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

West Virginia

Medicaid Section 1115 Waiver Demonstration:

Evolving West Virginia Medicaid's Behavioral Health Continuum of Care

Working DRAFT – December 1, 2021

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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).

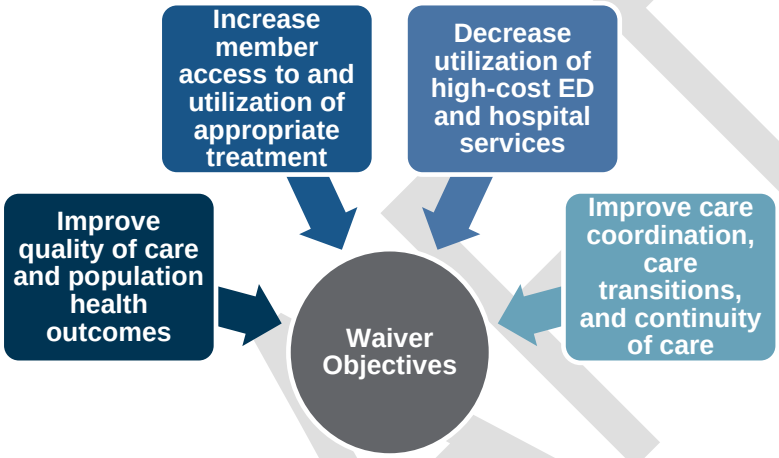
Through this waiver extension, BMS will evolve its continuum of care for individuals with serious mental and behavioral health disorders. BMS requests federal authority to:

- **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 for care for individuals with serious mental and behavioral health disorders in response to:

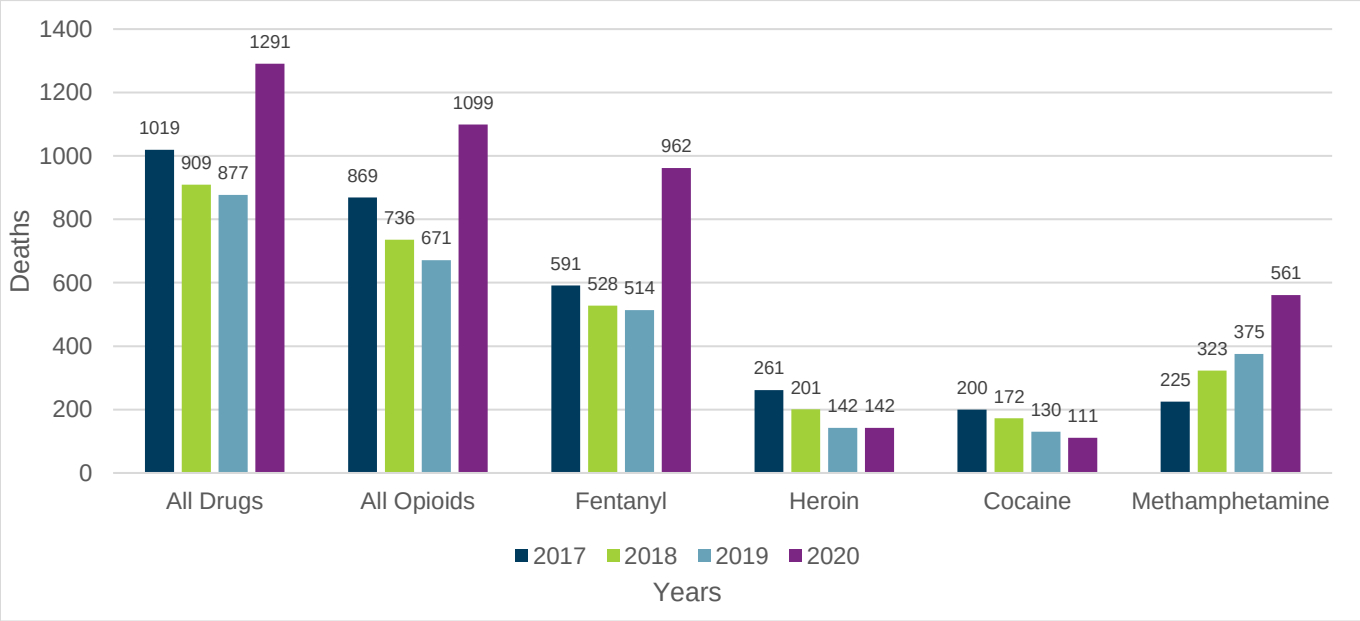
- Preliminary successes of the current waiver program for Medicaid members with SUD
- Opportunities to expand services identified through operational lessons learned and stakeholder feedback
- New federal guidance regarding demonstrations to support individuals with SMI and SDOH needs
- Numerous outbreaks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

