DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

December 11, 2024

Cynthia Beane
Commissioner
Bureau for Medical Services
West Virginia Department of Human Services
350 Capitol St., Room 251
Charleston, WV 25301

Dear Commissioner Beane:

The Centers for Medicare & Medicaid Services (CMS) is approving West Virginia's request to extend its section 1115 demonstration entitled, "Evolving West Virginia Medicaid's Behavioral Health Continuum of Care" (Project Number 11-W-00307/3), in accordance with section 1115(a) of the Social Security Act (the Act). This extension also authorizes the state to change the title of the demonstration, from "West Virginia Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders (SUD)" to "Evolving West Virginia Medicaid's Behavioral Health Continuum of Care." This title change reflects the state's efforts to evolve its continuum of care by adding and expanding services in the demonstration to better support Medicaid enrollees with SUD. This approval is effective January 1, 2025, through December 31, 2029.

Approval of this request will extend most of the authorities from the original 2017 demonstration, including SUD treatment for individuals residing in an Institution for Mental Diseases (IMD), peer recovery support specialist (PRSS) services, and the requirement that beneficiaries in the Children with Serious Emotional Disorder 1915(c) Waiver (CSEDW) have a lock-in period with a single, specialized managed care organization (MCO).[1] The extension also provides new authorities, which include certain housing supports under the health-related social needs (HRSN) framework, coverage of post-overdose response teams called Quick Response Teams, and recovery-related support services to help individuals with SUD manage their symptoms that interfere with employment. In addition, approval of this demonstration extension will provide expenditure authority for limited coverage for certain services furnished to certain incarcerated individuals for up to 90 days immediately prior to the individual's expected date of release.

[1] West Virginia added this authority via an amendment approved on September 30, 2019. It is expenditure authority #3: Expenditures related to administrative simplification and delivery systems. Under a section 1915(c) waiver, a beneficiary ordinarily must have a choice of MCOs as required under section 1902(a)(23) and have the right under section 1903(m)(2)(A)(vi) to disenroll from the MCO in which the beneficiary is enrolled. This expenditure authority permits FFP to be provided in the MCO contract notwithstanding non-compliance with section 1903(m)(2)(A)(vi).

The overall goal of West Virginia's SUD demonstration is to evolve the continuum of care for individuals with SUD to provide the right care at the right time, in the right setting. For the extension period, West Virginia is continuing and building upon the specific objectives from the first demonstration period, which are:

1. Improve quality of care and population health outcomes for Medicaid members with SUD;
2. Increase member access to and utilization of appropriate SUD treatment services according to American Society of Addiction Medicine (ASAM) criteria, or another comparable, nationally recognized set of SUD program standards based on evidence-based SUD clinical guidelines;
3. Decrease utilization of high-cost emergency department and hospital services; and
4. Improve care coordination, care transitions, and continuity of care for Medicaid members with SUD.

CMS's approval is subject to the limitations specified in the attached waiver and expenditure authorities, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent that those requirements have been specifically listed as waived or not applicable to expenditures under the demonstration.

Extent and Scope of the Demonstration Extension

With this extension, West Virginia will continue to operationalize and refine its SUD demonstration initiatives. CMS is extending the state's current authority to receive federal financial participation (FFP) for clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as an IMD and PRSS services (called peer recovery support services in the first demonstration period). CMS is also extending the state's current authority for mandatory enrollment into an MCO for CSEDW beneficiaries but is adding new STCs to ensure beneficiary protections. West Virginia received section 1115 authority for medication-assisted treatment (MAT), including methadone treatment, in the 2017 approval, but MAT was moved to state plan authority during the first demonstration period.[2]

The extension includes new authorities requested by the state and approved by CMS. The following sub-sections provide a detailed explanation of the new authorities in the demonstration, the requests not being approved at this time, and the requests withdrawn by West Virginia or where CMS approval is not required.

New Authorities

1) Pre-Release Services under the Reentry Demonstration Initiative

Expenditure authority is being provided to West Virginia to provide limited coverage for a targeted set of services furnished to certain incarcerated individuals for 90 days immediately

[2] MAT was moved to state plan authority as a mandatory Medicaid benefit on October 7, 2021, via State Plan Amendment (SPA) (WV-21-0002), which was effective October 1, 2020, as required by the SUPPORT Act.

prior to the individual's expected date of release. The state's proposed approach closely aligns with CMS' "Reentry Demonstration Opportunity" as described in the State Medicaid Director Letter (SMDL) released on April 17, 2023.

