 Results: Outcome Importance

| Outcome of Waiver | Number of Times Selected | Percentage |
|--|--------------------------|------------|
| Improve quality of care | 15 | 57.7% |
| Improve care coordination and transitions | 6 | 23.1% |
| Increase access to and utilization of SUD services | 5 | 19.2% |
| Decrease utilization of high-cost ED and hospital services | 0 | -- |

Table 6: Aggregated Results: Outcome Importance

| Outcome of Waiver | Number of Times Selected | Percentage |
|--|--------------------------|------------|
| Improve quality of care | 32 | 47.06% |
| Improve care coordination and transitions | 19 | 27.94% |
| Increase access to and utilization of SUD services | 16 | 23.53% |
| Decrease utilization of high-cost ED and hospital services | 1 | 1.47% |

2.3 Stakeholder Participation Outside of the Public Hearings

BMS made stakeholders aware that they were invited to submit questions about or comments on the proposed 1115 waiver renewal draft via email, phone, or postal mail in addition to their opportunities to do so at the public hearings. The questions and comments received by phone, email, and/or postal mail are documented in the appendices of this document.

2.4 Key Themes from Stakeholder Engagement

Common themes and lines of discussion emerged during the comment period and are discussed here at a high level.

As indicated by the poll results from the public hearings, recovery housing was the service stakeholders felt would benefit waiver members the most, coming first in the rankings at both public hearings. QRT services and Continuity of Care for Justice-Involved Individuals also ranked in the top five at each hearing, though in a slightly different ranked order. The consistency of these services ranking in the top half of the order, and recovery housing in particular ranking first in both instances, indicates that a wide range of stakeholders believe the availability of these services would have significant beneficial impacts on waiver members. Contingency Management was ranked lowest at both hearings.

As for which outcome stakeholders felt was the most important for the waiver to achieve, attendees selected improving quality of care and population health outcomes as most important at both public hearings. The polling order of importance of the four outcomes was the same across both hearings. Improving quality of care and population health outcomes was followed by improving care coordination, care transitions, and continuity of care second, increasing member access to and utilization of appropriate treatment third, and decreasing utilization of high-cost ED and hospital services ranking lowest.

Of note, the improving quality of care and population health outcomes outranked the next highest outcome by nearly 20%, indicating it as a clear priority among stakeholders. On the other end of the order, decreasing utilization of high-cost ED and hospital services was distinctly less important as the top priority to stakeholders; only one individual selected this as the most important of the waiver's four proposed outcomes.

The questions stakeholders asked during the question-and-answer portion of the hearings were generally focused on a couple of the proposed services. Several questions were raised pertaining to the expansion of Peer Recovery Support Specialist (PRSS) services and different sites for consideration, and stakeholders also raised multiple questions about the proposed HIV/HCV community outreach, education, and integration service. Attendees at the second hearing engaged in a conversation with BMS staff about PRSS, exchanging thoughts and sharing personal experiences from the field. Another stakeholder submitted a comment about PRSS, suggesting the State removes certain employment requirements for peers to make them more sustainable and accessible.

There were additional questions received about other proposed waiver services, such as SMI residential services, as well as several logistical questions pertaining to public comment and waiver renewal timelines. A full list of questions and comments received during and outside of the two hearings, as well as BMS' responses, are listed in the appendices of this document.

Appendix A: Poll Result Rankings and Calculations

| Combined Hearings Poll Result Rankings | |
|--|--|
| Recovery Housing | |
| Continuity of Care for Justice-Involved Individuals | |
| (Tie with below) Quick Response Teams | |
| (Tie with above) Group Residential Treatment Services | |
| (Tie with below) Expansion of Residential Treatment Services at ASAM Level 3.7 for Medically Complex Individuals | |
| (Tie with above) Supported Housing/Supported Employment Services | |
| Expanded Length of Stay in IMDs | |
| HIV/HCV Community Outreach, Education, and Integration | |
| Secure Involuntary Withdrawal Management and Stabilization (SWMS) | |
| Contingency Management | |

