

**West Virginia  
Proposed Medicaid Section 1115  
Waiver Application:**

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

*September 19, 2016*

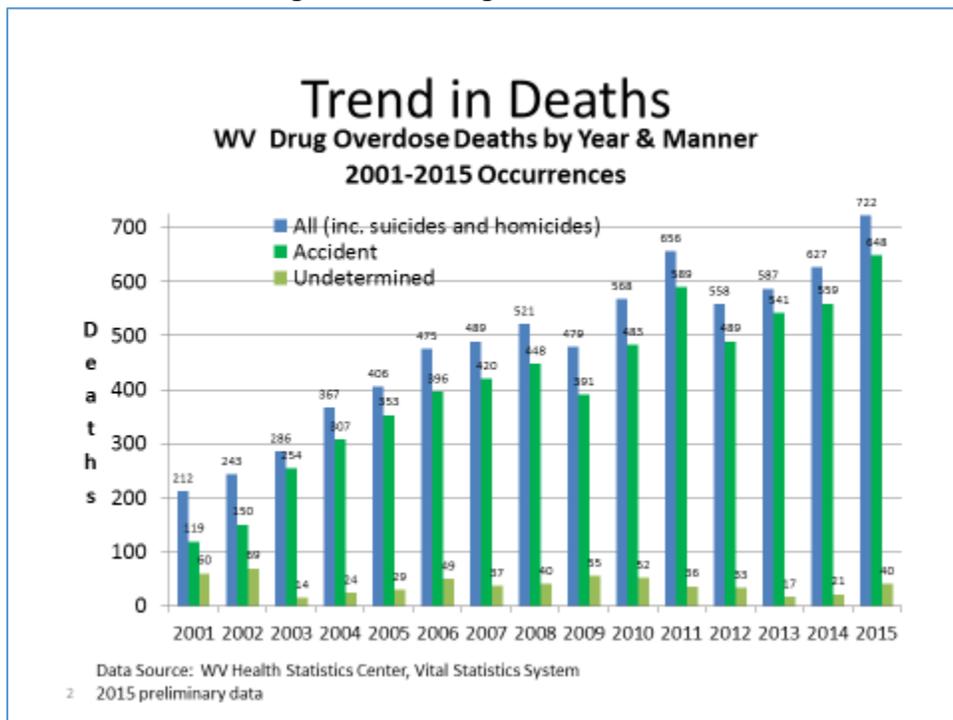
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## 1 West Virginia Substance Use Disorder Delivery System

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

Figure 1. WV Drug Overdose Trend



In August 2015, the state’s unemployment rate was the highest in the nation at 7.5 percent,<sup>3</sup> despite the national economic recovery in recent years. West Virginia’s annual average per capita income was only \$28,555 in 2014, with nearly 15% of the population living in poverty.<sup>4</sup> The combination of these socio-economic factors and the prevalence of substance use in the

<sup>1</sup> West Virginia Health Statistics Center. Available at: <http://www.wvdhhr.org/bph/hsc/>.

<sup>2</sup> Centers for Disease Control and Prevention, “Incidence of Neonatal Abstinence Syndrome, 28 States, 1999-2013”, August 12, 2016. Available at [http://www.cdc.gov/mmwr/volumes/65/wr/mm6531a2.htm?s\\_cid=mm6531a2\\_w](http://www.cdc.gov/mmwr/volumes/65/wr/mm6531a2.htm?s_cid=mm6531a2_w).

<sup>3</sup> “WV Reports Highest Unemployment Rate in the Nation at 7.5%,” The State Sun Journal, August 2015. Available at: <http://www.statejournal.com/story/29852205/wv-reports-highest-unemployment-rate-in-the-nation-at-75-percent>.

<sup>4</sup> United States Census. Available at: <http://www.census.gov/quickfacts/table/PST045215/00>.

state creates both an acute challenge and a significant opportunity for the Medicaid program. West Virginia is submitting this Medicaid Section 1115 waiver proposal to develop a comprehensive and cohesive continuum of care for individuals with substance use disorder (SUD) issues.

### **Current Delivery System**

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

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

#### *Infrastructure and Delivery System*

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

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

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<sup>5</sup> Centers for Medicare & Medicaid Services, Medicaid and CHIP Eligibility and Enrollment Report, June 2016. Available at <https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/june-2016-enrollment-report.pdf>.

<sup>6</sup> West Virginia MARS450A Report.

<sup>7</sup> West Virginia Bureau for Medical Services. Managed Care Enrollment, July 2016.

**Table 1: West Virginia Medicaid Enrollment by Managed Care Plan**

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

West Virginia’s publicly-funded, community-based behavioral health system is anchored by 13 regionally-based Comprehensive Behavioral Health Centers (CBHCs), operating full-service and/or satellite offices in each of the counties located in the center’s catchment area. There are 97 Licensed Behavioral Health Centers in West Virginia that provide the same array of services that the CBHCs provide. Federally Qualified Health Centers (FQHCs) also play a major role in providing SUD services—19 of the state’s 34 FQHCs across 108 sites employ a behavioral health provider. There are nine licensed social work (LCSW) practices, 164 psychiatric practices, and 219 psychological practices that provide assessments, testing, individual, group, family, and crisis therapy to West Virginia Medicaid members across the state. Five of the state’s largest CBHCs provide coordinated primary health care services in a community mental health setting and share behavioral health staff with rural primary care centers through co-location and integration agreements.