Eligible Individuals

West Virginia will cover a set of pre-release benefits for certain individuals who are inmates residing in a state/local jail, state prison, and youth correctional facility (herein after referred to as "correctional facilities"). To qualify for services covered under this demonstration approval, individuals residing in a correctional facility have been determined eligible for Medicaid pursuant to an application filed before or during incarceration, are 18 years of age or older, meet the state's health-related criteria, and have an expected release date within 90 days.

Medicaid Eligibility and Enrollment

CMS is requiring, as a condition of approval of this demonstration extension, that West Virginia make pre-release outreach, along with eligibility and enrollment support, available to all individuals incarcerated in the correctional facilities listed above and outlined in the STCs.

For a Medicaid covered individual entering a correctional facility, West Virginia will not terminate Medicaid coverage but will suspend the individual's coverage. For individuals not enrolled in Medicaid upon entering a correctional facility, West Virginia will ensure the individual receives assistance with completing and submitting a Medicaid application sufficiently prior to their anticipated release date such that the individual can receive the full duration of pre-release services, unless the individual voluntarily refuses such assistance or chooses to decline enrollment.

Scope of Pre-Release Benefit Package

The pre-release benefit package is designed to improve care transitions of such eligible individuals back to the community, including by promoting continuity of coverage, service receipt, and quality of care, as well as the proactive identification of both physical and behavioral health needs and HRSNs. It is designed to address these overarching demonstration goals, while aiming to ensure that participating correctional facilities can feasibly provide all pre-release benefits to qualifying incarcerated individuals.

CMS is authorizing West Virginia to provide coverage for the following services to be detailed in an attachment to the demonstration's STCs:

- Case management to assess and address physical and behavioral health needs and health-related social needs;
- Medication-assisted treatment (MAT) for all types of SUDs as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies;

- A 30-day supply of all prescription medications provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid state plan coverage authority and policy.

CMS recognizes that many individuals exiting correctional facilities may not have received sufficient health care to address all of their physical or behavioral health care needs while incarcerated. This demonstration initiative will provide individuals leaving correctional facilities the opportunity to receive short-term Medicaid pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, while providing the state the opportunity to test whether these pre-release services improve uptake and continuity of MAT and other SUD and behavioral health treatment, as appropriate for the individual, to reduce decompensation, suicide-related death, overdose, and overdose-related death. In addition, West Virginia has state specific goals for the reentry demonstration initiative including increasing access to and utilization of appropriate SUD treatment services, according to American Society of Addiction Medicine (ASAM) criteria or another comparable, nationally recognized set of SUD program standards based on evidence-based SUD clinical guidelines. Therefore, CMS is approving a demonstration benefit package in West Virginia that is designed to improve identification of physical and behavioral health needs and HRSNs to facilitate connections to providers with the capacity to meet those needs in the community during the period immediately before an individual's expected release from a correctional facility. Once an individual is released, the coverage for which the individual is otherwise eligible must be provided consistent with all requirements applicable to such coverage.

Eligible Juveniles and This Reentry Demonstration Initiative

Section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328) amends the Act and describes a mandatory population (eligible juveniles and targeted low-income children) and set of pre-release and post-release services, while section 5122 of the CAA, 2023 amends the Act and gives a state the option to receive FFP for the full range of coverable services for eligible juveniles and targeted low-income children while pending disposition of charges. Every state is required to submit Medicaid and CHIP State Plan Amendments (SPAs) attesting to meeting the requirements in Section 5121 beginning January 1, 2025.[3]

To the extent there is overlap between the services required to be covered under sections 1902(a)(84)(D) of the Act and coverage under this demonstration, we understand that it would be administratively burdensome for states to identify whether each individual service is furnished to a beneficiary under the state plan or demonstration authority. Accordingly, to eliminate unnecessary administrative burden and ease implementation of statutorily required coverage and this demonstration, we are approving a waiver of the otherwise mandatory state plan coverage requirements to permit the state instead to cover at least the same services for the same beneficiaries under this demonstration. This approach will ease implementation, administration,

[3] SHO# 24-004, RE: Provision of Medicaid and CHIP Services to Incarcerated Youth. https://www.medicaid.gov/federal-policy-guidance/downloads/sho24004.pdf

and claiming, and provide a more coherent approach to monitoring, and evaluation of the state's reentry coverage under the demonstration. The state will provide coverage under the reentry demonstration to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act, at a level equal to or greater than otherwise would be covered under the state plan. Compliance and state plan submission requirements under section 5121 of the CAA, 2023 will remain unchanged. Coverage of the population and benefits identified in sections 1902(a)(84)(D) of the Act, as applicable, will automatically revert to state plan coverage in the event that this demonstration ends or eliminates coverage of beneficiaries and/or services specified in those provisions.