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

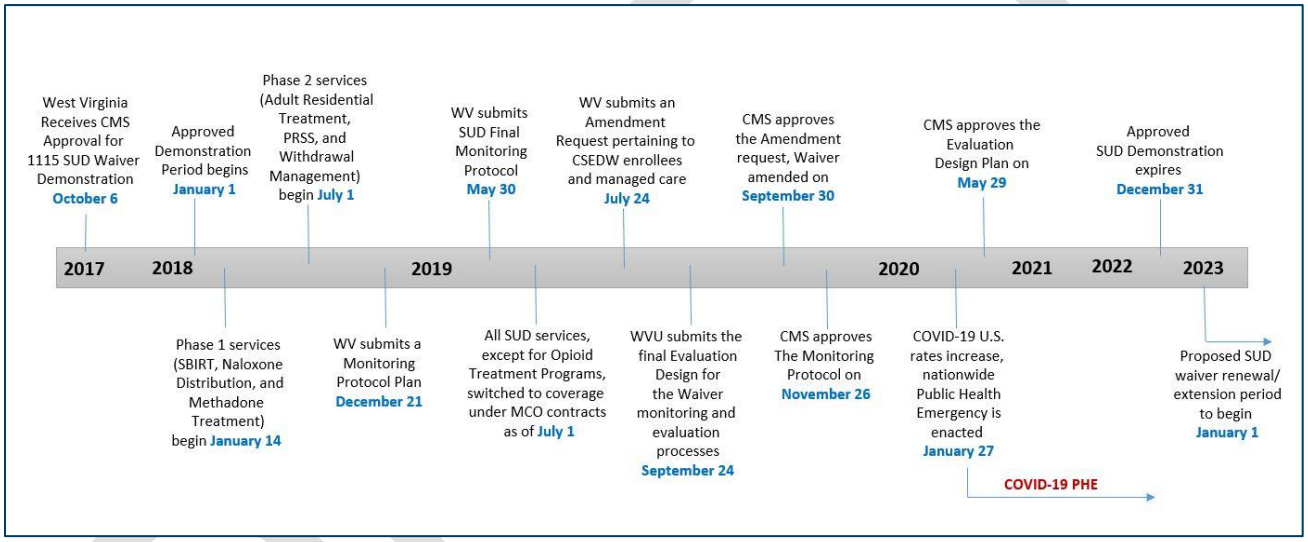
BMS is also seeking to extend the behavioral health continuum of care to include individuals with SMI who need extended services in a high-quality, clinically appropriate institution for mental diseases (IMD) setting while residing short term in the IMD primarily to receive mental health treatment.

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]

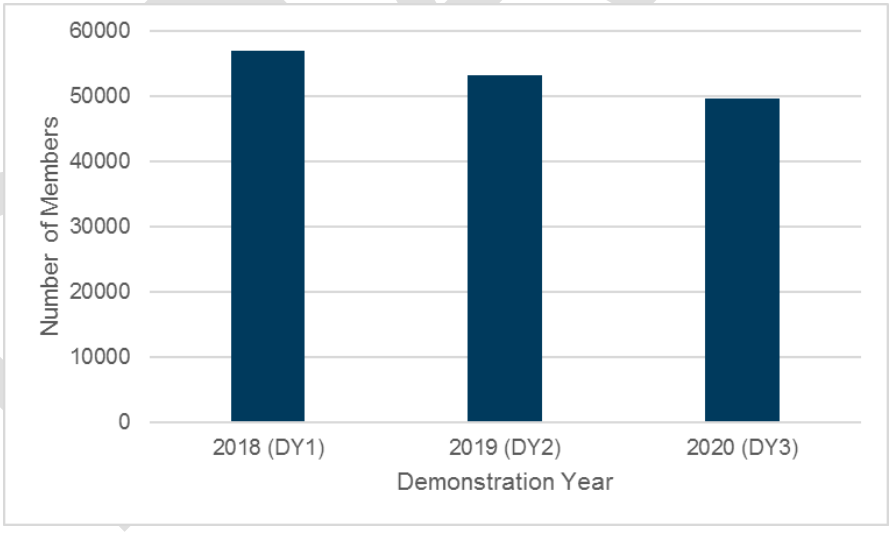
BMS has been successful in addressing several of these program objectives over the course of the waiver period, particularly regarding increasing member access to and utilization of appropriate SUD treatment services. BMS has also identified areas for continued improvement, especially in the context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

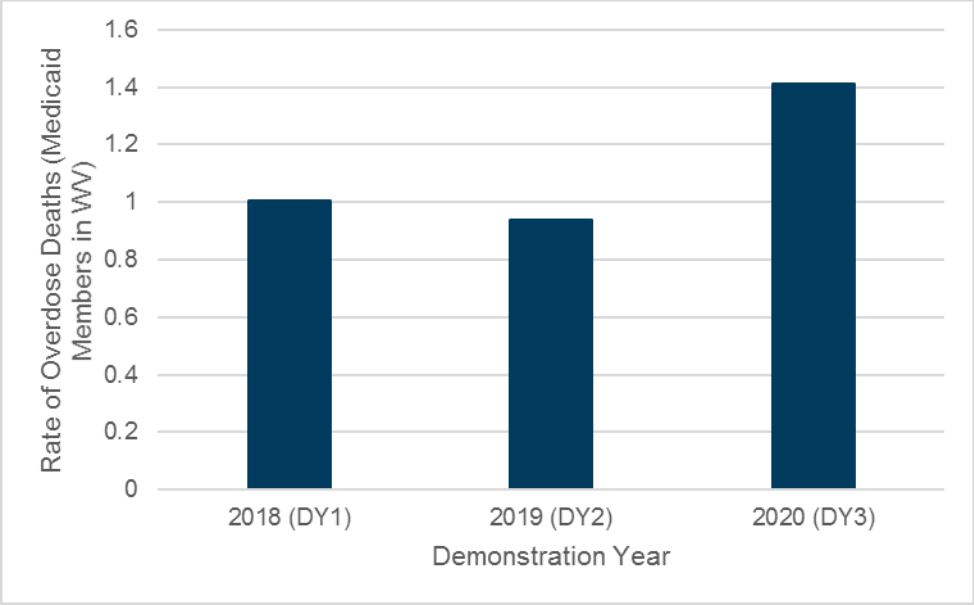
Figure 4 shows the number of Medicaid members with a SUD diagnosis on an annual basis. This number decreased during all three years of available annual data. BMS views this as a successful measure for DY1 and DY2, and an inconclusive measure for DY3. In DY1 and DY2, the number of members assessed for 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]