| Ranking | Hearing 1 | Count/ Percentage | Hearing 2 | Count/ Percentage |
|---------|---|-------------------------------|---|-------------------------------|
| 1. | Recovery Housing | 21 21/140= 15% | Recovery Housing | 14 14/89= 15.73% |
| 2. | Continuity of Care for Justice-Involved Individuals | 18 18/140= 12.9% | Group Residential Treatment | 12 12/89= 13.48% |
| 3. | QRTs | 17 17/140= 12.1% | Supported Housing/ Supported Employment | 11 11/89=12.36% |
| 4. | Expansion of Residential Treatment Services at ASAM Level 3.7 | 17 17/140= 12.1% | QRTs | 17 17/140= 12.1% |
| 5. | Expanded Length of Stay in IMDs | 16 16/140= 11.4% | Continuity of Care for Justice-Involved Individuals | 10 10/89= 11.23% |
| 6. | Group Residential Treatment | 15 15/140= 10.7% | Expansion of Residential Treatment Services at ASAM Level 3.7 | 8 8/89= 8.99% |

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|-----|--|-----------------------------|--|-------------------------|
| 7. | Supported Housing/Supported Employment | 14 14/140= 10% | HIV/HCV Community Education & Outreach | 7 7/89= 7.86% |
| 8. | HIV/HCV Community Education & Outreach | 9 9/140= 6.4% | SWMS | 7 7/89=7.86% |
| 9. | SWMS | 7 7/140= 5% | Expanded Length of Stay in IMDs | 7 7/89=7.86% |
| 10. | Contingency Management | 6 6/140= 4.3% | Contingency Management | 3 3/89= 3.37% |

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Appendix B: Documentation of Stakeholder Questions and Comments

Documentation of Stakeholder Questions and Comments Received During Post-Presentation Discussion at Public Hearings

Question: Can we get more information on the PRS?”

Answer: This draft is looking to expand peers to Federally Qualified Health Centers (FQHCs) and possibly hospitals. The waiver is also looking to expand peers to Drug Free Moms and Babies (DFMB) sites.

Question: How will WV BMS assure that Federal MH/SUD parity laws are enforced?

Answer: Every year, BMS does a review of parity to help ensure mental health and SUD parity. Once the 1115 waiver proposed services are approved, they will be subject to parity review on an annual basis.

Follow-up Question: Is this parity review an internal BMS review?

Answer: Yes, there is a grid that BMS must complete and then show CMS every year.

Question: Why not expanded time for residential treatment?

Answer: Because of medically necessity criteria; the addition of the extended length of stay at the 3.7 level of care is for medically complex diagnoses co-occurring with SUD, specifically for wound care and endocarditis. It is harder to find nursing care for those conditions, which is the rationale for the longer length of stay for this level of care and population.

Question: Will these slides be accessible?

Answer: Yes, the slides will be posted on the BMS website.

[<https://dhhr.wv.gov/bms/Public%20Notices/Pages/Medicaid-Section-1115-Waiver-Renewal-Demonstration-Public-Hearings.aspx>]

Question: Will this recording be accessible to the public?

Answer: Yes, the recording will be available to the public as soon as the recording is downloaded and made into a format suitable to be posted.

Question: What type of treatment sites will HIV/HCV outreach and education services be integrated into?

Answer: Licensed Behavioral Health Centers because they reach the majority of individuals. BMS' goal is to also include office-based medication-assisted treatment (OBMAT) sites to do that type of HIV/HCV education.

Question: We are finding that this is a 30-day program rather than a person-centered treatment and needing to meet medical necessity. So how can we be a person-centered facility when we find this is based on a 30-day program?

Answer: Assuming that this question is referring to residential treatment facilities, residential treatment is based on the needs of members. There is not a hard cap on a 30-day stay in residential facilities if a member's needs indicate a longer stay is medically necessary.

Question: Is there a full list of the settings that are proposed to expand PRSS to? I know [the moderator] said EDs, FQHCs and DFMB programs - any additional settings?

Answer: The EDs, FQHSs, and the DFMB programs are the three areas the Peer Recovery Support Services (PRSS) would be expanded.

Question: Would the HIV/HEP C community outreach include syringe exchange?

Answer: The State does educate on the purpose of needles and syringes, but a traditional needle exchange will not be included in the education program.

Question: Would the PRSS also include medical floors at hospitals? The attendee clarified that this question is related to a Project Engage request from the Office of Drug Control and Policy (ODCP).

Answer: It has been proposed for the PRSS to go into the EDs. The service could be discussed further down the line during negotiations with CMS. The State is looking for PRSS services in the ED as an engagement source and not a typical PRSS program.

Comment: Peers have been shown to improve retention in outpatient treatment but not all outpatient treatment services are licensed behavioral health settings, so I would support expansion to additional outpatient settings that bill CMS for their services.