Implementation and Reinvestment Plans

As described in the demonstration STCs, West Virginia will be required to submit to CMS a Reentry Initiative Implementation Plan (Implementation Plan) and Reinvestment Plan documenting how the state will operationalize coverage and provision of pre-release services and how existing funding for correctional facility health services will continue to support access to necessary care and achievement of positive health outcomes for the justice-involved population.

The Implementation Plan must be submitted to CMS consistent with the STCs, must describe the milestones and associated actions being addressed under this demonstration extension and provide operational details not captured in the STCs regarding implementation of those demonstration policies. At a minimum, the Implementation Plan will include definitions and parameters related to the implementation of the reentry authorities and describe the state's strategic approach for making significant improvements on the milestones and actions, as well as associated timelines for meeting them, for both program policy implementation and investments in transitional nonservice elements, as applicable. The Implementation Plan will also outline any potential operational challenges that the state anticipates and the state's intended approach to resolving these and other challenges the state may encounter in implementing the reentry demonstration initiative. The operational plan requirement in section 1902(a)(84)(D) of the Act is satisfied by the state's Implementation Plan. The state is still required to provide coverage and otherwise meet state plan requirements with respect to any population or service specified in section 1902(a)(84)(D) of the Act that is not covered under this demonstration.

The reentry demonstration initiative is not intended to shift current correctional facility health care costs to the Medicaid program. Section 5032(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) (P.L. 155-271) makes clear that the purpose of the demonstration opportunity contemplated under that statute is "to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under title XIX." Furthermore, demonstration projects under section 1115 of the Act must be likely to promote the objectives of title XIX, which includes the inmate payment exclusion, in recognition that the correctional authority bears the costs for health care furnished to incarcerated individuals. This demonstration does not absolve correctional authorities in West Virginia of their Constitutional obligation to ensure needed health care is furnished to inmates in

their custody and is not intended as a means to transfer the financial burden of that obligation from a tribal, state, or local correctional authority to the Medicaid program.

West Virginia agrees to reinvest the total amount of new federal matching funds for the reentry demonstration initiative received under this demonstration extension into activities or initiatives that increase access to or improve the quality of health care services for individuals who are incarcerated (including individuals who are soon-to-be released) or were recently released from incarceration, or for physical and behavioral health needs that may help prevent or reduce the likelihood of criminal justice system involvement. Consistent with this requirement, West Virginia will develop and submit a Reinvestment Plan to CMS outlining how the federal matching funds under the demonstration will be reinvested. The Reinvestment Plan should align with the goals of the state's reentry demonstration initiative. It should detail the state's plans to increase access to or improve the quality of health care services for those who have recently been released, and those who may be at higher risk of future criminal justice system involvement, particularly due to untreated behavioral health conditions. The Reinvestment Plan should describe the activities or initiatives selected by West Virginia for investment and a timeline for implementation. Any investment in carceral health care must add to and/or improve the quality of health care services and resources for individuals who are incarcerated and those who are soon to be released from carceral settings, and not supplant existing state or local spending on such services and resources. The reinvestment plan may include the services provided to eligible juveniles under section 1902(nn)(2) of the Act, who are covered under this demonstration.

2) HRSN Services

CMS is authorizing the state to offer coverage of certain services that address HRSN for qualifying beneficiaries, as evidence indicates that these benefits are critical drivers of an individual's access to health services that keep them well.[4,5] Under this demonstration, the state will receive authority to cover the following HRSN housing interventions without room and board:

- Case management services for access to housing (e.g., outreach and education; linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees);

- Pre-tenancy navigation services (e.g., finding and securing housing);

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[4] As discussed in a letter to State Health Officials issued on January 7, 2021, https://www.medicaid.gov/federalpolicy-guidance/downloads/sho21001.pdf, addressing Social Determinants of Health can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid program. While "social determinants of health" is a broad term that relates to the health of all people, HRSN relates more specifically to an individual's adverse conditions reflecting needs that are unmet and contribute to poor health. See also https://www.healthaffairs.org/do/10.1377/forefront.20191025.776011/full/

[5] Bachrach, D., Pfister, H., Wallis, K., Lipson, M. Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment. The Commonwealth Fund; 2014; https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2014_may_1749_bachrach_addressing_patients_social_needs_v2.pdf.