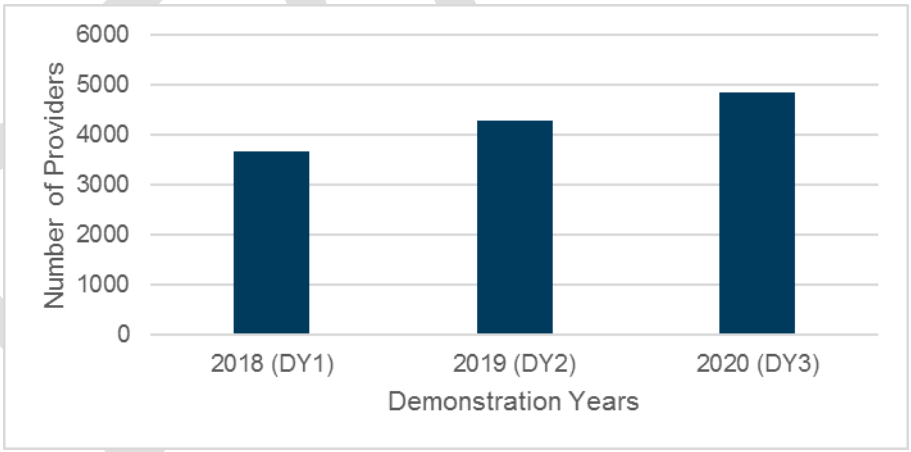
Additionally, as previously discussed, overdose deaths in West Virginia appeared to be declining overall prior to the COVID-19 PHE. Waiver data for Medicaid members is consistent with that trend. Figure 5, on the following page, shows the annual rate of overdose deaths per 1,000 adult Medicaid members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

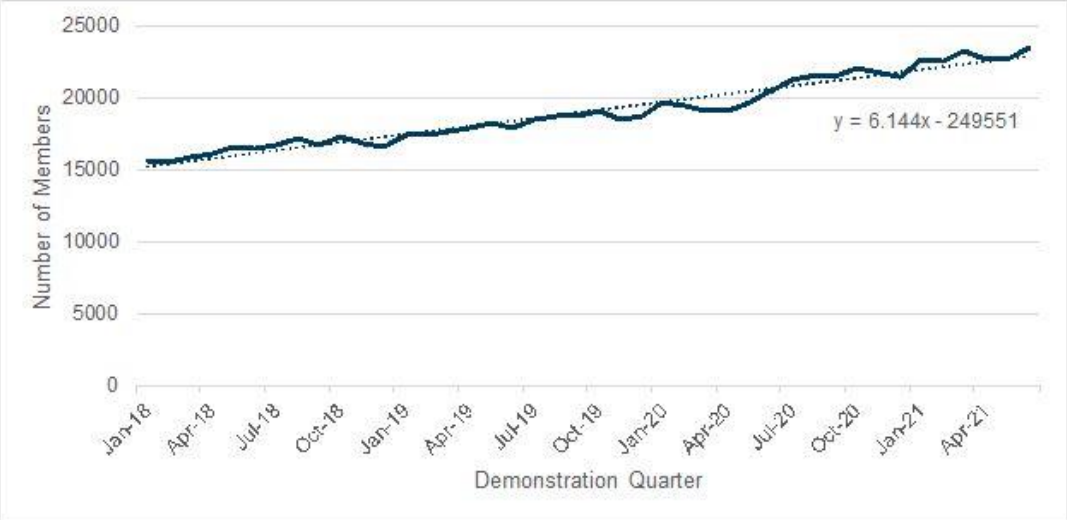


The addition of peer recovery support has been particularly successful. When asked, a focus group of providers from a variety of clinical settings unanimously agreed that peer recovery support services were extremely beneficial for individuals in recovery. Providers recommended increasing support and 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.

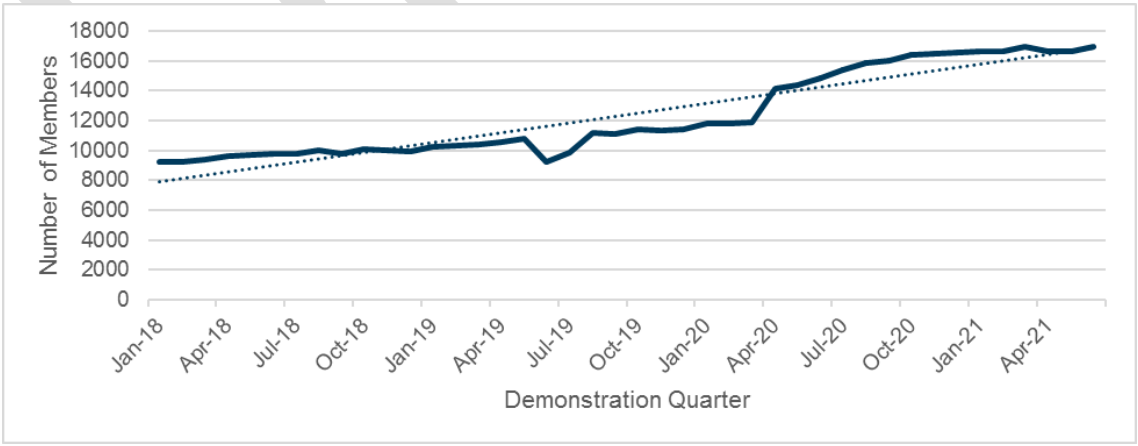
The implementation of the waiver program has increased both member access to and resulting utilization of SUD treatment services, as shown in the graph below. Member enrollment has increased in a relatively linear mode since the waiver began in January 2018, as shown in Figure 7.