Comment: (In response to the previous comment) I would agree with that. That is one of the barriers to us getting appropriate peer services in settings such as OBGYN offices.

Documentation of Stakeholder Questions and Comments Received by Email, Phone, or Postal Mail

| Number | Date Received | Comment | Status Result |
|--------|---------------|--|--|
| 1 | 12/2/21 | Would I be able to get access to the proposed changes to the 1115 waiver in advance of this meeting? | Yes, new, proposed services were uploaded to the BMS website prior to the public hearings. |
| 2 | 12/2/21 | Once change I would strongly suggest is to remove the requirement that Peer Recovery | We are looking to expand Peer Recovery Support |

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| | | Support Specialist have to be employed as part of a licensed behavioral health setting in order to bill for their services. Peers are valuable in many settings but currently not sustainable and as long as they are appropriately supervised should be able to bill for services if the setting is set up to do so | Specialist (PRSS) services to be employees of Federally Qualified Health Centers (FQHC), Drug Free Moms and Babies (DFMB), and Emergency Department (ED) settings. |
| 3 | 12/08/21 | I have a follow up question to the public hearing I just attended. Regarding the new services proposed with the demonstration, specifically SMI Residential, are you envisioning a service that doesn't currently exist, or are you envisioning SUD waiver certification for existing MH group homes as well as expansion of them? Some comps, Valley included, currently offer residential group home programs for clients with SMI. | Yes, we are looking to develop this as a new service. |
| 4 | 12/08/21 | If the answer is no, can you describe SMI Residential in more detail please so I can have a better idea what that service would look like? | See the above answer. |
| 5 | 12/9/21 | Is there any discussion on the daily rates increasing with the increasing demand for salary increases for staff | Rates will be developed as services are approved by Center for Medicaid and Medicare Services (CMS). |
| 6 | 12/10/21 | When is the final day to submit comments on the 1115 waiver renewal? | The final day to submit questions and comments to the 1115 Waiver Renewal is January 4 th , 2022. |
| 7 | 1/3/2022 | Clarify that 3.7 units include hospital settings (Thomas Health/St. Francis Addiction Healing Center which is a 3.7 sub-acute unit on a medical floor) | Thank you for your comment, but this does not directly involve the new services for the 1115 Waiver Renewal. |
| 8 | 1/3/2022 | Request that PRSS expansion to hospital medical floors be considered. Many patients in hospitals are admitted with co-occurring Medical and SUD conditions. When these patients are identified, staff who have Lived- | We are looking to expand Peer Recovery Support Specialist (PRSS) services to be employees of Federally Qualified |

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| | | Experience with SUD can be an asset in motivating patients to follow through with SUD Treatment once they are medically stabilized and discharged from a hospital floor | Health Centers (FQHC), Drug Free Moms and Babies (DFMB), and Emergency Department (ED) settings |
| 9 | 1/3/2022 | Consider adding trauma assessment as a component of determining medical necessity for Residential SUD treatment at 3.7, 3.5, 3.3, and 3.1 levels of care. Some consideration of ACE's scores could assist in determining readiness for patients to accept responsibility to follow through with the continuum of care | Thank you for your comment, but this does not directly involve the new services for the 1115 Waiver Renewal. |
| 10 | 1/3/2022 | Re-evaluate the use of ASAM criteria as the sole determinate of admission and continued stay in residential levels of care | Thank you for your comment, but this does not directly involve the new services for the 1115 Waiver Renewal. |
| 11 | 1/3/2022 | Review BMS determinants that MCO's are following federal parity guideline/mandates; | Thank you for your comment, but this does not directly involve the new services for the 1115 Waiver Renewal. |
| 12 | 1/3/2022 | Find a mechanism to assure that medical necessity/length of stay criteria for medically complicated patients treated on 3.7 level of care are sufficient to foster successful outcomes | We are looking to expand the length of stay for individuals in a 3.7 Medically Monitored ASAM level of care, who have medically complicated disorders co-occurring with SUD. |
| 13 | 1/3/2022 | Review interpretation of ASAM guidelines to provide consistency among MCO's. Develop a mechanism for provider input regarding ASAM guideline interpretation; | Thank you for your comment, but this does not directly involve the new services for the 1115 Waiver Renewal. |
| 14 | 1/3/2022 | Develop a means of blending social necessity into the medical necessity criteria as a more prudent mechanism to assure patients are ready to move through the SUD continuum of care | Thank you for your comment, but this does not directly involve the new services for the 1115 Waiver Renewal. |
| 15 | 12/30/21 | Contingency Management ("CM") is an approach that uses incentives to increase healthy behaviors. CM has been demonstrated to be one of the most effective treatments for substance use disorders. | Presently, providers in WV can incorporate contingency management (CM) into their therapeutic milieu. BMS |