- One-time transition and moving costs other than rent, to assist with identifying, coordinating, securing, or funding one-time necessary services and modifications to help a person establish a basic household (e.g., security deposits, application and inspection fees, utilities activation fees, movers);
- Tenancy and sustaining services (e.g., eviction prevention, tenant rights education);

Coverage of targeted HRSN services and supports is likely to assist in promoting the objectives of Medicaid because it is expected to help beneficiaries stay connected to coverage and access to needed health care. The housing services authorized in the demonstration are expected to stabilize the housing situations of eligible Medicaid beneficiaries and thus increase the likelihood that they will keep receiving and benefitting from the Medicaid-covered services to which they are entitled.

Coverage of targeted, clinically appropriate HRSN services will also provide a regular source of care to meet individuals' comprehensive health needs. This is likely to improve health outcomes directly, as well as improve the use of other clinical services. By providing the short-term services needed to stabilize housing, this demonstration will test whether the individual's health outcomes will improve in addition to their utilization of appropriate care.

Moreover, the Medicaid statute, including both sections 1905 and 1915 of the Act, already includes mechanisms that reflect the critical role of upstream services (i.e., those that help avert more intensive medical interventions) in meeting the medical assistance needs of certain Medicaid-eligible populations (e.g., individuals with disabilities).

Medical assistance made available under a state plan option authorized under section 1915(i) of the Act provides that same package of home and community-based services (HCBS) to individuals meeting needs-based criteria that are less stringent than criteria required for institutional placement. These services are also intended to avert a need for nursing facility care.

Available evidence[6] suggests there may be populations in addition to those eligible under section 1915(c) or 1915(i) criteria that would benefit clinically from the section 1915(c) or 1915(i) services described above, as well as additional upstream HRSN services. Additional research is needed to better understand the effects of providing these types of services to a broader group of people. To that end, this demonstration will test whether expanding eligibility for these services to additional populations or providing additional services can improve the health outcomes of certain Medicaid beneficiaries. The demonstration will also test whether extending eligibility for a broader range of Medicaid beneficiaries or providing additional services will help to maintain coverage by preventing health-related incidents that could lead to enrollment churn.[7]

Moreover, access to these services for individuals with poorer health outcomes may help to reduce health disparities. Expanding who can receive these services is expected to help a broader range of Medicaid beneficiaries not only receive, and benefit from, the medical

[6] September 23, 2021. ASPE Contractor Project Report: Building the Evidence Base for Social Determinants of Health Interventions. https://aspe.hhs.gov/reports/building-evidence-base-social-determinants-health-interventions
[7] April 12, 2021. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic. https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf

assistance to which they are entitled, but also, these services are expected to further reduce health disparities often rooted in socioeconomic factors.[8] Thus, broadening the availability of certain HRSN services is expected to promote coverage and access to care, improve health outcomes, reduce disparities, and create long-term, cost-effective alternatives or supplements to traditional medical services.

As specified further in the STCs, HRSN services authorized in this demonstration must be clinically appropriate for the beneficiary. Beneficiaries qualified to receive HRSN services are those eligible for and enrolled in Medicaid with a documented medical need for the services. Attachment K, which CMS is approving concurrently with this demonstration approval, reflects a comprehensive list of the populations, clinical criteria, and social risk factors that the state will incorporate into the post-approval protocol that will define beneficiary qualifications for HRSN services.

CMS also expects the state to maintain existing state funding and efforts for HRSN services, without this demonstration authority supplanting existing efforts, and to have in place partnerships with other state and local entities to coordinate possible pathways to permanency for services to be provided without demonstration authorities.