Figure 7: Members Receiving SUD Treatment, DY1Q1 – DY4Q2



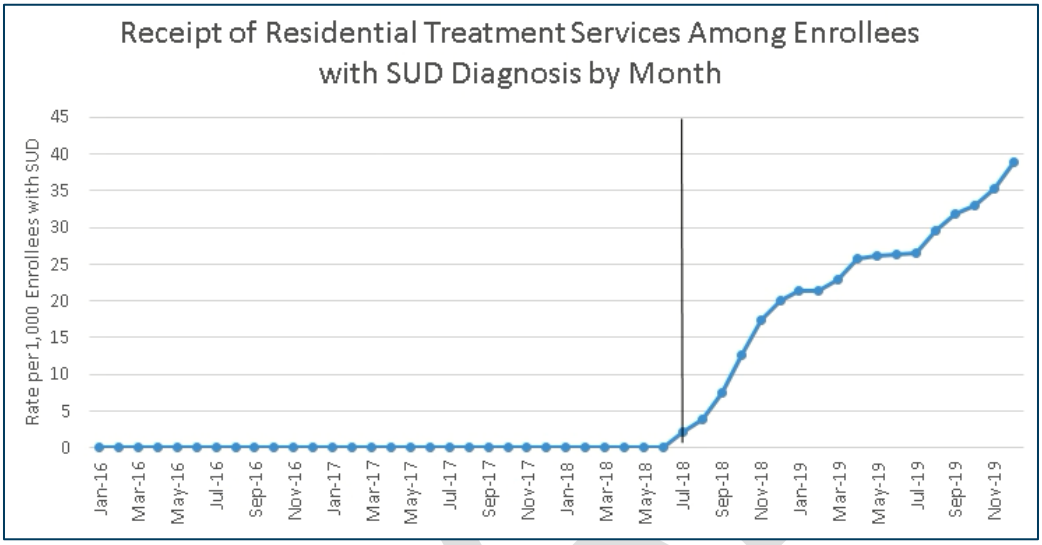
The number of members who used MAT services increased by 126 per 1,000 members with SUD due to the waiver's implementation.[xxiii] Notably, MAT has been one of the only services with steady continued growth during the COVID-19 PHE, as illustrated in the figure below.

Figure 8: Members Receiving MAT, DY1Q1 – DY4Q2



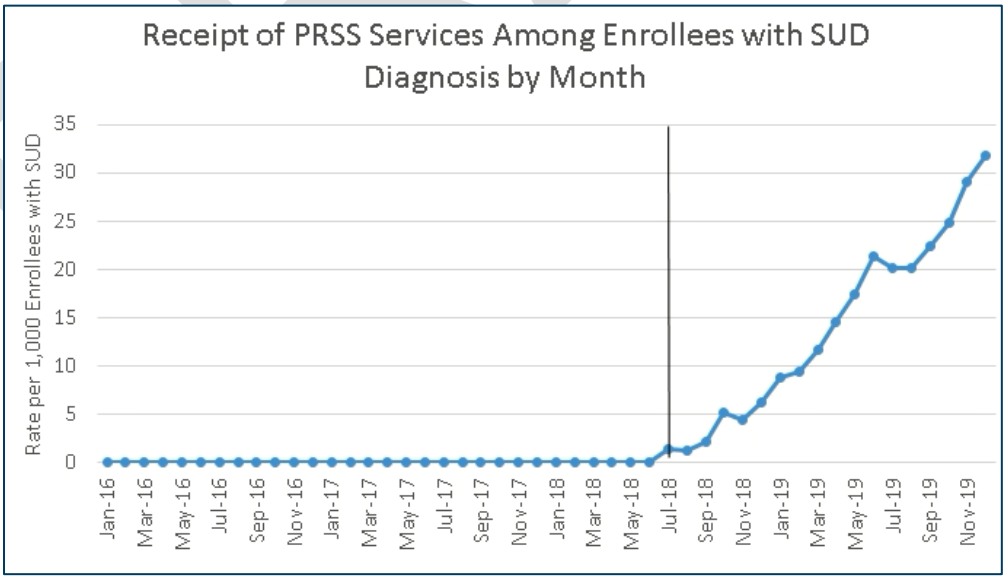
Additionally, with the expansion of facilities able to cover and offer residential treatment services, receipt of these services steadily increased since the waiver program's beginning in January 2018 to just below 500 per 1,000 members with a SUD diagnosis at the end of December 2019.[xxiv] This steady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