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| | <p>Decades of evidence have suggested CM is an effective treatment for the more than 40 million Americans in our communities who are struggling with SUD today. However, historically, due to the cumbersome nature of providing oversight and accountability for the rewards members earn through CM programs, many Medicaid and commercial health plans have yet to scale the practice or struggled to support the implementation of quality CM programs. But with recent technology advancements, this landscape has begun to shift. Mobile technology has made CM safer, cheaper, and more flexible to implement. Addiction treatment networks can now finally safely deploy CM and realize significant improvement by combining emerging technology with CM practices. WEconnect Health Management has introduced a mobile application that streamlines and facilitates implementation of CM for substance use disorders where an individual can earn an incentive through verifiable participation and we are concerned about the limited approach BMS is taking in the proposed renewal only targeting individuals with Stimulant Use Disorder and through a finite outpatient model. In 2019, WEconnect Health partnered with a Medicaid plan in Pennsylvania to implement the WEconnect platform with a select cohort of members. The plan introduced WEconnect to five providers who then referred members to the WEconnect platform. The providers included: two large health systems with inpatient and outpatient departments, an outpatient FQHC, and a chain of outpatient Medication-Assisted Treatment (MAT)</p> <p>DocuSign Envelope ID: DF13CF13-85F7-4899-9D56-C4A7100417E2 WEconnect Health Management • 4730 University Way NE, Ste-104, #2032, Seattle, WA 98105</p> <p>Saving lives, providing accurate outcomes data, and supporting healthcare ecosystems, communities, and families.</p> | <p>is attempting to provide additional coverage for the incentive-based treatment with the addition of the CM Treatment for Stimulant Use Disorder commonly known as TRUST. The TRUST model provides evidenced based resources for the rising methamphetamine problem. Although there are other CM models, several states are attempting to add this service as it demonstrates success through a array of psychometrics and positive outcomes. If this service becomes added to the 1115 Waiver Renewal, BMS may look at expanding CM to other models in the future. Thank you for your comment.</p> |
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| | | <p>www.weconnectrecovery.com facilities. With 200 members using the WEconnect platform, the pilot began in Q1 of 2019 and continued through Q2 of 2020. Prior to a long-term claims analysis, the program was evaluated based on a series of metrics assessing member engagement with their treatment plan. Targets were exceeded in almost all areas measured, including activation, engagement, retention, and helpfulness rate. Of the 200 members on the WEconnect app, 95 were selected to be included in the claims analysis. Those 95 members were all patients at Crossroads treatment centers with OUD, and were chosen for comparison with the control group of Crossroads patients not using the WEconnect app. Controls were also matched on demographic data. The comparison resulted in the following: The claims analysis showed a significant increase in PCP engagement and MAT refills among the WEconnect cohort. In the study, use of the WEconnect app was associated with a 76% higher rate of Primary Care Provider (PCP) engagement. Patients who engage with their PCP in an initial incentivized visit are more likely to develop a relationship with their doctor and continue to adhere to their treatment plans. Patients who see a PCP are also more likely to be referred to appropriate levels of outpatient care, and one study showed that this led to a decrease in non-emergent ED visits by 19%. Medication-Assisted Treatment (MAT, or pharmacotherapy), incentivized by use of the WEconnect app, is an extremely effective treatment for substance use disorder (SUD) that can significantly reduce long-term healthcare costs. Even including higher pharmacy expenses, studies show that a six-month period on MAT results in 29% lower overall annual health plan costs for members compared to those with no medication (Baser et al., 2011). In a 2010 five-year study, members on MAT had 50%–62% lower total</p> | |
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| | | <p>annual commercial health plan costs (McCarty et al., 2010). Individuals who attended one or more MAT appointments had significantly fewer emergency room visits, recurrences of use (relapses), primary care visits, inpatient stays, and other non-addiction treatment visits. The results align BMS goals for the 1115 renewal and support the expansion of the proposal to include individuals with OUD at a minimum. We strongly believe that individuals with any type of SUD and polysubstance use can benefit from the proposed CM program the State is seeking approval for and encourage BMS to expand the current draft to align with the rest of 1115 planned renewal. We would be happy to meet with the BMS team to discuss these comments.</p> | |
| 16 | 12/23/21 | <p>The BMS states that it is seeking to roll out a new Contingency Management (CM) program using a specific TRUST model solely for use with individuals who have stimulant use disorder. While this is an exciting and important expanded benefit to improve the tools providers have on hand to support West Virginia Medicaid members, limiting the potential use to one of the smallest populations of impact from SUD in West Virginia and to a specific intervention will place an unnecessary burden on deploying the program. CM is a treatment that is effective for people with SUD across all substances, including people with OUD. According to the CMS's T-MSIS SUD Data Book, only 9% of West Virginia Medicaid members treated for an SUD were treated for stimulants in 2018. Excluding tobacco the most prevalent substances for the people treated for SUD in the data were 49.4% for opioids, 29.3% for polysubstance, and 16.2% for alcohol. While stimulant use disorder is certainly an important use case for the development of a CM program, the practice in West Virginia should not be restricted to only one subtype of SUD and can be more</p> | <p>Although Contingency Management (CM), specifically the TRUST model could have some benefit for other SUD populations, primary literature, research, and metrics has focused on the stimulant use disorder with successful outcomes. As we look to add this new service in a therapeutic capacity in this waiver demonstration, stimulants, cocaine, and methamphetamine will be the target for treatment. During the next period for the wavier demonstration, we may look at piloting this model with other SUD populations to obtain success rates and WV analytics. Thank you for your comment.</p> |

