Section 1115 Demonstration Waiver Proposal

For Substance Use Disorder Treatment

Submitted by the

Ohio Department of Medicaid
I. SUMMARY
The Ohio Department of Medicaid (ODM) is requesting an 1115 Demonstration Waiver for substance use disorder (SUD) inpatient and residential treatment in managed care and fee-for-service (FFS) for adults and children. Ohio also requests this Demonstration to ensure a complete American Society of Addiction Medicine (ASAM) levels of care (LOCs) array is available as part of an essential continuum of care for Medicaid-enrolled individuals with opioid or other SUDs. This Demonstration waiver is requested to be effective immediately upon approval to use Institutions for Mental Diseases (IMDs) as a Medicaid-covered setting.

Ohio Medicaid covers all ASAM levels of care 0.5 through 4.0. The Demonstration would permit ODM, largely through our contracted Medicaid MCPs, to maintain critical access to medically necessary SUD treatment services in the most appropriate setting for the member, regardless of length of stay, as part of a comprehensive continuum of SUD treatment services. Recent Medicaid managed care regulations impose new limitations on ODM’s use of IMDs as alternative settings for state plan behavioral health (BH) services. In Ohio, these regulations will impede access to inpatient and residential SUD treatment services at a critical time in Ohio’s efforts to implement Medicaid BH reform, and provide SUD treatment to confront Ohio’s opioid epidemic.

The Demonstration would also permit ODM, through the FFS program, to provide medically-necessary healthcare, mental health (MH) and SUD services in the most appropriate setting for individuals who are not eligible for enrollment in managed care. This will permit Ohio to divert individuals from repeat, costly BH admissions at general hospitals to more appropriate and cost-effective community-based BH treatment.

II. BACKGROUND AND THE IMPACT OF THE MANAGED CARE RULE

Background
Modernizing Ohio Medicaid’s system of delivering BH services has been an ongoing and sequential process beginning with elevation of the funding of the behavioral health benefits to the State level in 2012, and fully integrating the behavioral health benefit package of services into the managed care program on July 1, 2018. In keeping with the goal of modernization, from August of 2014 through the end of 2017, the Ohio Department of Medicaid (ODM), in collaboration with the Ohio Department of Mental Health and Addiction Services (OhioMHAS), developed and implemented a comprehensive redesign of the behavioral health benefit package of services provided by community mental health and substance use disorder services providers. The behavioral health redesign was implemented on January 1, 2018.
The new benefit service package was divided among five separate state plan authorities, and these State Plan Amendments were approved by CMS for a January 1, 2018 effective date. This comprehensive restructuring of the behavioral health benefit package of services and the transition of the service package to the Managed Care delivery system created a comprehensive, coordinated system of care for children and adults. Prior to the January 1, 2018 implementation date for Behavioral Health Redesign, Ohio had not adopted a complete array of SUD services using a national placement criteria (ASAM) or national provider standards, nor had Ohio required providers of behavioral health services to adopt national correct claim coding. Most importantly for individuals in need of SUD treatment, there were limited options for outpatient, community-based SUD services.¹

The new Behavioral Health Redesign benefit package introduced new evidence based practices, such as Assertive Community Treatment (ACT) for adults and promising practices, such as Intensive Home-Based Treatment (IHBT) for children with MH conditions, while also modernizing the SUD treatment benefit to align with the ASAM LOCs for outpatient and residential treatment. The introduction of ASAM is intended to increase the use of community-based and non-hospital residential programs, and assured that inpatient hospitalizations are primarily utilized for situations in which there is a need for safety, stabilization, or acute detoxification (ASAM LOC 4).

The implementation of the new behavioral health benefit package resulted in integrated behavioral health in capitated managed care for adults and children on July 1, 2018. Since July 1, 2018, the MCPs are responsible for providing all healthcare (including BH services) for adults and children, targeting the goal of improved models of care focused on supporting individuals in the community and home outside of institutions, increasing outpatient MH rehabilitation services, introducing a continuum of SUD services aligned with the ASAM criteria, and deemphasizing the role of hospitals and large institutions (IMDs) in the delivery of covered services. Note: The MyCare Duals Demonstration plans have been responsible for all behavioral health services, whether furnished by independent practitioners in the community, or furnished by community behavioral health agencies certified by OhioMHAS, since their inception on May 1, 2014.