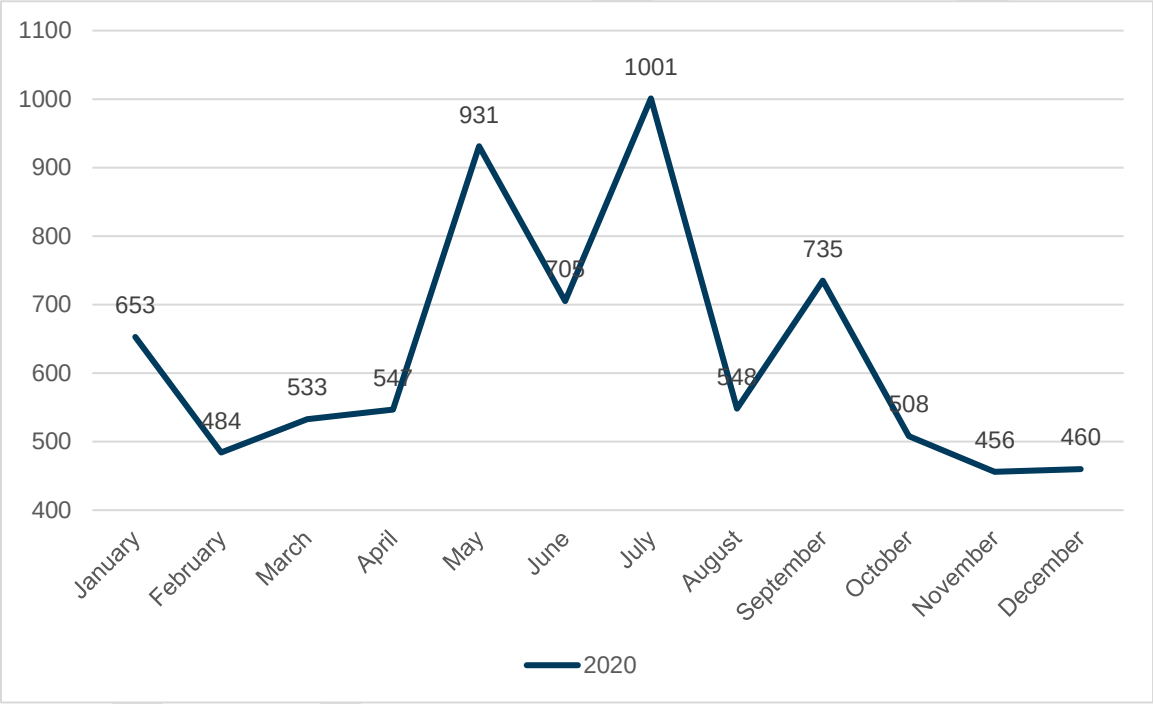
Figure 10: Members Receiving Peer Recovery Support Services, Pre-Waiver – December 2019



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.

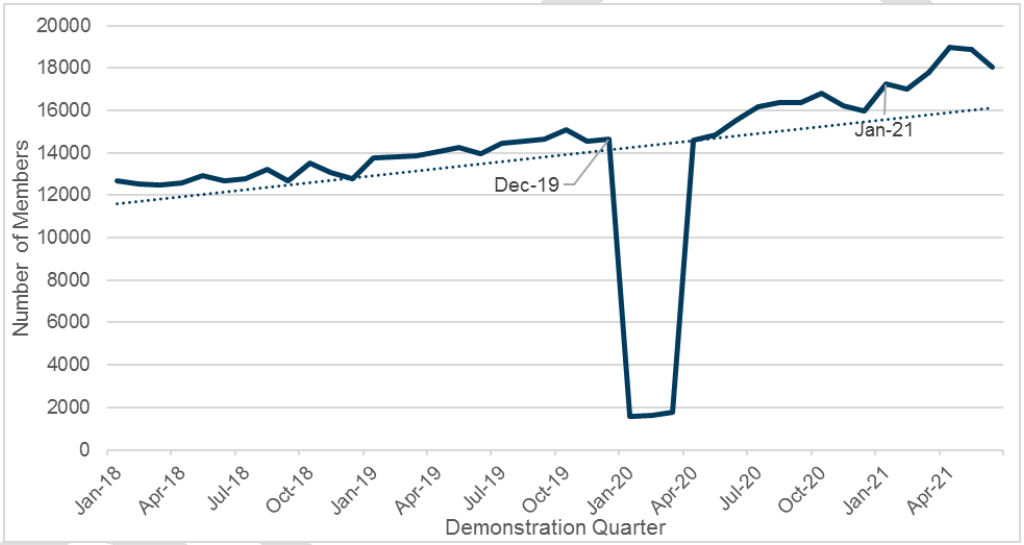
During DY3, ED utilization increased by 11.8%, and inpatient stays for SUD increased by 5.4%.[xxix] These trends run counter to waiver objectives and what BMS anticipated would happen with the waiver program implementation.[xxx] The increases were likely a result—at least in part—of the ongoing COVID-19 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