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| | | <p>practically explored, piloted, and tested by expanding eligibility to the broader impacted population in alignment with the rest of 1115 planned renewal. Furthermore, expanding eligibility also supports more equitable access and eliminates situations where certain clients in a treatment program are eligible for CM and others in the same program are not. Additionally, CM has emerging deployment opportunities with promising Medicaid results leveraging a variety of mobile technology-based implementations and uses. The new benefit should not be limited only to a specific overly prescriptive intervention or model.</p> | |
| 17 | 12/23/21 | <p>As recovery housing operators and alumni of the benefits of recovery housing, we believe this benefit inclusion for Medicaid members can be of tremendous support to individuals in West Virginia. However, the proposed benefit being exclusively for “recovery homes offering clinical-level treatment services to SUD members” runs in conflict with the spirit and intention of the added service. Given the expansion of residential services for SUD that already require clinical services envisioned in renewal, because of the limited supply of recovery housing, we believe that Levels 1-3 of NARR standards should be considered for inclusion. SAMHSA provides support for all four NARR levels of housing in their 2018 issue brief, Recovery Housing: Best Practices and Suggested Guidelines. While we do support the general premise of the following hypothesis quoted in the renewal draft with regard to recovery housing, we do not believe the evidence supports it be exclusive to houses offering clinical treatment services. Therefore, we propose the following edit: BMS believes that increasing support for and coverage of recovery housing offering clinical treatment services will reduce relapse rates, overdoses, and preventable ED admissions and hospitalizations. Therefore, the increased expenditures for recovery housing included in this waiver will be offset by the decrease in</p> | <p>During our initial waiver application that was approved in 2018, we requested recovery housing services, from CMS and were denied. With the additional requirement of clinical services, the ability for Medicaid to cover an otherwise uncovered, and needed service may be viable. Thank you for your comment.</p> |

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| | | costly expenditures covering avoidable ED admissions and hospitalizations for SUD overdoses and treatment, providing a budget-neutral intervention. | |
| 18 | 12/23/21 | <p>Comments on Value-Based Payment: When reflecting on the original outcomes objectives of the first iteration of the West Virginia 1115 waiver, "West Virginia Creating a Continuum of Care for Medicaid Enrollees with SUD," BMS concludes that there were mixed and inconsistent results for Objectives 3: Decrease medically inappropriate and avoidable utilization of high-cost ED and hospital services by members with SUD, and Objectives 4: Improve care coordination and care transitions for Medicaid members with SUD. For example, in year 3 of the program, "ED utilization increased by 11.8%, and inpatient stays for SUD increased by 5.4%. These trends run counter to waiver objectives and what BMS anticipated would happen with the waiver program implementation."</p> <p>Ascension Recovery Services has experiences working in a variety of states implementing alternative payment strategies and actively participates as a member of the Alliance for Addiction Payment Reform working to advance value-based payment efforts for SUD. It is our belief that the systematic transformation needed to provide deep linkages across the West Virginia SUD continuum of care will not take place or become sustainable until reimbursement becomes linked to value, wellness, and outcomes, not simply volume. One of the greatest impediments to sustained recovery for patients is that various specialty SUD programs and treatment settings operate in isolation from hospitals, emergency departments, and primary care with limitations in referrals and/or requisite information sharing with other key parties. In most fee-for-service payment models for addiction, providers and payers are unable to control or directly influence all facets of a person's</p> | BMS is reviewing and researching the possibility of value-based payments in the future. Thank you for your comment. |