*Current SUD Services and Initiatives*

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

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

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

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

- **Statewide Implementation:** The recommendations include increasing public education and outreach regarding the disease of addiction, improving access to appropriate treatment and the multiple pathways to recovery, increasing the dissemination and education of Naloxone, improving access to licensed medication assisted treatment (MAT) centers and waived physicians, and expanding school-based behavioral health services.
- **Regional Capacity:** In order to fill some of the identified service delivery gaps, the Council is working to promote SUD treatment capacity by region across the state. The recommendations also include developing infrastructure for recovery housing.
- **Legislative and Policy:** The recommendations for legislative and policy change include developing/supporting "Second Chance for Employment Act" legislation to help remove barriers to obtaining employment, assessing an Alcohol and Tobacco User Fee with a percentage set aside for SUD services, reviewing the Certificate of Need process for behavioral health services to recommend ways to reduce barriers for new and existing program expansions, shifting Benzodiazepines from Schedule 4 to Schedule 3, and increasing usage of and accountability measures for the Prescription Drug Monitoring Program (PDMP).

The West Virginia legislature recently passed SB 454<sup>8</sup> which licenses and regulates medication-assisted treatment programs for substance use disorders. Over the past five

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<sup>8</sup> Senate Bill [454](http://www.legis.state.wv.us/Bill_Status/bills_history.cfm?INPUT=454&year=2016&sessiontype=RS). Available at:  
[http://www.legis.state.wv.us/Bill\\_Status/bills\\_history.cfm?INPUT=454&year=2016&sessiontype=RS](http://www.legis.state.wv.us/Bill_Status/bills_history.cfm?INPUT=454&year=2016&sessiontype=RS)

years, West Virginia has implemented several pieces of legislation (including West Virginia Senate Bills 335<sup>9</sup>, 437,<sup>10</sup> and 523<sup>11</sup>) to address prescription drug abuse and opioid overuse. Senate Bill 437, passed on March 10, 2012, takes a comprehensive approach to address prescription drug diversion and substance use issues. The law increases regulation of opioid treatment centers; establishes licensing and regulation of chronic pain clinics; and creates mechanisms to flag abnormal or unusual usage patterns of controlled substances by patients and unusual prescribing or dispensing patterns by licensed practitioners. It also implements requirements for continued education for physicians and others who administer controlled substances; and establishes a system for tracking sales of pseudoephedrine, limiting the amount that can be legally purchased daily (3.6g), monthly (7.3g), and annually (48g).<sup>12</sup>

### Existing SUD Services

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

### Substance Use Prevention and Treatment Block Grant Services<sup>13</sup>

The Substance Use Prevention and Treatment (SAPT) Block Grant is a major source of funding in West Virginia, allocating \$6.5 million for substance abuse early intervention, treatment, and recovery services in FY 2016/2017. BBHMF provides funding support for a continuum of treatment options, including outpatient and intensive services, and short and long-term residential treatment that are not otherwise covered by Medicaid, Medicare, or private insurance. Block grant funds provide for community-based recovery support services that include expanding best practices in peer supports. BBHMF has trained over 200 recovery

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<sup>9</sup> Senate Bill 335. Available at:

[http://www.legis.state.wv.us/Bill\\_Text\\_HTML/2015\\_SESSIONS/RS/bills/SB335%20SUB1%20ENR2.pdf](http://www.legis.state.wv.us/Bill_Text_HTML/2015_SESSIONS/RS/bills/SB335%20SUB1%20ENR2.pdf).

<sup>10</sup> Senate Bill 437. Available at:

[http://www.legis.state.wv.us/Bill\\_Status/bills\\_text.cfm?billdoc=sb437%20sub3%20enr.htm&yr=2012&sess\\_type=RS&billtype=B&houseorig=S&i=437](http://www.legis.state.wv.us/Bill_Status/bills_text.cfm?billdoc=sb437%20sub3%20enr.htm&yr=2012&sess_type=RS&billtype=B&houseorig=S&i=437).

<sup>11</sup> Senate Bill 523. Available at:

[http://www.legis.state.wv.us/Bill\\_Status/bills\\_text.cfm?billdoc=SB523%20SUB1%20enr.htm&yr=2015&sess\\_type=RS&billtype=B&houseorig=S&i=523](http://www.legis.state.wv.us/Bill_Status/bills_text.cfm?billdoc=SB523%20SUB1%20enr.htm&yr=2015&sess_type=RS&billtype=B&houseorig=S&i=523).

<sup>12</sup> "West Virginia Legislature Enacts Comprehensive Substance Abuse Laws," Health Law Monitor, 2012. Available at: <http://healthlawmonitor.jacksonkelly.com/2012/04/west-virginia-legislature-enacts-comprehensive-substance-abuse-laws.html>.

<sup>13</sup> West Virginia FY 2016-2017 State Behavioral Health Assessment and Plan Block Grant Application. Available at:

<http://www.dhhr.wv.gov/bhhf/newsandevents/Documents/2016%202017%20Combined%20MHSA%20Block%20Grant%20Application1.pdf>.

coaches statewide in every region with 29 trained as trainers and has expanded recovery residences that provide focused short and long-term housing access for people who need safe and supportive housing to live drug and/or alcohol free. MTM has been awarded a contract to be the state of West Virginia's non-emergency medical transportation (NEMT) manager. The organization provides rides free of charge for eligible Medicaid members throughout the state for covered medical services. The program was put in place to alleviate transportation barriers to treatment in a rural state.

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

With regard to Medication Assisted Treatment, there are currently 187 physicians who are waived to prescribe buprenorphine. Medicaid provides coverage for buprenorphine, mono-buprenorphine, and vivitrol. There are currently 165 physicians that are licensed under Medicaid to provide these services. The BBHMF has worked with BMS and the Office of Health Facility Licensure and Certification (OHFLC) to develop an Opioid Treatment Center oversight committee to review: (1) clinic policies/procedures; (2) the implementation of the revised quarterly reports for the Health and Human Services Legislative Committee; (3) licensure reports; and (4) exception requests for take home doses.

The Committee also developed a waiver process for staff with felony convictions. The administrative rules governing Opioid Treatment Centers was revised in 2010 based on recommendations from BBHMF. The revised rules hold Opioid Treatment Centers more accountable for the services they provide, particularly clinical and recovery-based services. Since the implementation of the rules there have been 14 pain management initial licensure surveys completed, five applications pending survey, five licensed clinics, and the closure of 11 pain clinics.