¹ Outpatient Hospital Behavioral Health (OPBH) was also implemented in August 2017. Previously some Ohio Medicaid hospital providers separately obtained certification from OhioMHAS and were enrolled in Ohio Medicaid as a Community Mental Health agency and/or a SUD Treatment program in order to provide services in the community under the former BH benefit package. CMS Medicare provider-based regulations prohibit the establishment of separate business entities within a 35-mile perimeter of the main hospital campus. Ohio informed these providers they should relinquish their separate Medicaid enrollment(s) and permitted them to furnish the new BH Redesign services within their outpatient hospital facilities beginning August 1, 2017. Ohio also opened the new BH service package to other outpatient hospitals, both to general hospitals and to psychiatric hospitals, who had not previously been able to furnish outpatient services. Essentially, this allowed the outpatient hospitals to provide the new BH service package on August 1, 2017.
The Ohio Medicaid Managed Care Program, currently contracts with five MCPs: Buckeye Community Health Plan (Buckeye), CareSource, Molina Healthcare (Molina), Paramount Advantage (Paramount), and UnitedHealthcare Community Plan (United). For the MyCare Ohio program, ODM contracts with four of those plans (all but Paramount) plus Aetna Better Health of Ohio (Aetna).

Today, Ohio requires most Medicaid/Children’s Health Insurance Program (CHIP) beneficiaries to enroll in capitated managed care. There are a few recipients (≈11%) who receive services under the FFS delivery system. Approximately 89% of Ohio Medicaid/CHIP beneficiaries are enrolled in either: Ohio Medicaid MCP or MyCare Ohio, a regional MCP for Medicare-Medicaid dual eligibles. This includes 100% of beneficiaries in Ohio’s adult expansion (extension adults) who receive the alternative benefit plan (aligned with the regular State Medicaid plan) and 97% of beneficiaries in Ohio’s CHIP program (Healthy Start), which is a Medicaid expansion program.

**The Impact of the Medicaid Managed Care Final Rule**

As stated previously, ODM has designed the current integrated managed care program, including SUD services, with the expectation that Federal Medicaid policy would permit the use of IMDs as cost-effective alternative services. These settings are a crucial part of Ohio’s SUD treatment provider network in order to maintain critical access to SUD residential treatment for Ohio Medicaid enrollees.

On May 6, 2016, CMS published new managed care regulations, which permit states to use federal Medicaid funds for capitation payments to managed care plans for persons receiving treatment in an IMD “in lieu of” other services covered under the Medicaid State Plan. Under this regulation, federal payments for IMD services are limited to 15 days per month for individuals ages 21-64. In addition, IMD services must be medically appropriate and cost-effective, and enrollees cannot be required to accept IMD services “in lieu of” other services covered under the Medicaid State Plan.

Ohio Medicaid is requesting this Demonstration in order to ensure Federal funding for SUD residential treatment and other health care services for people residing in facilities that meet the IMD definition. Seeking an 1115 Demonstration is the logical next step, following successful redesign implementation and managed care integration to continue to assure Ohio’s Medicaid beneficiaries have access to the entire continuum of ASAM levels of care. Ohio has a strong foundation for this Demonstration request already in place because of the redesign and managed care integration completed July 1, 2018.

**III. DEMONSTRATION OBJECTIVES**

The objective of this Demonstration is to maintain critical access to cost-effective SUD treatment services for Ohio Medicaid enrollees and continue the delivery system
improvements for these services to provide more coordinated and comprehensive SUD treatment by Medicaid.

This Demonstration seeks to improve outcomes for Medicaid individuals diagnosed with substance use disorders by maintaining critical access to SUD treatment services, including inpatient and residential SUD treatment in IMDS, as part of a full continuum of ASAM LOCs aligned treatment services. Under Behavioral Health Redesign, Ohio designed a comprehensive, integrated BH benefit that includes cost-effective alternatives to State Plan residential treatment settings by IMDS. However, recent changes to Medicaid managed care regulations and existing IMD limitations in FFS create barriers to ensuring individuals are able to access SUD treatment at a level of care appropriate to their needs using the ASAM criteria. This Demonstration seeks authority so Federal Medicaid managed care restrictions on IMDS as SUD treatment settings do not disrupt the Medicaid SUD treatment continuum in Ohio by inadvertently reducing critical access to SUD treatment recently expanded through Behavioral Health Redesign.