Provider Rate Increase

Given the level of projected HRSN expenditures under this approval, West Virginia is not subject to the provider rate increase requirement.[3]

3) Quick Response Teams (QRTs) Pilot

CMS is providing expenditure authority for coverage of quick response teams (QRTs) that contact individuals who have experienced an overdose or other SUD-related emergency within 24-72 hours of the event to provide follow-up support, encouragement for recovery, and links to treatment and recovery options, if desired. Additional QRT services include brief assessments and interventions, provision of naloxone and patient education on the use of naloxone, PRSS services, development of a care plan, and support and education for family members/roommates on overdose symptoms and the characteristics of addiction. The goal of QRTs is to prevent repeated overdoses and SUD emergencies by building trust and rapport with individuals in the critical time period immediately after a SUD emergency to encourage the individual to seek treatment. QRTs consist of at least two individuals who have either a clinical background (e.g., a

[8] April 1, 2022. Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Effort. https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

[3] CMS developed the de minimis amount by arraying in order the requests we had from states for HRSN expenditures, as well as the range of likely costs for increasing provider rates, and examined the relationship between these ranges. CMS determined the rate increase requirement only applies if the annualized (divided across lifespan of demonstration period) expenditure authority for HRSN services and infrastructure is equal to or greater than the lesser of 0.5% of the state's annual Medicaid expenditures and $50 million. West Virginia's annual HRSN expenditure authority is below $50M and 0.5% of the state's total annual Medicaid spend.

social worker) or is a certified PRSS, who are enrolled in Medicaid as a provider, and who have received training in areas like motivational interviewing and trauma-informed care.

CMS is providing expenditure authority for QRTs to allow West Virginia to test the effectiveness of QRTs statewide. West Virginia must transition QRTs to state plan authority before the next demonstration period begins.

4) Recovery-Related Support Services (RRSS)

CMS is newly authorizing coverage of recovery-related support services (RRSS). RRSS assist and support individuals who are working and/or who desire to work. These services include rehabilitative services and supports that help individuals manage behavioral health challenges, develop strategies for engaging in work, assist in resolving workplace issues, and help individuals address their recovery needs while at work. Individuals eligible to receive RRSS are adults enrolled in West Virginia Medicaid who have a SUD and who are expected to benefit from RRSS. Individuals must also have other risk factors, which include the inability to be gainfully employed for at least 90 consecutive days in the past 12 months, unlikely to succeed in a competitive work setting without additional support and accommodation, and who have at least one condition/circumstance, like a history of repeated avoidable ED visits or a chronic health condition. West Virginia will determine an individual's risk factors using a comprehensive assessment, including an employment assessment. The individual's risk factors will documented as part of a broader health and HRSN needs history, which will be included in medical records and in the individual's treatment plan.

RRSS providers include licensed social workers, PRSS, and case managers, and RRSS will be delivered in facilities like licensed behavioral health centers and community mental health centers. RRSS does not include vocational services, for example, direct support with helping an individual find and procure a job (i.e., resume writing, completing applications), job coaching, and completing benefits paperwork on an individual's behalf.

Requests Not Being Approved at this Time

CMS and West Virginia are continuing discussions regarding some of the state's pending requests under the demonstration extension application submitted June 1, 2022. The requests below continue to be under review:

1) IMD stays for Medicaid Enrollees with Serious Mental Illness (SMI)

Due to a smaller population who would benefit from SMI IMD stays than the SUD population, West Virginia would like to postpone approval of this request from its demonstration extension to focus its efforts on expanding SUD services. The state may revisit this request in the future.

2) Recovery Residential Services (RRS)

CMS's HRSN framework currently does not allow coverage of recovery residential services (RRS), including room and board, for individuals with a SUD diagnosis who are leaving

institutional settings (inpatient or EDs) or residential treatment settings. CMS and West Virginia will revisit this request if there are changes to the framework that can accommodate the request.

3) Contingency Management

West Virginia requested authority to implement a contingency management program for Medicaid enrollees with a stimulant use disorder. At this time, CMS can only approve requests for contingency management from states that have sufficient budget neutrality savings to cover the costs of this program. Since West Virginia's demonstration does not generate budget neutrality savings, CMS cannot approve the state's contingency management proposal. CMS and the state will revisit this request if the policy changes.

Withdrawn Requests or CMS Approval Not Needed

West Virginia has withdrawn its proposal for involuntary secure withdrawal management and stabilization (SWMS) and its proposal for human immunodeficiency virus (HIV) and hepatitis C virus (HCV) care integration. The state may pursue these initiatives through other pathways outside of section 1115 authority.

West Virginia had requested new authority to clarify and inform MCOs and providers that the state will reimburse SUD IMD stays of up to 60 days at the ASAM 3.7 level of care for medically complex individuals. CMS confirmed this policy clarification is acceptable provided the state maintains the 30-day average length of stay. No changes are needed to the authorities or to the STCs to include this policy clarification.