Since the passage of Senate Bill 437, more physicians are accessing the Controlled Substance Monitoring Program database at patient intake before administering, prescribing, or distributing prescriptions, and physicians receive required continuing education on best prescribing practices. Pharmacists have also received education on dispensing prescription buprenorphine and electronically-submitting certain information to the Multi-State Real-Time Tracking System (MSRTTS) administered by the National Association of Drug Diversion Investigators (NADDI). The number of Peer-Operated Recovery Homes and Facilities has increased, providing safe housing for individuals age 18 and older who are recovering from substance use and/or co-

occurring substance use and mental health disorders. These facilities house individuals for up to twelve months. Residents are encouraged to participate in outpatient and intensive services provided off-site so that Medicaid may pay for Medicaid reimbursable services that do not occur at the facility. Service areas provided by the facility include: prevention, health promotion and wellness, and recovery support services.

Key components of a Recovery Residence include, but are not restricted to: drug screening, house/resident meetings, mutual aid/self-help meetings, structured house/resident rules, peer-run groups, life skill development emphasis, and clinical treatment services in the community. Staff positions include, but are not restricted to, a Facility Manager, Certified Peer Coach(s), Case Manager(s), and other Certified Peer staff. Resident capacity is six to eight for home settings and 60 – 100 beds for recovery housing. All grantees abide by National Association of Recovery Residence Standards. There were no Recovery Coaches in 2010. Through BBHFF's capacity development efforts, West Virginia now has a total of 201 Recovery Coaches trained and available in all regions of the state. The West Virginia BBHFF has developed a certification process for Peer Specialists who will provide peer services for addiction, mental health, and developmental disabilities.

### Health Homes

West Virginia has also implemented a Medicaid Health Homes initiative in six counties for individuals who have a bipolar disorder and have, or are at risk of having, Hepatitis B or C. Health Homes provide a place for individuals to have their health care needs identified and to receive the medical, behavioral health, and related social services and supports they need in a coordinated manner. Services include comprehensive care management, care coordination, health promotion, and community and social supports. There are seven organizations enrolled as Health Home providers. As of June 30, 2016, 681 individuals were enrolled in a Medicaid Health Home. Since launching in July 2014, nearly 1,500 individuals have participated in the program.<sup>14</sup>

### Addressing Neonatal Abstinence Syndrome

Another population that West Virginia has been focusing on are mothers and newborns born with addictions. According to data from the state Health Care Authority from the Hospital Discharge Data Set, 637 babies were born with Neonatal Abstinence Syndrome (NAS) in 2014. The state currently has an NAS rate of 31 per 1,000 births (approximately 3%).<sup>15</sup> At 11%,

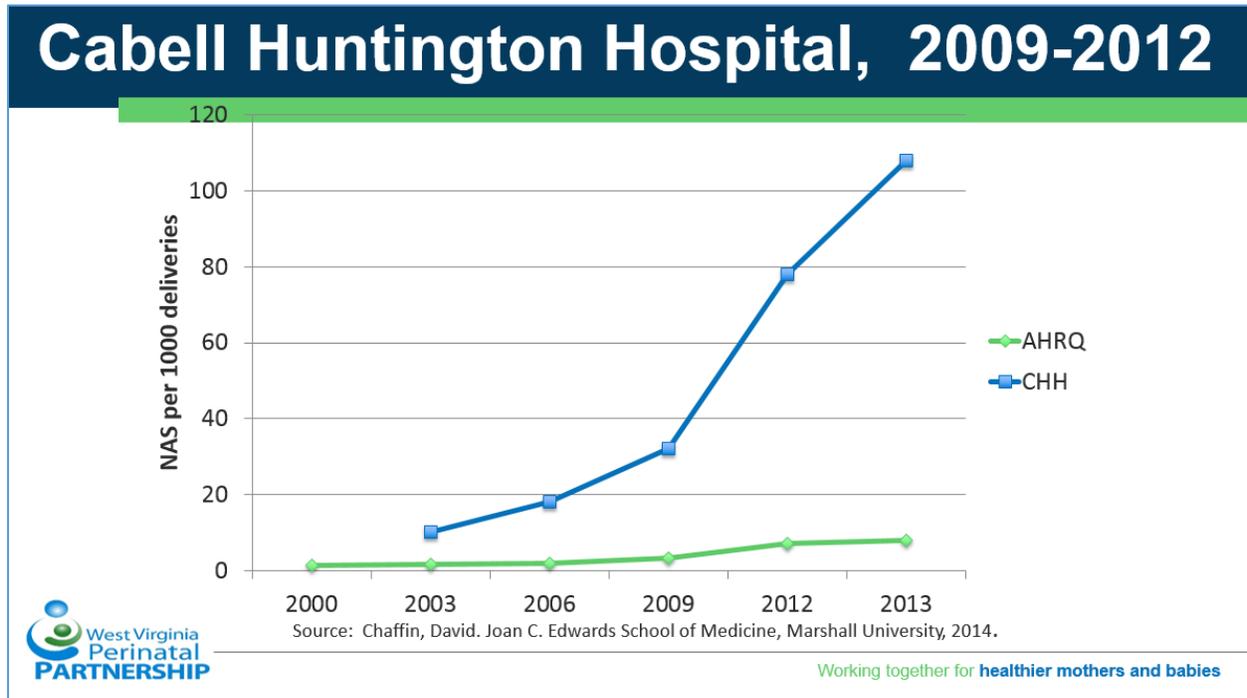
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<sup>14</sup> West Virginia DHHR Health Homes Data, July 2016.