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| | <p>recovery journey, including the various manifestations of recovery disruptions. We view the disintegration of economic resources as chiefly responsible for the fragmentation of addiction treatment and recovery services. In recent years, government and commercial payers have increasingly introduced payment demonstrations designed to promote improved integration of disparate parts of the delivery system to foster improved collaboration and efficiency. An alternative payment model aligned with BMS' stated objectives in the 1115 demonstration has the potential to create conditions and engagement protocols that materially improve the patient's likelihood of long-term recovery, generating savings for the system and providing a benefit to participants. We believe BMS should review the Addiction Recovery Medical Home – Alternative Payment Model (ARMH-APM) published by The Alliance for Addiction Reform and consider including the model in the proposed 1115 renewal. The ARMH-APM is a flexible and adaptable model designed to promote improved integration of treatment and recovery resources with corresponding financial incentives that inure to the stakeholders' benefit when the patient is on a sustained path to recovery. This model is guided by shared principles which include the development of care recovery teams; the formation of integrated and coordinated community-based treatment; and the creation of a recovery network, treatment, and recovery plan that encompasses not just physical and psychological health needs, but social determinants of health; means to manage disruptions in the recovery journey; and a multi-year economic model that rewards the system's performance. West Virginia's integrated managed care system combined with the recent CMS award of the Phase 2 demonstration of Section 1003 of the SUPPORT Act to West Virginia, uniquely positions the state to align these 1115</p> | |
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| | | <p>renewal goals with the 2020 guidance provided in CMS SMD # 20-004 on Value-Based Care Opportunities in Medicaid impacting both fee-for-service members and managed care enrolled members across the state. Ascension Recovery Services believes this 1115 renewal could help West Virginia become a national leader in their Medicaid program by implementing SUD value-based payment model demonstration programs. Thank you for continuing to drive toward ambitious improvements for the services provided to West Virginia members struggling with SUD and for considering our comments to make even more significant progress under the next 1115 waiver period. We would be happy to meet with the BMS team to discuss these comments</p> | |
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Informational Flyer for Public Hearings Disseminated to Stakeholders

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MEDICAID SECTION 1115 WAIVER DEMONSTRATION RENEWAL - PUBLIC HEARING

EVOLVING WV MEDICAID'S BEHAVIORAL HEALTH CONTINUUM OF CARE

PLEASE JOIN WEST VIRGINIA'S BUREAU FOR MEDICAL SERVICES
(BMS) AS THEY DISCUSS PROPOSED CHANGES TO THE CURRENT
SUBSTANCE USE DISORDER (SUD) 1115 WAIVER

DECEMBER 8, 2021: 3:00PM - 4:00PM

ZOOM LINK:

[HTTPS://BERRYOUNN.ZOOM.US/J/96706074245](https://berryyounn.zoom.us/j/96706074245)

DIAL-IN BY PHONE: 312-626-6799

MEETING ID: 967 0607 4245

DECEMBER 16, 2021: 11:00AM - 12:00PM

ZOOM LINK:

[HTTPS://BERRYOUNN.ZOOM.US/J/94576778118](https://berryyounn.zoom.us/j/94576778118)