Budget Neutrality[9]

CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs likely would have been in that state absent the demonstration. The demonstration extension is projected to be budget neutral to the federal government, meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the "without waiver" [WOW] costs). The state will be held to the budget neutrality monitoring and reporting requirements as outlined in the STCs.

[9] https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality/index.html.

Rebasing Without Waiver Baseline

Under this extension, for existing Medicaid Expenditure Groups (MEGs) that were implemented, CMS calculated the WOW baseline (which refers to the projected expenditures that could have occurred absent the demonstration and which is the basis for the budget neutrality expenditure limit for each approval period) by using a weighted average of the state's historical WOW per-member-per-month (PMPM) baseline and its recent actual PMPM costs. The projected demonstration expenditures associated with each MEG in the WOW baseline (except MEGs with aggregate cost limits) have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President's Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

Hypothetical Budget Neutrality Treatment

Under its current approach to budget neutrality, CMS generally treats expenditures for populations or services which could have otherwise been covered via the Medicaid state plan, or other title XIX authority, such as a section 1915 waiver, as "hypothetical" for the purposes of budget neutrality. In these cases, CMS adjusts budget neutrality to account for the spending which the state could have hypothetically provided through the Medicaid state plan or other title XIX authority. CMS does not, however, currently allow for budget neutrality savings accrual as a result of including hypothetical populations or services in section 1115 demonstration projects. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent budget neutrality "supplemental test" for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state's "with waiver" (WW) hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending with savings elsewhere in the demonstration or to refund the FFP to CMS. The "Supplemental HRSN Aggregate Ceiling," or SHAC, for HRSN expenditures is different, as discussed below.

For each of these MEGs, discussed below in this section, CMS calculated the WOW baseline (which refers to the projected expenditures that could have occurred absent the demonstration and which is the basis for the budget neutrality expenditure limit for each approval period). The projected demonstration expenditures associated with each of these MEGs in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President's Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

Under this approval, projected demonstration expenditures associated with QRTs and RRSS will be treated as hypothetical for the purposes of budget neutrality, and the WOW baselines have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the approval period.

The Medicaid expenditures for pre-release services furnished to incarcerated beneficiaries under the reentry demonstration initiative include coverage of services that states can and do cover through Medicaid state plan or other title XIX authority, for beneficiaries who are not subject to the inmate payment exclusion. CMS considers these expenditures to be hypothetical because the pre-release services would be coverable under the Medicaid state plan or other title XIX authority if furnished to a beneficiary outside a carceral setting, similar to how CMS treats expenditures for services furnished to certain beneficiaries who are short-term residents in an IMD primarily to receive treatment for SUD, or SMI or SED, under the SUD and SMI/SED section 1115 demonstration opportunities. Any population identified in section 1902(a)(84)(D) of the Act and covered instead under this demonstration will be included in the reentry MEG.

HRSN Budget Neutrality

CMS is treating HRSN expenditures authorized under this approval as "hypothetical" for the purposes of the budget neutrality calculation. Some of these expenditures could be covered under other title XIX authority, and treating those expenditures as hypothetical is consistent with how CMS has historically treated similar expenditures. Other HRSN expenditures could not otherwise be covered under title XIX authority, such as expenditures on section 1915 services for beneficiaries who are not otherwise eligible for them under section 1915, but there are insufficient or inconsistent data to calculate a WOW baseline for at least some of these expenditures. Treating those expenditures as hypothetical is also consistent with how CMS has historically treated similar expenditures. Additionally, treating demonstration HRSN expenditures as hypothetical will give the state the flexibility to test these worthy innovations, especially as CMS anticipates that they might result in overall reductions in future Medicaid program costs, based on robust academic-level research, but predicting these downstream effects on overall Medicaid program costs is extremely difficult. To ensure that treating HRSN expenditures as hypothetical does not have a significant negative fiscal impact on Medicaid, CMS is applying a budget neutrality ceiling to HRSN services expenditures and is referring to these expenditures collectively as the "Supplemental HRSN Aggregate Ceiling (SHAC)" expenditures in the STCs. The SHAC differs from the usual limit CMS places on hypothetical expenditures (the "supplemental test" discussed above) in several respects. The expenditures subject to the SHAC are narrowly defined to reflect only expenditures associated with services that research indicates are likely to have certain positive downstream effects. The upper limit on the SHAC is based on a range of estimates of the likely cost of these expenditures over a 5-year period and is set at a mid-point in that range, but in no case can it exceed 3 percent of the state's total computable Medicaid spending. And, if the state exceeds these limits, it will not be permitted to offset the additional costs with savings from the rest of the demonstration.