<sup>15</sup> Ko, Jean et al., Centers for Disease Control and Prevention, "Incidence of Neonatal Abstinence Syndrome, 28 States, 1999-2013," August 12, 2016. Available at [http://www.cdc.gov/mmwr/volumes/65/wr/mm6531a2.htm?s\\_cid=mm6531a2\\_w](http://www.cdc.gov/mmwr/volumes/65/wr/mm6531a2.htm?s_cid=mm6531a2_w).

Cabell County had the highest rate of babies born with NAS (Figure 2). Of all of the NAS births in West Virginia, 86.5% (551) were born to Medicaid mothers.<sup>16</sup>

**Figure 2. Cabell Huntington Hospital NAS Rates, 2009-2012**



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

In August 2016, BMS released a State Plan Amendment (SPA) for public comment that establishes requirements, standards and a payment methodology to enable the state to use pediatric residential treatment nursing facilities to provide specialized care and treatment for infants born with NAS.<sup>17</sup> The changes proposed under this SPA will contribute to building the comprehensive continuum of care. West Virginia will use the Medicaid section 1115 waiver as an opportunity to augment its efforts in this area.

<sup>16</sup> West Virginia Perinatal Partnership, 2014 Uniform Billing Data.

<sup>17</sup> Pediatric Residential Treatment Nursing Facilities State Plan Amendment. Posted for public comment on August 12, 2016. Available at: <http://www.dhhr.wv.gov/bms/Public%20Notices/Pages/Pediatric-Residential-Treatment-Nursing-Facilities-State-Plan-Amendment-Available-for-Public-Comment-Until-September-16,-20.aspx>.

## 2 Transforming the Substance Use Disorder Delivery System

Building on the foundation of both legislative and operational efforts to combat substance use in West Virginia, this proposed Medicaid section 1115 waiver (waiver) will permit the state to increase the availability of SUD prevention and treatment services and create a continuum of care that will improve overall health and health outcomes, while at the same time promoting economic stability across the state. Reducing the number of West Virginia residents that are substance users will broaden the employment pool and hopefully generate economic advancement. Given that managed care plans are already responsible for providing the full continuum of care to meet beneficiaries' physical health and behavioral health needs, this waiver presents a tremendous opportunity to improve care for beneficiaries with chronic conditions. This integration will also move West Virginia toward value-based purchasing for both physical and behavioral health services. Upon approval, the state plans to have a six-month planning period, with an initial launch of the waiver in July 2017 and a goal of having all MCOs achieve certification for network adequacy by January 2018.

### 2.1 Waiver Goals and Objectives

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

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

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

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

- Increase the availability of community-based and outpatient SUD treatment services.
- Make residential treatment opportunities available to Medicaid beneficiaries, as appropriate.
- Add access to Methadone as a treatment strategy.
- Widely distribute Naloxone.

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

- Decrease emergency department visits, inpatient admissions, and readmissions to the same level of care or higher for a primary SUD diagnosis.

- Leverage prevention strategies and design and implement a public awareness campaign around Naloxone in order to prevent and reverse overdoses.
- Provide recovery support services designed to promote and sustain recovery.

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

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

*Eligibility*

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

There are a small number of individuals who will not be enrolled in a managed care plan, including individuals receiving long-term services and supports and home and community-based services. BMS and BBHF will ensure that these individuals receive the substance use services they need. Medicaid members who are not currently enrolled in a managed care plan will still be able to access treatment for substance abuse under the codes and policy in Chapter 503 of the DHHR BMS Provider Manual.<sup>18</sup> Individuals who are not eligible for Medicaid may still receive the same services listed in Chapter 503, but would receive them through the Charity Care funding made available through BHHF, which funds the 13 CBHCs to render services to these individuals.

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

*Delivery System*

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

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<sup>18</sup> West Virginia BMS Provider Manual, Chapter 503-Behavioral Health Clinic Services. Available at: [http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20503%20Behaviorial%20Health%20Rehab%20Services/Chapter\\_503\\_Behavioral\\_Health\\_Rehabilitation\\_Services.pdf](http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20503%20Behaviorial%20Health%20Rehab%20Services/Chapter_503_Behavioral_Health_Rehabilitation_Services.pdf).

### *Continuum of Care*

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

One of the key goals of the waiver is to ensure that individuals have access to the approach to achieving recovery that is most appropriate based on their circumstances. Building on the delivery system integration efforts that are already underway, and working to establish a seamless continuum of care will enable West Virginia to move toward value-based purchasing for SUD services and facilitate meeting the goals of the Triple Aim of improved quality of care, improved population health and decreased costs.

## **2.2 Comprehensive Evidence-Based Benefit Design**

West Virginia has designed a comprehensive set of SUD prevention and treatment benefits that, when combined with the existing foundation of Medicaid and BBHFF-funded behavioral health services, will provide a full continuum of care. Table 2 provides a complete listing of current and proposed Medicaid benefits. The key expansions in Medicaid coverage designed to support and augment West Virginia's continuum of care include:

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

## Medical Necessity Criteria<sup>19</sup>

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

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

Services must be:

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

### 2.3 Appropriate Standards of Care

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

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

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<sup>18</sup> West Virginia BMS Provider Manual, Chapter 503-Behavioral Health Clinic Services. Available at: [http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20503%20Behaviorial%20Health%20Rehab%20Services/Chapter\\_503\\_Behavioral\\_Health\\_Rehabilitation\\_Services.pdf](http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20503%20Behaviorial%20Health%20Rehab%20Services/Chapter_503_Behavioral_Health_Rehabilitation_Services.pdf).