Implementing the limitations of the Medicaid managed care final rule has the potential to hinder Ohio’s progress with BH reform by reducing access to community-based residential treatment services, creating a critical access problem in the State for SUD treatment services, and increasing costs to the State and Federal governments. There may not be enough SUD residential treatment programs in Ohio with 16 or fewer treatment beds to address the extent of the opioid epidemic in the State. This is particularly true since the State expanded Medicaid eligibility (effective January 2014) and such services are available to more than 700,000 Expansion-eligible individuals. Restricting Medicaid funding at this juncture would cripple the State’s ability to address the surge of SUD treatment needs for Medicaid enrollees.

The Demonstration will also remove Medicaid payment barriers in FFS for SUD residential treatment for individuals in need of these services. By preserving critical access to residential treatment capacity, Ohio will be able to continue to provide an effective SUD treatment continuum of care with interventions capable of meeting individuals’ changing needs for various ASAM LOCs. As individuals move throughout the continuum in their SUD recovery, they may need to transition to LOCs of greater or lesser intensity.

IV. Comprehensive Description of Strategies for Addressing Goals and Milestones
The State’s initial approach to key system reform milestones will be addressed in the comprehensive Implementation Plan submitted concurrently with this Demonstration request. The Implementation Plan addresses system reforms required in the 2017 State Medicaid Director’s Letter and outlines a path toward an IMD exception using the 1115
Demonstration authority. A brief summary of the State’s current environment for each milestone is listed below.

**Milestone 1: Access to Critical LOCs for SUDs**
Ohio’s SUD treatment system includes coverage of a) outpatient, b) intensive outpatient services, c) MAT (medications, as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the State), d) intensive LOCs in residential and inpatient settings, and e) medically supervised withdrawal management.

The State ensures sufficient coverage by contractually requiring the MCPs to demonstrate network adequacy for services. If services are unavailable within the specific region, the MCP is required to contract for services with providers outside the defined geographical boundaries.

**Milestone 2: Use of ASAM Placement Criteria**
The State requires all SUD treatment providers to assess and provide services using the ASAM criteria. ODM requires SUD treatment providers enrolled in Medicaid to use multi-dimensional assessments based on the six dimensions of care as outlined in ASAM. In addition, for providers who must be certified by OhioMHAS, the ASAM criteria is required as a condition of certification.

Ohio Administrative Code (OAC) rule 5160-27-09 describes SUD treatment services provided to Medicaid recipients regardless of delivery system. This regulation requires the use of the ASAM treatment criteria for addictive, substance related, and co-occurring conditions for admission, continued stay, discharge, or referral to each LOC.

Currently the ODM MCP provider agreement requires all plans to follow the prior authorization standards established under Behavioral Health Redesign for both the FFS and managed care delivery systems. On and after July 1, 2019, SUD services provided in the managed care and FFS delivery systems will comply with the ASAM criteria for all prior authorization and utilization review decisions resulting in continued continuity across the Medicaid delivery systems. The MCP provider agreement will be updated to emphasize the required use of the ASAM criteria for all SUD services regardless of site, provider type or level of care. MCPs prior authorize SUD residential treatment services for their members while SUD residential treatment for individuals enrolled in the FFS delivery system is prior authorized by ODM or its designee. This will ensure that members have access to SUD treatment at the appropriate LOC and interventions are appropriate for each person's diagnosis and LOC.
Milestone 3: Use of ASAM Program Standards for Residential Provider Qualifications

ODM and OhioMHAS require Medicaid participating providers of SUD treatment services to use of the ASAM criteria. These requirements apply to SUD residential treatment service providers under both the managed care and FFS delivery systems. OhioMHAS’s certification regulation in OAC rule 5122-29-09 require residential, withdrawal management, and inpatient SUD treatment services to be provided in accordance with the ASAM LOC 3. ODM’s rule, 5160-27-09, also requires residential services/inpatient services to be provided in accordance with ASAM LOC 3. ASAM’s LOC 3 and associated sub levels are to be provided as appropriate to the needs of the individual being served and as published in The ASAM Criteria, Third Edition, 2013®.

In the future, Medicaid policy manuals will be modified to include more detail about the ASAM residential program requirements including the particular types of practitioner services, hours of clinical care, and credentials of staff for residential treatment. This will include a requirement that residential treatment providers offer MAT on-site or facilitate access off-site with a MAT provider not associated with the residential treatment owner. Medicaid will also implement a process for reviewing residential treatment providers to ensure compliance with these requirements and for IMD determination.