DIAL-IN BY PHONE: 301-715-8592

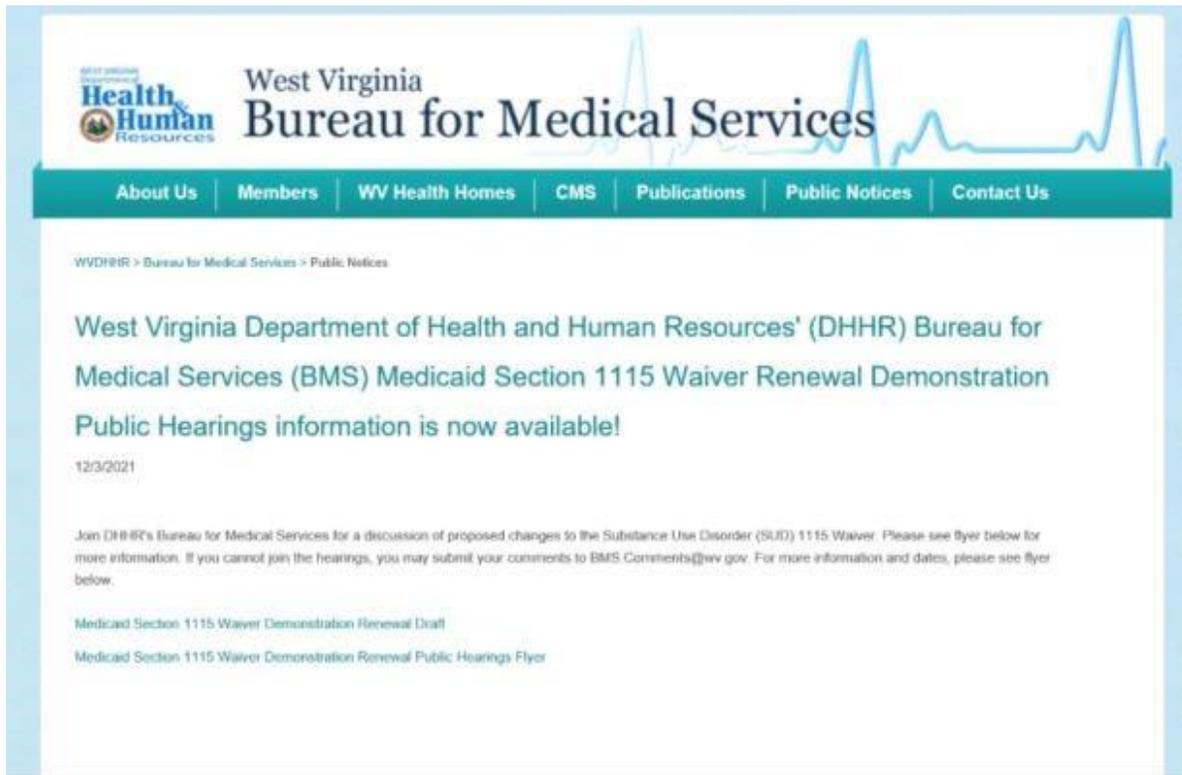
MEETING ID: 945 7677 8118

HOW YOU CAN PARTICIPATE:

THE ZOOM LINKS ABOVE MAY BE CLICKED ON OR ENTERED IN YOUR BROWSER TO JOIN A PUBLIC FORUM OF YOUR CHOICE. YOU MAY ALSO JOIN OVER THE PHONE BY DIALING IN USING THE PHONE NUMBERS ABOVE AND ENTERING THE RELEVANT MEETING ID.

IF YOU ARE UNABLE TO ATTEND A PUBLIC FORUM, YOU MAY SUBMIT COMMENTS TO BMS.COMMENTS@WV.GOV

BMS Public Notice Post for Public Hearings



Hearing Information and Meeting Purpose (Documentation taken from first Public Hearing)

| | |
|----------------------------|--|
| Meeting Title | WV Substance Use Disorder (SUD): Public Comment Hearing 1 |
| Date | Wednesday, December 8, 2021 |
| Time and Location | 3 – 4 p.m. ET Web Conference via Zoom |
| Dial-In Information | Dial: 1-646-876-9923 Access Code: 942 7991 2435 |
| Web Conference | URL: https://berrydunn.zoom.us/j/91785220028 |
| Meeting Facilitator | Susan Chugha |
| Note Taker | Alex Glowacky |
| Attendees | West Virginia Bureau for Medical Services (BMS): Cynthia Parsons, Keith King BerryDunn: Sarah Abbott, Susan Chugha, Alex Glowacky Stakeholders: West Virginia (WV) General Public |

Attachments

Link to the recording:

<https://berrydunn.zoom.us/rec/share/Tg8ltv4qxFXrUpCfjJqRkGF7clhOP-USyWE3NxnD7mITxtqDDIeGE50IY8BbLogf.BYiQ7zEffwcBVgcd>

Passcode: 5Z=t=NJy

Meeting Purpose: To present and answer stakeholder questions about the proposed WV 1115 waiver renewal draft.

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Endnotes

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