**Table 2: West Virginia Services by ASAM Level of Care**

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

ASAM Level of Care	ASAM Service Title	ASAM Brief Definition	Is this an existing Medicaid service?	Is this a new Medicaid service under the Waiver?	What Medicaid Authority is needed for new services?
3.7	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. 16 hour per day counselor availability.	Yes (covers ages 18-21 and over 64)	No	§430.1010 and 1115(a)(2)
OTS	Opioid Treatment Services	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder. West Virginia is currently OBOT and OTP.	Yes	No (West Virginia will add coverage of methadone)	§440.50, §440.60, §440.90
1-WM	Ambulatory Withdrawal Management Without Extended On-site Monitoring	Mild withdrawal with daily or less than daily outpatient supervision.	Yes	No	§440.130, §440.50, §440.60, §440.90
2-WM	Ambulatory Withdrawal Management with Extended On-site Monitoring	Moderate withdrawal with all day withdrawal management/support and supervision; at night has supportive family or living situation.	Yes	No	§440.130, §440.50, §440.60, §440.90
3.2-WM	Clinically Managed Residential Withdrawal Management	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.	No	Yes	§440.130, §440.50, §440.60, §440.90
3.7-WM	Medically Monitored Inpatient Withdrawal Management	Severe withdrawal, 24-hour nursing care and physician visits; unlikely to complete withdrawal management without medical monitoring	Yes (for certain ages)	No	§440.130, §440.50, §440.60, §440.90
Other	Targeted Case Management	Services to assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.	Yes	No	§440.169

ASAM Level of Care	ASAM Service Title	ASAM Brief Definition	Is this an existing Medicaid service?	Is this a new Medicaid service under the Waiver?	What Medicaid Authority is needed for new services?
Other (ASAM Dimension 6 – Recovery / Living Environment)	Recovery Support Services	Services to support the beneficiary’s recovery and wellness after completing their course of treatment, whether they are triggered, have relapsed, or as a preventative measure to prevent relapse.	No	Yes	§440.130
Other (ASAM Dimension 6 – Recovery / Living Environment)	Recovery Housing	Recovery Environment that encompasses the external supports for recovery.	No	Yes	§440.130

### Description of Current SUD Services

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

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

Additionally, West Virginia has a comprehensive Safety and Treatment Program for people whose licenses have been revoked for driving a motor vehicle under the influence of alcohol, controlled substances and/or drugs. These efforts include both an in-state and out-of-state component. In state, DHHR is responsible for educating service providers on program developments, including any legislative decisions that would impact the program. During 2015, DHHR closed 1,218 cases for out-of-state offenders. Additionally, the driver’s rehabilitation fees collected totaled \$152,250.00 from January 1, 2015 through December 31, 2015 from out-of-state offenders.

**Outpatient Services:** Medicaid currently provides extensive outpatient SUD services, including professional and supportive individual and group behavioral health counseling, crisis psychotherapy, family therapy, case consultation crisis intervention services screening by licensed psychologists, prescription drugs, medication assisted treatment with phosphine, vivitrol and medications used to treat alcohol dependence. The state also provides lab, radiology, and other diagnostic services rendered in hospital outpatient departments and emergency departments, observation services, and partial hospitalization. These services will continue to be provided under the Medicaid state plan and in support of the continuum of care under the waiver.

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

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

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

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

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

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

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

***Opioid Treatment Services:*** Medicaid provides general services to assist enrollees in accessing behavioral health medication and medication services. Medicaid covers non-methadone MAT services for individuals seeking opioid addiction treatment for Suboxone/Subutex or Vivitrol within specified phases and guidelines. Under the waiver, West Virginia will add Medicaid coverage of methadone and methadone administration as part of its Opioid Treatment Program.

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

**Withdrawal Management:** Medicaid currently provides withdrawal management and detoxification as a Medicaid outpatient service in approximately eight crisis stabilization units across the state. Under the waiver, West Virginia will ensure that these services are integrated into the larger system of care and BMS will pursue additional regionally identified providers to make these services available. For example, now that residential treatment will be available under Medicaid, West Virginia will be able to provide withdrawal management services in residential settings as part of the course of treatment.

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

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

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

### **Current SUD Licensing/Credentialing Requirements**

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

**Table 3: Current Provider Licensing/Credentialing Standards**

Service	Licensing/Credentialing Standard
Early Intervention	Licensed as an ambulatory health care facility, ambulatory surgical facility, hospital, or extended care facility by the State Director of Health.
Outpatient Services	Licensed as an ambulatory health care facility by the State Director of Health.
Intensive Outpatient Services	Licensed as an ambulatory health care 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.
Ambulatory Withdrawal Management without Extended On-Site Monitoring	Licensed as an ambulatory health care facility by the State Director of Health.
Ambulatory Withdrawal Management with Extended On-site Monitoring	Licensed as an ambulatory health care facility by the State Director of Health.
Clinically Managed Residential Withdrawal Management	Licensed as a Behavioral Health Agency.
Medically Monitored Inpatient Withdrawal Management	Licensed as a hospital or free-standing 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.
Recovery Housing	N/A

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

#### **2.4 Network Development Plan**

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

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

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

The approach for determining network adequacy will be based on the requirements already in place under the West Virginia Medicaid 1915(b) waiver.<sup>20</sup> As part of the July 2015 integration of behavioral health into managed care, the MCOs were required to submit plans to BMS illustrating the gaps in available services within their behavioral health networks. These plans described strategies and processes for how the network gaps would be addressed and how member access to all covered behavioral health services would be ensured. Each MCO's plan outlined contracting strategies for missing providers, as well as a process for allowing members to access services at out-of-network providers, if necessary. BMS is continuing to monitor these MCO plans. As part of this waiver, MCOs will be required to build on the existing plans in order to ensure network adequacy for the new and expanded SUD services that will be provided.

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<sup>19</sup> West Virginia Medicaid 1915(b) waiver, Attachment A. Available at <http://www.dhhr.wv.gov/bms/CMS/SMP/Documents/SPAs/SPAs%202015/Managed%20Care%20SPA/Attachment%20A%20-%20BH%20Network%20Adequacy.pdf>.

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

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

## **2.5 Care Coordination Design through Targeted Case Management**

Providing strong care coordination services between SUD levels of care and between SUD providers will be a crucial part of ensuring that individuals have access to a comprehensive continuum of care. West Virginia will leverage existing targeted case managers to ensure that beneficiaries successfully transition between levels of SUD care, SUD providers, settings and facilities (e.g. behavioral health, primary care, emergency department), and physical and behavioral health care systems.