Milestone 4: Provider Capacity of SUD Treatment including MAT

As part of preparing for the inclusion of Behavioral Health Redesign benefit package in MCP contracts on July 1, 2018, ODM conducted readiness reviews of the MCPs to ensure the panel standards required of plans were met. This included ensuring each MCP had at least a minimum number of comprehensive Alcohol and Drug treatment providers in each region. If a covered Medicaid service is not available in network, the MCP must arrange for that service to be provided out-of-network at no additional charge to the member.

Ohio has 4,135 SUD residential treatment beds across 178 OhioMHAS certified SUD residential, withdrawal management and inpatient SUD services programs that might meet the definition of an IMD.
The estimated number of residential days for each residential LOC based on 2014 data was estimated to be:

<table>
<thead>
<tr>
<th>STATE FISCAL YEAR 2014</th>
<th>ADULT DAYS</th>
<th>CHILD DAYS</th>
<th>TOTAL ESTIMATED DAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASAM 3.1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ASAM 3.2 WM</td>
<td>371</td>
<td>35</td>
<td>406</td>
</tr>
<tr>
<td>ASAM 3.3 (adults only)</td>
<td>22,061</td>
<td>N/A</td>
<td>22,061</td>
</tr>
<tr>
<td>ASAM 3.5</td>
<td>70,759</td>
<td>39,171</td>
<td>109,930</td>
</tr>
<tr>
<td>ASAM 3.7</td>
<td>5,404</td>
<td>1,868</td>
<td>7,272</td>
</tr>
<tr>
<td>ASAM 3.7 WM</td>
<td>3,947</td>
<td>563</td>
<td>4,510</td>
</tr>
<tr>
<td>Total</td>
<td>102,542</td>
<td>41,637</td>
<td>144,179</td>
</tr>
</tbody>
</table>

The State expects to be able to develop an assessment of the availability of the providers enrolled in Medicaid and accepting new patients in each of the SUD residential LOCs within 12 months of Demonstration approval. This assessment will indicate whether facilities accept clients funded through the managed care by plan, FFS, or both delivery systems.

Milestone 5: Implementation of OUD Comprehensive Treatment and Prevention Strategies

Opioid Prescribing Guidelines and Other Interventions to Prevent Opioid Abuse

To address the opioid crisis (which is discussed in the next major section below), Ohio has implemented five sets of prescribing guidelines to prevent opioid abuse. Prescribing guidelines addressed the easiest sources of uncoordinated prescription medications through the emergency departments. Tighter guidelines for patients requiring the highest doses of prescription opioids addressed issues for those already taking opioid medications. Additional interventions included:

2. Eliminating the possibility of calling in Schedule II drugs such as hydrocodone (Vicodin®).
3. Reducing the number of patients starting their first opioid.
4. Requiring Medicaid MCPs to put edits in place within their pharmacy programs to support prescribing guidelines.
5. Requiring MCPs to implement Medication Therapy Management for those with problematic polypharmacy and a Coordinated Services Program to provide care management services for members who overuse or misuse services.
Over the course of the development of these guidelines and rules, the State of Ohio was able to achieve a 28% reduction in solid doses of opioids prescribed from 196 million doses per quarter in Q2 2013 to 136 million Q2 2017.\textsuperscript{2} For acute pain, prescriptions fell from 70 million per quarter to 51 million over that same time frame with a reduction in number of patients with any opioid falling from 1.29 million per quarter to 948,000 per quarter.

These initiatives have resulted in direct impacts on Medicaid prescribing. The Medicaid opioid claims have reached a low of 116,348 claims in December 2017.

Ohio is one of the first states to realize a reduction in opioid deaths related to prescription drugs in the midst of escalating overall deaths driven by illicit drug use. Of all unintentional drug overdose deaths, the percentage of prescription opioid-related deaths in Ohio declined for a fifth straight year in 2016, and the number of these deaths declined 15.4% from 667 in 2015 to 564 in 2016 — the fewest since 2009.\textsuperscript{3}

**Expanded Coverage of, and Access to, Naloxone for Overdose Reversal**

Ohio has taken steps to prevent drug overdose deaths through the expanded availability and use of the opiate overdose reversal drug Naloxone. One of the most effective steps for expanding coverage included permitting pharmacists to dispense Naloxone without a prescription in 2015. To assist pharmacies, the State of Ohio Board of Pharmacy developed a dedicated web page, [www.pharmacy.ohio.gov/naloxone](http://www.pharmacy.ohio.gov/naloxone), which features helpful resources including a guidance document, sample protocol, and a listing of all participating pharmacies. The Pharmacy Board also offers printed, no-cost patient educational materials to any participating pharmacy. By 2017, more than 1,600 Ohio pharmacies in 87 counties offer Naloxone without a prescription.