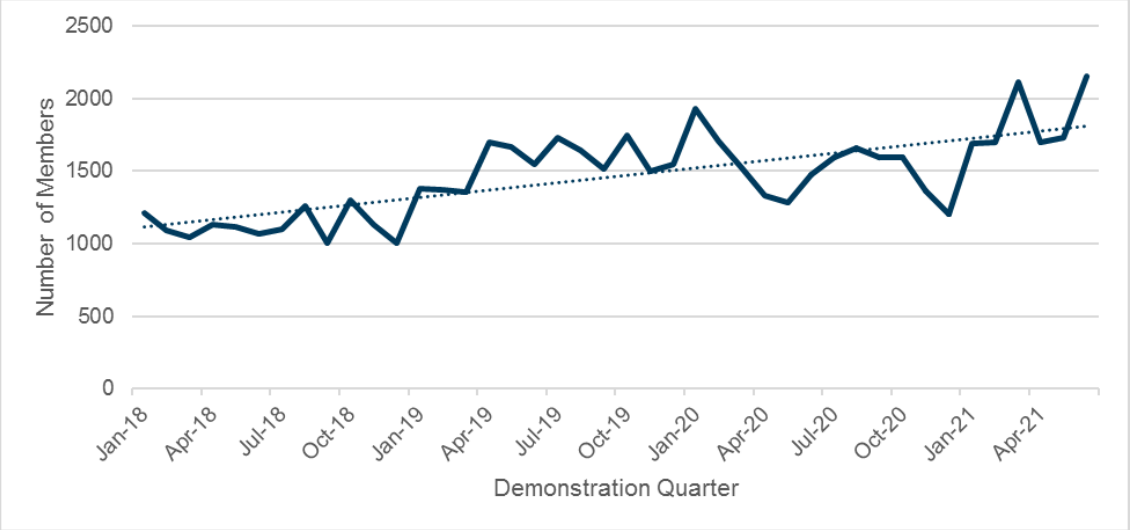
Objective 4: Improve care coordination and care transitions for Medicaid members with SUD.

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

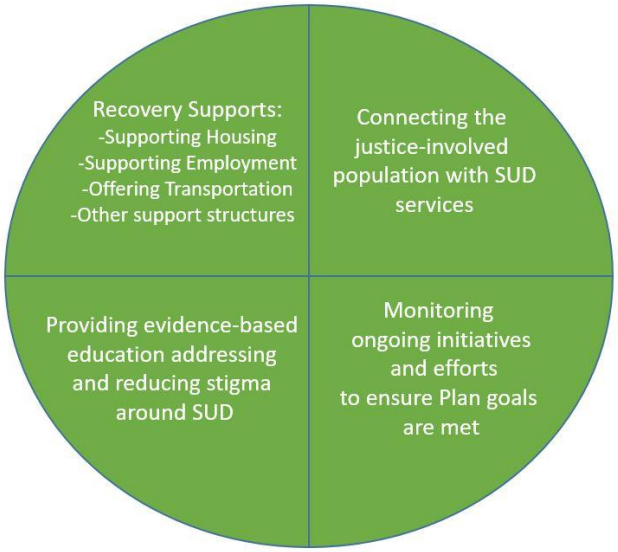


BMS' monitoring protocol projected increases for both metrics; the actual increases are significantly higher than projected.[xxxvii]

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.[xl] 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.[xli]

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.

***8.9%** of young adults in West Virginia have an SMI*

+

***6.1%** of adults in West Virginia have an SMI*

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."[xlii] 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.[xliii]

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.***[xliv] 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

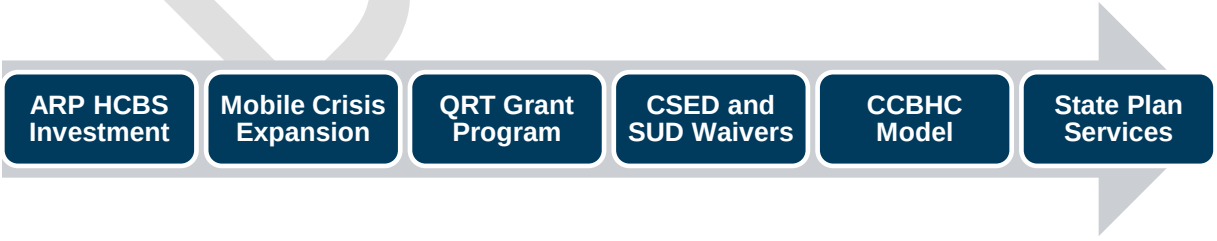
The services under this waiver will allow for the full continuum of care while maintaining focus on developing community-based, individual, and family driven services. BMS has demonstrated its commitment to a responsive and coordinated statewide continuum of care in recent years by:

- 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:* Further expand 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	25,419
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).[li] 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 LOCs[lii]

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.[liii]

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.[liii] 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.

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 goods and services 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
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
Clinically Managed Residential WM Services – 3.2-WM ASAM LOC	SUD

Benefit	Type
Medically Monitored Inpatient WM Services – 3.7-WM ASAM LOC	SUD
Opioid Treatment Program Services (OTP)	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, 3.5, and OTP 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.[lxi] 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.[xci] 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 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]

Incentives will be in the form of monthly goods and services that must support the individual's health (e.g., gym membership, exercise equipment, food delivery). Specifically, BMS will provide $75 per month 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 methadone treatment	While these services could be covered under the Medicaid State Plan, BMS has elected to cover the services through expenditure authority.
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 via gift cards 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

A summary of evaluation activities and findings to date for the waiver program is attached to this application as "SUD_InterimReport_20211123," conducted by the independent evaluator, West Virginia University (WVU). The preliminary evaluation report is attached to this application as "SUD_InterimReport_20211123."

BMS intends to continue all evaluation activities related to this waiver program consistent with its existing, approved evaluation plan. Additional evaluation hypotheses for the new demonstration features are included in the table below.

Table 6: 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 ***and/or SMI***."	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.

Based on the goals identified with BMS, the goals were translated into quantifiable targets for improvement. Table 7: Evaluation Questions and Hypotheses below lists the evaluation

questions and hypotheses. A comprehensive list of the Evaluation Measures Table can be located in the Appendix. Please note the items listed here are not final and subject to change.