Mid-Course Correction

CMS has also updated its approach to mid-course corrections to budget neutrality calculations in this demonstration extension approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies, in the STCs, a list of circumstances under which a state's baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the state's control (for example, if expensive new drugs that the state is

required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (for example, unexpected costs due to a public health emergency); and/or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (for example, a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment. CMS considers this a more rational, transparent, and standardized approach to permitting budget neutrality modifications during the course of a demonstration.

Monitoring and Evaluation

Consistent with the demonstration STCs, the state submitted the Interim Evaluation Report[10] for the prior demonstration approval period with the extension application and also submitted the Summative Evaluation Report for that approval period during the temporary extension period. The evaluations report some notable progress toward the demonstration goals. For example, compared to the pre-demonstration period, findings suggest that the numbers of Medicaid providers offering SUD treatments and peer recovery support specialists increased during the demonstration approval period. After implementation, there was an increase in the number of residential facilities as well as in the utilization of residential treatment services. There also were statistically significant reductions in inpatient stays and all-cause mortality during the demonstration period compared to the pre-implementation period. However, the COVID-19 public health emergency, which coincided with part of the evaluation period, may have confounded the trends in outcomes.

With this extension of the demonstration, the state is required to continue conducting systematic monitoring and robust evaluation of the demonstration, including the policies and initiatives newly approved through this extension, per applicable CMS guidance and technical assistance. In collaboration with CMS, the state must undertake demonstration monitoring, including reporting of relevant metrics data and narrative details describing progress with implementation of all components of the demonstration. In addition, the state is also required to conduct independent mid-point assessments of the SUD and reentry demonstration initiatives, as described in the STCs, to support identifying risks and vulnerabilities and subsequent mitigation strategies.

The state is required to conduct an evaluation of the demonstration, including the temporary extension approval periods from January 1, 2023 through December 31, 2024, to support a comprehensive assessment of whether the demonstration components, including components added to the demonstration through this extension, are effective in producing the desired outcomes for its beneficiaries and providers, as well as the state's overall Medicaid program. The demonstration evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components, as described in the STCs. The state's

[10] See the West Virginia SUD Interim Evaluation Report, available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wv-creating-continuum-care-medicaid-enrollees-cms-aprvd-intrn-evltn-rprt.pdf.

monitoring and evaluation efforts must facilitate understanding the extent to which the demonstration might support reducing existing health disparities.

Consideration of Public Comments

CMS posted the application on Medicaid.gov for a 30-day federal public comment period from June 10, 2022, through July 10, 2022. CMS received five written comments, two of which were not on topic. The remaining comments were generally supportive of West Virginia's demonstration extension request, especially the coverage of pre-release services. However, one commenter expressed concerns about the state's involuntary SWMS and recovery residence proposals and noted that housing supports are of limited value without access to affordable housing. The commenter also explicitly opposed waiving the IMD exclusion for SMI due to concerns that it could lead to less investment in community-based services. We appreciate the commenter's feedback, but these proposals are outside the scope of this demonstration review, and we acknowledge that affordable housing is limited and encourage the state to utilize all levers available to improve the availability of such housing. Another commenter suggested specific features West Virginia should adopt in its technology platform for HRSN services. We thank the commenter for these recommendations, but these decisions fall within the state's discretion.

After carefully reviewing the public comments submitted during the federal comment period and information received from the state public comment period, CMS has concluded that the demonstration is likely to assist in promoting the objectives of Medicaid.

Other Information

CMS's approval of this demonstration extension is conditioned upon compliance with the enclosed set of waiver and expenditure authorities and the STCs defining the nature, character, and extent of anticipated federal involvement in the demonstration. The award is subject to our receiving your acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter. Your project officer, Jamie John, is available to answer any questions concerning this demonstration extension, and her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Jamie.John@cms.hhs.gov

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

Sincerely,

Chiquita Brooks-LaSure
Administrator

Enclosure

cc: Nicole Guess, State Monitoring Lead, Medicaid and CHIP Operations Group