Additionally, as part of an early adoption of components of the BH redesign project, beginning January 1, 2017, Ohio’s opioid treatment programs (OTPs) are now able to...

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\textsuperscript{2} OARRS data, Ohio’s Opioid Epidemic, The Medicaid Experience & Progress to Date, Agency Briefing on Opioids October 2017 SPA-5, Mary Applegate, MD, FAAP, FACP, Slide 33.

\textsuperscript{3} Mortality data can be found at the following website: [http://publicapps.odh.ohio.gov/EDW/DataBrowser/Browse/Mortality](http://publicapps.odh.ohio.gov/EDW/DataBrowser/Browse/Mortality)
administer and dispense Naloxone and their physicians to personally furnish Naloxone in accordance with the State of Ohio Board of Pharmacy requirements.

**Increasing Utilization and Improving Functionality of Prescription Drug Monitoring Programs**

Ohio first mandated use of the Ohio Automated Reporting Rx System (OARRS), the State’s prescription drug monitoring program by prescribers in 2011, with additional provisions added in 2013. OARRS is a tool to track the dispensing and personal furnishing of controlled prescription drugs to patients. OARRS is designed to monitor this information for suspected abuse or diversion (i.e., channeling drugs into illegal use), and can give a prescriber or pharmacist critical information regarding a patient’s controlled substance prescription history. This information can help prescribers and pharmacists identify high-risk patients who would benefit from early interventions.

Since the latest mandate in 2013, the use of the OARRS system has grown. In 2017, the OARRS reported a record high of 265,242 requests by prescribers and pharmacists in a single day. By comparison, the single day high in 2016 was 86,129 prescriber and pharmacist requests. In August 2018, OARRS reported an average of more than 599,000 requests per weekday – more than double the previous year’s high.

OARRS has also documented that fewer Ohioans are using multiple prescribers or pharmacies (i.e., doctor shopping). In 2017, data from OARRS found the number of individuals using more than five prescribers for prescription opiates has decreased 88% since 2011. Similarly, the number of Medicaid members with four or more pharmacies has continuously dropped since January 2017 (see graph).

The State of Ohio plans to leverage opportunities described in SMD Letter 16-003 to help professionals and hospitals eligible for Medicaid Electronic Health Record (EHR) Incentive Payments connect to other Medicaid providers through the integration of OARRS into electronic medical records and pharmacy dispensing systems. All hospitals

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and pharmacies now have ability to have OARRS integrated into their EHRs and Pharmacy management systems. Nearly half of physicians now have integrated access to OARRS.5 This initiative will allow the State to meet the following objectives:

- Reduce further the number of individuals who doctor shop.
- Provide health care providers critical information regarding a patient’s controlled substance prescription history and expand collection of other data sources to support clinical decision-making.
- Support clinician interventions for patients exhibiting high-risk behaviors.
- Assist providers in achieving the medication reconciliation meaningful use objective and measure.6

An additional goal of this integration initiative is to provide as many avenues as possible for an authorized health care provider to access Ohio’s Prescription Drug Monitoring Program (PDMP), including integrated access through Health Information Exchanges (HIEs). In fact, Ohio’s two largest HIEs – CliniSync and The Health Collaborative (HealthBridge) – have already been integrated with OARRS under this initiative.

**Milestone 6: Improved Care Coordination and Transitions between LOCs**

Ohio has multiple interventions for coordinating the care of individuals with SUD and transitioning between LOCs, including but not limited to, targeted case management, facility discharge requirements, care coordination in MCP contracts, and the proposed Behavioral Health Care Coordination (BHCC) Program, also implemented in the managed care delivery system.

**V. Comprehensive Plan to Address Opioid Abuse and Assessment of How the Demonstration Complements and Does Not Supplant Other State Activities**

The Governor’s Cabinet Opiate Action Team (GCOAT) comprises all of the cabinet-level agencies and is charged with the coordination of all activities addressing Ohio’s escalating opioid crisis. This Demonstration is being coordinated with that larger effort and will complement and not supplant State activities called for or supported by other Federal authorities and funding streams.