Table 7: Evaluation Questions and 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.

Upon approval of this extension, BMS will work with the independent evaluator and CMS to develop an evaluation design plan consistent with the Special Terms and Conditions (STCs) and CMS policy.

7. 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	$817,702	$889,926	$976,892	$1,072,356
SUD Residential	$54,722,609	$60,742,201	$67,985,895	$76,093,422	$85,167,796
Peer Recovery Support Services	$28,900,575	$31,527,867	$34,680,654	$38,148,720	$41,963,592
Methadone					
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	$8,100,960	$8,577,853	$9,082,819	$9,617,513

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	$13,075,679	$33,081,467	$41,848,056	$46,032,861	$50,636,147
Expanded IMD for Medically Complicated SUD	$10,400,503	$12,377,445	$14,852,934	$17,823,521	$21,388,225
Involuntary Secure WM and Stabilization	$684,796	$719,115	$761,449	$806,274	$853,739

Below is a table of projected annual member enrollment for waiver services. Of note, some services include projections based on Medicaid members expected to utilize the service, and other services base enrollment projections on all projected Medicaid members enrolled in the waiver program.

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)	16,571	18,394	20,588	23,043	25,791
Peer Recovery Support Services (Enrolled MM)	6,287,166	6,235,200	6,235,200	6,235,200	6,235,200
Methadone (Enrolled MM)					
Recovery Housing (Enrolled MM)	6,287,166	6,235,200	6,235,200	6,235,200	6,235,200

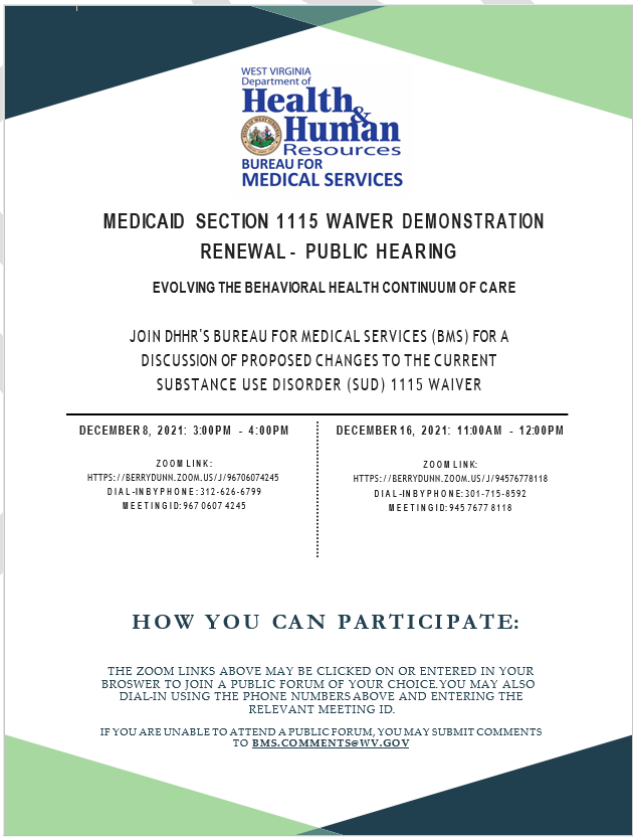
Supported Housing (Enrolled MM)	6,287,166	6,235,200	6,235,200	6,235,200	6,235,200
Supported Employment (Enrolled MM)	6,287,166	6,235,200	6,235,200	6,235,200	6,235,200
Continuity of Care for Justice-Involved (Enrolled MM)	6,287,166	6,235,200	6,235,200	6,235,200	6,235,200
HIV/HCV Education and Outreach (Enrolled MM)	6,287,166	6,235,200	6,235,200	6,235,200	6,235,200
Quick Response Teams (QRTs) (Enrolled MM)	QRTs to start in DY2	6,235,200	6,235,200	6,235,200	6,235,200
Contingency Management (Enrolled MM)	6,287,166	6,235,200	6,235,200	6,235,200	6,235,200
SMI IMD (Utilizing MM)	347	361	379	398	418
SMI Residential (Utilizing MM)	2,344	5,905	7,469	8,216	9,038
Expanded IMD for Medically Complicated SUD (Utilizing MM)	753	896	1,076	1,291	1,549
Involuntary Secure WM and Stabilization (Enrolled MM)	6,287,166	6,235,200	6,235,200	6,235,200	6,235,200

8. Public Notice Process

Per the Code of Federal Regulations (CFR) 42 Part 431.408 regarding the State public notice process for demonstrations, a state must provide at least a 30-day public notice and comment period regarding demonstration project applications. In accordance with the CFR requirement, West Virginia will hold a public notice and comment period for this proposed waiver from December 1, 2021, through December 31, 2021.

During this 30-day period, BMS will have this proposed 1115 waiver application posted to the BMS website for stakeholders to review and provide comments on. BMS will additionally hold two virtual public comment hearing events for stakeholders within the provider community and the general public to attend. At these hearings, individuals in attendance may ask questions or raise comments about the proposed waiver.

At the close of the 30-day public notice period, BMS will collect all comments received (in both public hearings as well as in emails to a designated State inbox for the waiver), review comments received, and make changes to the application draft as necessary prior to submitting the final application to CMS.



Appendix A: Quality and Access to Care Reports

BMS posts MCO 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.

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.