Targeted case management services will continue to be in place under the Medicaid state plan and will provide a critical element of the care transition planning process. Targeted case management services are defined as services furnished to assist individuals, in gaining access to needed medical, social, educational, and other services. Services related to treating SUD issues may include:<sup>21</sup>

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services
- Transition to a higher or lower level SUD of care
- Development and periodic revision of a client plan that includes service activities;
- Communication, coordination, referral, and related activities
- Monitoring service delivery to ensure beneficiary access to service and the service delivery system
- Monitoring the beneficiary's progress
- Patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services.

West Virginia recently implemented changes to the eligibility criteria for TCM that permit case management services to be incorporated into the transition planning process as Medicaid beneficiaries move from residential settings back into the community, and also through outpatient care transitions. For example, under the waiver, targeted case managers would engage with individuals ten days prior to discharge to create a care coordination plan, and ensure that the necessary health and social supports are available to promote and sustain the

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<sup>21</sup> West Virginia BMS Provider Manual, Chapter 523-Targeted Case Management. Available at: [http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/BMS\\_Proposed\\_Targeted\\_Case\\_Management\\_Policy.pdf](http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/BMS_Proposed_Targeted_Case_Management_Policy.pdf).

individuals' recovery. Case managers would also coordinate with the peer recovery coaches that are assisting individuals as they leave treatment and transition back to their communities.

The Medicaid MCOs will help ensure smooth transitions by facilitating the transfer of necessary clinical information between providers. The MCOs will also work with providers across health care settings to develop workflows to streamline transitions and communication, and maximize efficiency.

## **2.6 Integration of Physical Health and SUD**

West Virginia is committed to integrating physical and behavioral health services for enrollees to improve health outcomes and reduce SUD costs. In July 2015, West Virginia integrated behavioral health services into managed care. Since the MCOs will be responsible for managing the physical and behavioral health services provided to enrollees, they will be able to integrate the SUD treatment services with physical health and traditional mental health treatment services. This integration will also move West Virginia toward value-based purchasing for both physical and behavioral health services.

## **2.7 Program Integrity Safeguards**

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

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

In accordance with NCQA Credentialing and re-credentialing requirements, MCOs will have the proper provisions in place to determine whether physicians and other health care professionals licensed by West Virginia and who are under contract with the plan or its providers are qualified to perform SUD services. MCOs will have written policies and procedures for the credentialing process.

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

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

## 2.8 Benefit Management

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

**Table 4: Minimum Utilization Management and Quality Review Process Requirements**

Process	Description
Standard Benefit Structure	Use of standardized benefit structure that defines service levels and supports placement using American Society of Addictions Medicine (ASAM) levels of care. The policies and procedures will require that providers use ASAM multidimensional assessment criteria to determine the level care needed.
Unified Model of Care	SUD benefits will be administered by all MCOs using a unified model of care that is defined by the use of standardized unit values, reimbursement codes, and a minimum reimbursement value for each service level.
Uniform Clinical Operations	Standardized service review formats will be used by the MCOs to ensure that clinical operation processes are uniform and designed to collect information in line with the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements to ensure appropriate placement and facilitate opportunities for integrated care and coordination of service delivery options for individuals.
Service Review Requirements	ASAM levels 3.1, 3.3, 3.3, 3.5 and OTP will be subject to utilization management requirements, including service review requirements to facilitate initiation of services with quality oversight structures in place as specified in the CMS State Medicaid Director Letter: <sup>22</sup> <ul style="list-style-type: none"> <li>Each service review will be provided to assess service needs, coordination needs, and to ensure appropriate placement into an effective level of care based on the individual’s needs, as demonstrated in the ASAM multi-dimensional assessment tool.</li> </ul>

<sup>22</sup> July 2015 State Medicaid Director Letter. “New Service Delivery Opportunities for Individuals with a Substance Use Disorder.” Centers for Medicare & Medicaid Services. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>.

Process	Description
Quality Reviews	Conduct targeted post-payment quality reviews to ensure fidelity with ASAM service models and access for the use of evidence-based delivery of services.

## 2.9 Community Integration

West Virginia expects to reach full compliance with the Home and Community-Based Services program regulations during the course of this waiver. The MCOs will work with the state to ensure that requirements for person-centered planning are incorporated into all SUD service planning and service delivery efforts. Medicaid enrollees receiving home and community-based services will not be enrolled in a managed care plan but will still be able to access treatment for substance abuse under the codes and policy that are found in Chapter 503.<sup>23</sup> BBHf will continue to pay through charity care funding for Medicaid eligible services for those individuals not Medicaid eligible.

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

## 2.10 Strategies to Address Prescription Drug Abuse

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

The Regional Taskforces have led the statewide Prescription Drug Take Back program, which seeks to provide a safe, convenient, and responsible way to dispose of prescription drugs, and educates the public about the potential for medication abuse. The Taskforce also advances the expansion of prevention coalitions, evidence-based practice (EBP) programs, SBIRT, and Recovery Coaching.<sup>24</sup>

To support interstate efforts, Governor Tomblin established the Interstate Prescription Drug Task Force with Ohio, Kentucky, and Tennessee. The Task Force's mission is to identify and

<sup>23</sup> West Virginia BMS Provider Manual, Chapter 503-Behavioral Health Clinic Services. Available at: [http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20503%20Behavioral%20Health%20Rehab%20Services/Chapter\\_503\\_Behavioral\\_Health\\_Rehabilitation\\_Services.pdf](http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20503%20Behavioral%20Health%20Rehab%20Services/Chapter_503_Behavioral_Health_Rehabilitation_Services.pdf)