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6 Stage 3 of Meaningful use consolidates Medication reconciliation into the Health Information Exchange Objective. The objective requires that the Eligible Professional provides a summary of the care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT. Providers must attest to all three measures and must meet the threshold for at least two measures to meet the objective.
Over the last several years, ODM has played a crucial role in the GCOAT. GCOAT’s interventions increased as opioids deaths rose from 1,914 in 2012 to 4,050 in 2016.\(^7\) See Figure 1 for maps outlining the growth in drug-related deaths in Ohio counties between calendar year (CY) 2012 and CY 2017.

Figure 1: Map of the rate of Drug-Related Overdose Deaths per 100,000 people in Ohio counties in 2017\(^8\).

**Number of Unintentional Opioid-Related Overdose Deaths**

<table>
<thead>
<tr>
<th>Quintile</th>
<th>CY 2012</th>
<th>CY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 - 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 - 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 - 21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;=22</td>
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ODM has been particularly assertive in this work as the Centers for Disease Control and Prevention (CDC) reported Medicaid members were prescribed opioids at more than

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\(^7\) Mortality data can be found at the following website: http://publicapps.odh.ohio.gov/EDW/DataBrowser/Browse/Mortality

\(^8\) "Governor’s Cabinet Opiate Action Team Dashboard" (slide 9)
twice the rate as those with commercial insurance and were at greater risk for opioid abuse and death.\textsuperscript{9}

ODM efforts have primarily focused on the five prongs of the Health and Human Services (HHS) Opioid Strategy (see Figure 2 for a visual of the HHS Opioid strategy) including:

1. Improving access to prevention, treatment, and recovery support services.
2. Targeting distribution of overdose-reversing drugs.
3. Advancing the practice of pain management.
4. Supporting cutting-edge research.
5. Strengthening timely public health data and reporting.

Figure 2: HHS Opioid strategy

\textbf{VI. DELIVERY SYSTEM}

This Demonstration will not change the current fee-for-service and managed care delivery systems. MCPs and MyCare Ohio Plans will continue to operate as approved in ODM’s Section 1932(a) State Plan authority for managed care and concurrent 1915(b) waivers.

VII. ELIGIBILITY
Medicaid eligibility requirements will not differ from the approved Medicaid State Plan.

VIII. BENEFITS
Benefits will not differ from the approved Medicaid State Plan. With the CMS approval of SPA 17-013, the State began reimbursing a full array of services using the ASAM criteria effective January 1, 2018. Ohio's Medicaid State Plan and MCP contracts currently cover a full-range of community-based care designed to prevent institutionalization. The benefit package developed over the past several years in close coordination and consultation with CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) best practice guidelines includes:

- Outpatient and residential SUD treatment, including withdrawal management, consistent with ASAM LOCs,
- Community-based MH evidence-based practices such as ACT, and
- Promising practices such as IHBT.

The Demonstration will permit Medicaid recipients in Ohio with SUDs to receive high-quality, clinically-appropriate State Plan-approved SUD treatment services in outpatient and community-based settings, as well as in residential and inpatient treatment settings that qualify as an IMD.

IX. COST-SHARING
Cost-sharing requirements under the Demonstration will not differ from the approved State Plan requirements.

X. HYPOTHESIS AND EVALUATION
The Demonstration will test whether Ohio can enhance the effectiveness of the SUD treatment system in Medicaid by maintenance and expansion of SUD residential treatment services as part of a coordinated continuum of care, resulting in increased access and improved health outcomes for individuals with SUD. This approach is particularly relevant given the needs of the Medicaid Expansion population, which has historically been underserved.

Through a contract with an independent contractor, Ohio will conduct an independent evaluation to measure and monitor the outcomes of the SUD Demonstration. The evaluation will focus on the six key goals of the Demonstration as outlined below. The researchers will assess the impact of providing the full continuum of SUD treatment services, particularly residential treatment, emergency department utilization, inpatient hospital utilization, and readmissions rates to the same LOC or higher. It will also assess the impact on the drug overdose death rate. 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 Demonstration’s goals, objectives, and metrics. As required by CMS, the evaluation design will include the following elements:

1. General Background Information
2. Evaluation Questions and Hypotheses
3. Methodology
4. Methodological Limitations
5. Attachments