Appendix C: Evaluation Design Table

Table 12: 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	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. 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. 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: • 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: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).	Beneficiaries who were diagnosed with a new episode of alcohol or drug dependency during the first 10 and ½ months (January 1 – November 14) of the measurement year •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. Report beneficiaries with multiple diagnoses on the Index Episode claim only once for the total rate for the denominator. • 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

Logic Model Component	Measure Description	Steward	Numerator	Denominator	Data Source	Analytic Approach
			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 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			

Logic Model Component	Measure Description	Steward	Numerator	Denominator	Data Source	Analytic Approach
			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 • 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, NQF #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

Logic Model Component	Measure Description	Steward	Numerator	Denominator	Data Source	Analytic Approach
	drug dependence treatment		more additional AOD services or medication treatment within 34 days of the initiation visit. 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. 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). These beneficiaries are numerator compliant if they have two or more engagement events where only one can be an engagement medication treatment event. 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: • At least two engagement visits • At least one engagement medication treatment event 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	dependency during the first 10 and ½ months (January 1 – November 14) of the measurement year •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. Report beneficiaries with multiple diagnoses on the Index Episode claim only once for the total rate for the denominator. • 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.		

Logic Model Component	Measure Description	Steward	Numerator	Denominator	Data Source	Analytic Approach
			criteria (there is no requirement that they be with different providers). Any of the following meet criteria for an engagement visit: • 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: 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
			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 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 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),			

Logic Model Component	Measure Description	Steward	Numerator	Denominator	Data Source	Analytic Approach
			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. • 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	The number of unique beneficiaries (de-duplicated total) who have a claim for a MAT dispensing event for SUD during the measurement period Step 1. Identify claims with a code from the following HEDIS 2018 medications lists: • MAT for Alcohol Abuse or Dependence Medications List • MAT for Opioid Abuse or Dependence Medications List Step 2. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Step 1.	All Medicaid beneficiaries with SUD, enrolled for any amount of time during the measurement period	Medicaid claims	Difference-in-differences

Endnotes

[i] BMS is the state agency that administers Medicaid in West Virginia. BBH is the federally designated State Authority for mental health and substance use.
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[v] West Virginia Center on Budget and Policy, "Medicaid in the Mountain State: A Health and Economic Necessity," July 21, 2021. Available at: https://wvpolicy.org/wp-content/uploads/2021/07/WVCBP-Medicaid-Budget-Report.pdf.
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[xi] ODCP, "Data Dashboard," October 11, 2021. Available at: https://dhhr.wv.gov/office-of-drug-control-policy/datadashboard/Pages/default.aspx.
[xii] CDC, "Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic," December 17, 2020. Available at: https://emergency.cdc.gov/han/2020/han00438.asp.
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[xiv] [xiv] ODCP, "Data Dashboard," October 11, 2021. Available at: https://dhhr.wv.gov/office-of-drug-control-policy/datadashboard/Pages/default.aspx.
[xv] WVU evaluation team data and monitoring report Part A data through DY4 Q2.
[xvi] BMS, "West Virginia Medicaid Section 1115 Waiver Application: Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders," November 22, 2016. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wv/continuum-care/wv-creating-continuum-care-medicaid-enrollees-substance-demo-app-12062016.pdf.
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[xxii] WVU, "1115 SUD Demonstration Evaluation Update," presentation on February 26, 2021.
[xxiii] WVU, "1115 SUD Demonstration Evaluation Update," presentation on February 26, 2021.
[xxiv] WVU, "1115 SUD Demonstration Evaluation Update," presentation on February 26, 2021.
[xxv] WVU, "1115 SUD Demonstration Evaluation Update," presentation on August 25, 2021.
[xxvi] WVU, "1115 SUD Demonstration Evaluation Update," presentation on August 25, 2021.
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[xxxiii] WVU, "1115 SUD Demonstration Evaluation Update," presentation on February 26, 2021.
[xxxiv] BMS, "Medicaid Section 1115 SUD Demonstration Monitoring Report – Part B: Retrospective Monitoring Report – January 1, 2018, through December 31, 2019," March 31, 2021.
[xxxv] As this monitoring protocol metric is an established annual quality measure, DY3 data is not yet available for comparison.
[xxxvi] BMS, "Medicaid Section 1115 SUD Demonstration Monitoring Report – Part B: DY3 Annual CMS Monitoring Report – January 1, 2020, through December 31, 2020," March 31, 2021.
[xxxvii] BMS, "Medicaid Section 1115 SUD Demonstration Monitoring Report – Part B: DY3 Annual CMS Monitoring Report – January 1, 2020, through December 31, 2020," March 31, 2021.
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[xlv] All enrollees between the ages of 18 and 21 receive the services available under Early Periodic Screening, Diagnostic and Treatment (EPSDT), which includes appropriate services needed to address behavioral health issues. The state will ensure that any SUD-related services provided to individuals under age 21 also meet the ASAM criteria or another comparable, nationally recognized set of SUD program standards based on evidence-based SUD clinical guidelines.
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[l] BBH, "Comprehensive Behavioral Health Centers." Available at https://dhhr.wv.gov/BBH/about/Adult%20Services/Pages/Comprehensive-Behavioral-Health-Centers.aspx.
[li] BMS, "RAS-PRSS Weekly Report," October 8, 2021.
[lii] BMS, "Chapter 504 Substance Use Disorder Services Appendix B," July 1, 2019. Available at: https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20504%20Appendix%20B%20Application.pdf.
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