<sup>24</sup> West Virginia Comprehensive Substance Abuse Strategic Action Plan, DHHR, 2010. Available at: <http://www.dhhr.wv.gov/bhfh/sections/programs/ProgramsPartnerships/AlcoholismandDrugAbuse/Documents/strategicactionplan-info.pdf>.

recommend opportunities for collaboration and cooperation to stem prescription drug abuse and provide for better treatment and recovery to those affected by prescription drug abuse.<sup>25</sup>

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

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

The distribution of prescription pills for pain management is increasingly controlled by West Virginia's OHFLC using the legislative authority of Article 5H Chronic Pain Clinic Licensing Act. The law also requires treating physicians to access the Controlled Substances Monitoring Program (CSMP) database maintained by the Board of Pharmacy to ensure that patients are not seeking controlled substances from multiple sources and places, dispensing limits on controlled substances. A primary goal of the legislation is to eliminate pill mills—illicit businesses that prescribe large volumes of opioids without a legitimate medical license or clinic registration. Additionally, any individual suspected of misusing a controlled substance must use a single prescriber and pharmacy (pharmacy lock-in program) to reduce doctor shopping for prescription drugs.<sup>26</sup> Doctor-shopping laws have been introduced to further prohibit patients from withholding information about prior prescriptions from their healthcare provider.

West Virginia requires prescribers to complete training on avoiding diversion of prescriptions drugs in the illicit market. West Virginia University has added a new online course: The Treatment of Pain and Addiction Utilizing Education and Proper Prescribing: The New Paradigm

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<sup>25</sup> "Governor Tomblin Announces State Participation in Interstate Task Force to Address Prescription Drug Abuse," 2011. Available at: <http://www.governor.wv.gov/media/pressreleases/2011/Pages/GovernorTomblinAnnouncesStateParticipationinInterstateTaskForcetoAddressPrescriptionDrugAbuse.aspx>.

<sup>26</sup> J. Levi, L. Segal and A. Miller, "Prescription Drug Abuse: Strategies to Stop the Epidemic," Trust for America's Health and The Robert Wood Johnson Foundation, 2013. Available at: [http://healthyamericans.org/reports/drugabuse2013/TFAH2013RxDrugAbuseRpt12\\_no\\_embargo.pdf](http://healthyamericans.org/reports/drugabuse2013/TFAH2013RxDrugAbuseRpt12_no_embargo.pdf).

Continued, for academic credit and to meet the state requirement.<sup>27</sup> The state also requires prescribers to require identification prior to dispensing a controlled substance. Prior to prescribing prescription medications, a healthcare provider must either conduct a physical exam of the patient, a screening for signs of substance abuse, or have a bona fide patient-physician relationship that includes a physician examination.<sup>28</sup>

The West Virginia Corrections Department established a voluntary Drug Court Program to provide a rehabilitative program for individuals involved in the federal criminal justice system who have substance abuse problems. The program is post-plea, pre-adjudication, of at least one year, designed for individuals who suffer from substance abuse or addiction.<sup>29</sup>

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

- (1) Help identify “doctor shoppers,” problem prescribers and individuals in need of treatment;
- (2) Implement community and insurer/health system interventions; and
- (3) Evaluate existing policies designed to reduce prescription drug overdose morbidity and mortality.<sup>30</sup>

## **2.11 Strategies to Address Opioid Use Disorder**

In West Virginia, opioid use disorder is largely the result of physicians overprescribing narcotics for pain management. According to the July 2014 CDC Vital Signs Report, West Virginia ranks third in the nation for the highest number of painkiller prescriptions per person—138 for every 100 people.<sup>31</sup> Between 2011 to 2015, West Virginia disciplinary boards reprimanded more than two dozen doctors.

The West Virginia state legislature has taken a number of actions to address opioid overuse, including establishing the GACSA and six Regional Task Forces to combat abuse and addiction throughout West Virginia (as previously noted). The Advisory Council has pushed for legislation

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<sup>27</sup> "WVU plans online opioid course for physicians," West Virginia Hospital Association, 2016. Available at: <http://www.wvha.org/Media/NewsScan/2016/May/5-5-16-WVU-plans-online-opioid-course-for-physicia.aspx>.

<sup>28</sup> J. Levi, L. Segal and A. Miller, "Prescription Drug Abuse: Strategies to Stop the Epidemic," Trust for America's Health and The Robert Wood Johnson Foundation, 2013. Available at: [http://healthyamericans.org/reports/drugabuse2013/TFAH2013RxDrugAbuseRpt12\\_no\\_embargo.pdf](http://healthyamericans.org/reports/drugabuse2013/TFAH2013RxDrugAbuseRpt12_no_embargo.pdf).

<sup>29</sup> Drug Court Program Summary, United States District Court for the Northern District of West Virginia, 2015. Available at: <http://www.wvnd.uscourts.gov/sites/wvnd/files/NDWV%20Drug%20Court%20Program%206-3-15.pdf>.

<sup>30</sup> "DHHR to receive \$1.3 million grant for prescription drug overdose prevention," B. Register-Herald, March 2016. Available at: [http://www.register-herald.com/news/dhhr-to-receive-million-grant-for-prescription-drug-overdose-prevention/article\\_e278c442-164b-5252-8781-fba431637790.html](http://www.register-herald.com/news/dhhr-to-receive-million-grant-for-prescription-drug-overdose-prevention/article_e278c442-164b-5252-8781-fba431637790.html).

<sup>31</sup> CDC Vital Reports, July 2014. Available at: <http://www.cdc.gov/vitalsigns/opioid-prescribing/infographic.html#map>.

to track medication sales using the prescription monitoring program and to expand the availability of Naloxone.

The legislature has also passed a number of bills to address opioid overuse, including Senate Bill 335.<sup>32</sup> This bill, passed in 2015, allows emergency responders, medical personnel, family and friends to possess and administer Naloxone to reverse the effects of an opioid overdose. Under the waiver, West Virginia is developing an initiative for distributing Naloxone and cross-training staff on the administration of the drug as part of its efforts to reduce overdose deaths across the state. Possible strategies for distribution include making Naloxone available for pick up at local health departments and ensuring that all emergency personnel and community facilities have adequate supplies of the drug available and are trained to administer it.