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

Providing services in a less restrictive and more cost-effective setting for the SUD population is critical to the evolution of the State’s BH network. ODM proposes to evaluate the Demonstration’s success and will include an evaluation of the following goals, research questions, and hypotheses:

<table>
<thead>
<tr>
<th>Goal 1: Reduce utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposed Change: Improve access to a complete SUD treatment service continuum of care.</td>
</tr>
<tr>
<td>1. Research Question: For participants who do not have access to a complete SUD treatment service continuum of care, are there critical services necessary for this population to achieve improved health and wellness outcomes?</td>
</tr>
<tr>
<td>Hypothesis: The 1115 SUD Demonstration will increase access to SUD treatment options for Ohio Medicaid members.</td>
</tr>
<tr>
<td>Hypothesis: The 1115 SUD Demonstration will promote the entire continuum of SUD treatment options.</td>
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</table>

<table>
<thead>
<tr>
<th>Goal 2: Increased rates of identification, initiation, and engagement in treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposed Change: Implement widespread use of evidence-based, SUD-specific patient placement criteria to promote the most appropriate treatment based upon the assessed needs of individuals.</td>
</tr>
<tr>
<td>1. Research Question: Will timely access to the correct SUD LOC addressing needs appropriately result in improved health outcomes?</td>
</tr>
<tr>
<td>Hypothesis: The 1115 SUD Demonstration will increase the percentage of Ohio Medicaid members affected by substance abuse who seek treatment for substance abuse.</td>
</tr>
<tr>
<td>Proposed Change: Ensure sufficient provider capacity at each ASAM LOC.</td>
</tr>
<tr>
<td>1. Research Questions: Will assessing the availability of providers in Medicaid and accepting new patients, including MAT, improve access to care?</td>
</tr>
<tr>
<td>Hypothesis: The 1115 SUD Demonstration will increase provider capacity for SUD treatment for Ohio Medicaid members.</td>
</tr>
</tbody>
</table>
### Goal 3: Increased adherence to, and retention in, treatment.

**Proposed Change:** Implementing nationally-recognized, evidence-based SUD program standards for residential providers.

**Research Question:** Will strengthened consistency with ASAM admission and discharge determinations for SUD residential treatment services result in better accessibility across LOCs?

**Hypothesis:** The 1115 SUD Demonstration will improve recovery outcomes for Ohio Medicaid members.

### Goal 4: Improved access to care for physical health conditions among beneficiaries.

**Proposed Change:** Integrating SUD with primary care.

**Research Questions:**
- To what extent are individuals with SUD accessing primary care?
- Are individuals with SUD accessing necessary services, such as health monitoring and prevention services?
- Are chronic health and BH conditions being managed appropriately?
- Are physical health and SUD better integrated through the addition of nursing and evaluation and management codes for SUD care? Is the new BHCC Program initiative improving care coordination?

**Hypothesis:** The 1115 SUD Demonstration will improve the health and quality of life for Ohio Medicaid members in SUD treatment.

### Goal 5: Reductions in overdose deaths, particularly those due to opioids.

**Proposed Change:** Implementing comprehensive treatment and prevention strategies to address opioid abuse and OUD.

**Research Questions:**
- Will implementing opioid prescribing guidelines reduce the number of overdose deaths across the State?
- Will expanded coverage of, and access to, Naloxone reduce overdose deaths?
- Will improvements in the OARRS program increase utilization of the OARRS prescription drug monitoring program?

**Hypothesis:** The 1115 SUD Demonstration will result in decreased overdose deaths. The 1115 SUD Demonstration will increase the utilization of the OARRS PDMP.
Goal 6: Fewer readmissions to the same or higher LOC where the readmission is preventable or medically inappropriate.

| Proposed Change: Improving Care Coordination and Transitions between LOC will result in better health for individuals diagnosed with a SUD. |
| Research Questions: Has the Demonstration impacted access to care by linking beneficiaries with community-based services and supports following stays in residential and inpatient facilities and reducing readmission rates for treatment? Are chronic health and BH conditions for individuals transitioning from residential and inpatient care being managed appropriately? |
| Hypothesis: The 1115 SUD Demonstration will reduce readmission rates to emergency departments and inpatient hospital settings for Ohio Medicaid members who have had a previous admission for substance abuse treatment. |

XI. LIST OF WAIVER AND EXPENDITURE AUTHORITIES

Waiver Authority
None. The waivers of freedom of choice and comparability are applied via the approved Section 1915(b) Ohio waivers and approved Section 1932(a) State Plan.