Additionally, in September 2015, West Virginia established a 24-hour substance abuse helpline—1-844-HELP4WV—to provide referral support for people seeking treatment and recovery services in their local communities.<sup>33</sup> To combat opioid use by pregnant women, DHHR and the West Virginia Perinatal Partnership are working to develop improved guidelines for diagnosis, reporting, and capturing of data to improve service provision.<sup>34</sup>

West Virginia Medicaid requires prior authorization for all prescriptions of Subutex and Suboxone, and their generic equivalents, if available. BMS developed prior authorization criteria that provides adequate doses of both Suboxone and Subutex, when appropriate, for pharmacologic support of addiction treatment. All doses for both of these medications will be prior authorized, and only for the Federal Drug Administration (FDA)-approved indication of opiate dependence/addiction.

All prescribers are required to have a DATA (Drug Addiction Treatment Act of 2000) waiver as proof of qualification to prescribe Subutex/Suboxone, and be enrolled with West Virginia Medicaid in order to bill Medicaid for treatment or management of opiate addiction in the patients for which they are prescribing. Submission of the DEA-X number and the Medicaid enrollment number are required and are verified when prior authorization requests are made. Requests for prior authorization must be submitted in writing to the Rational Drug Therapy Program by fax, mail, or electronic submission using an approved form. Maintenance dosing is limited to 16 mg per day. Dose optimization will be required and may necessitate tablet splitting for Medicaid members. Subutex is only approved for patients who are pregnant. Concomitant use of benzodiazepines, hypnotics, and opiates with Subutex or Suboxone are not approved and prescriptions for these agents in combination will be denied at the pharmacy. Other

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<sup>32</sup> Senate Bill [335](#). Available at:

[http://www.legis.state.wv.us/Bill\\_Text\\_HTML/2015\\_SESSIONS/RS/bills/SB335%20SUB1%20ENR2.pdf](http://www.legis.state.wv.us/Bill_Text_HTML/2015_SESSIONS/RS/bills/SB335%20SUB1%20ENR2.pdf).

<sup>33</sup> Behavioral Health Helpline (2015). Available at: [http://www.pds.wv.gov/Annual-](http://www.pds.wv.gov/Annual-Conference/2016/Documents/Sessions/McDaniel.%20Heather%20-%20Help4WV%20-%20Combined.pdf)

[Conference/2016/Documents/Sessions/McDaniel.%20Heather%20-%20Help4WV%20-%20Combined.pdf](http://www.pds.wv.gov/Annual-Conference/2016/Documents/Sessions/McDaniel.%20Heather%20-%20Help4WV%20-%20Combined.pdf)

<sup>34</sup> 2015 GACSA Progress Report. Available at:

<http://www.wvsubstancefree.org/docs/GACSA%20Progress%20Report%202015%20FINAL%20low-res.pdf>

depressants such as sedatives, antidepressants, muscle relaxants, etc., are considered for payment, but patients are required to be educated and warned of the extreme danger of these combinations. Alternative treatment options are encouraged while the patient is receiving Subutex/Suboxone. As part of this waiver, West Virginia is adding Medicaid coverage of methadone and methadone administration as part of its Opioid Treatment program.

## 2.12 Services for Adolescents and Youth with an SUD

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

## 2.13 Reporting of Quality Measures

BMS will collect reliable and valid data from the MCOs to enable the reporting of the SUD quality measures listed in Table 5. These measures are either required or recommended in the July 2015 CMS State Medicaid Director Letter.<sup>35</sup> West Virginia will explore adding other measures and will incorporate any new behavioral health Healthcare Effectiveness Data and Information Set (HEDIS) measures as they are developed, in order to continue to improve the quality of care based on data-driven results. These quality measures will be assessed as part of the program evaluation and will be reported to CMS.

**Table 5: Quality Measures**

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

<sup>35</sup> July 2015 State Medicaid Director Letter. “New Service Delivery Opportunities for Individuals with a Substance Use Disorder.” Centers for Medicare & Medicaid Services. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>.

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

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

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

#### **2.14 Collaboration with Single State Agency for Substance Abuse**

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

### 3 Demonstration Hypothesis and Evaluation Plan

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

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

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

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

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

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

## 4 Projected Waiver Impact

The West Virginia Medicaid program currently spends approximately \$9,000 per person per year (not including residential treatment) on substance use disorder treatment, and treats approximately 12,000 beneficiaries, or 2% of the average enrolled population annually. Under the waiver, West Virginia estimates that the percentage of beneficiaries who will receive SUD treatment will increase to 3.5% of the average enrolled Medicaid population – or 22,000 beneficiaries. We anticipate that the combination of increased availability of appropriate SUD treatment services and the reduction in emergency department and inpatient hospital utilization will improve health outcomes in West Virginia and result in a 2.2% reduction in program costs over the course of the waiver (Table 6).

**Table 6. Projected Impact**

Demonstration Year	Current SFY 15	DY 0	DY 1	DY2	DY3	DY 4	DY 5	Total Projected Impact
Beneficiaries Receiving SUD Treatment	12,000	13,200	15,000	18,000	20,000	21,000	22,000	10,000 additional beneficiaries
Annual SUD Treatment Cost per beneficiary	\$8,917*	\$8,917	\$8,725	\$7,591	\$6,605	\$5,747	\$5,000	2.2% decrease in total program expenditures

\*Not including residential treatment.

\*\*Note: This table provides preliminary estimates of the potential impact of the proposed waiver over a five-year period. The estimates are subject to change as additional data and other information becomes available and the calculations for establishing budget neutrality are refined.

## 5 Waiver and Expenditure Authorities

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