Expenditure Authority
ODM is requesting expenditure authority under Section 1115 to claim as medical assistance.

- Residential Treatment for Individuals with SUDs.
  Expenditures for otherwise covered services furnished to otherwise eligible individuals who are receiving treatment and withdrawal management services for SUDs in an IMD.

XII. ESTIMATE OF EXPECTED INCREASE/DECREASE IN ANNUAL ENROLLMENT AND ANNUAL AGGREGATE EXPENDITURES

Medicaid expenditures and enrollment under managed care are not expected to change as a result of this Demonstration. This Demonstration would permit Ohio to reimburse SUD treatment services, including services for individuals who receive services in an IMD, which is generally a cost-effective alternative setting.

Medicaid expenditures and enrollment under FFS are also not expected to change as a result of this Demonstration. Utilization of State Plan-covered services for individuals who receive SUD treatment services in an IMD will only be authorized if ODM, or its designee, determines the admission to a residential setting is appropriately consistent with ASAM placement criteria. This will be cost-effective compared to inpatient hospital admissions.
**Budget Neutrality**

Milliman, Inc. (Milliman) was engaged by the State of Ohio, Department of Medicaid (ODM) to develop the response to the Budget Neutrality Form section for the Section 1115 Medicaid Demonstration Waiver Application (1115 Waiver) for substance use disorder (SUD) residential services. Budget neutrality is a comparison of without waiver expenditures (WoW) to with waiver expenditures (WW). CMS recommends two potential methodologies of demonstrating budget neutrality:

1. **Per Capita Method:** Assessment of the per member per month (PMPM) cost of the Demonstration
2. **Aggregate Method:** Assessment of both the number of members and PMPM cost of the Demonstration

Budget neutrality for the 1115 Waiver will be demonstrated through the use of the per capita method. The budget neutrality projections were developed using CMS budget neutrality requirements. The SUD residential budget neutrality worksheets prepared by Milliman are attached as Attachment A.

Milliman has relied upon certain data and information provided by ODM in the development of the estimates contained in the Budget Neutrality Worksheet. Milliman has relied upon the ODM for the accuracy of the data and accepted them without audit. To the extent that the data provided are not accurate, the results of this analysis may need to be modified to reflect revised information.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience. It should be emphasized that the values in the Budget Neutrality Form are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this analysis.

**XII. PUBLIC NOTICE AND TRIBAL CONSULTATION**

**Summary of Public Comments**

A summary of the feedback from commenters is also provided in Attachment B.

*Note: this section, Attachment B and the underlined text below will be completed after public comment period is completed.*

**Public Notice Process**
Information on the 1115 Demonstration application and a copy of the public notice is available on ODM’s website.

*Note: this section, and the underlined text above, will be completed after public comment period is completed.*

**Tribal Consultation**

Ohio does not have any Federally-recognized tribes.
Attachment A: Budget Neutrality

The 1115 Waiver SUD residential services budget neutrality worksheets are below. The rest of this section documents the supporting data and methodology included in the worksheets using guidance provided by CMS in the Budget Neutrality Form.

I. Without- and With-Waiver Projections for Historical Medicaid Populations

A. Recent Historical Actual Data

We have provided actual historical data in two separate Medicaid eligibility groups (MEGs) for the managed care eligible population and those enrolled in the fee-for-service program. The historical data includes SUD treatment in residential settings for all Medicaid eligible beneficiaries. We have included member months where a beneficiary received SUD treatment of any length. For each of these member months, we have reflected all (both SUD and non-SUD) of their corresponding Medicaid eligible service expenditures within the month.

Effective January 1, 2018, ODM submitted a 1932 state plan amendment for their behavioral health redesign, which included a full spectrum of SUD treatment following American Society of Addiction Medicine (ASAM) criteria. This new behavioral health benefit included SUD treatment in a residential facility under specific procedure codes. Prior to January 1, 2018, SUD treatment in a residential facility was not clearly defined. Instead, SUD residential facilities billed for each specific SUD treatment separately (e.g. assessments, counseling, therapy, etc.). As a result, we have limited our historical experience to the first quarter of CY 2018, as it more appropriately reflects the projected per member per month (PMPM) cost during the five-year Demonstration.

B. Bridge Period

The bridge period is April 1, 2018 to June 30, 2018 (3 months). DY 00 reflects the July 1, 2018 to June 30, 2019-time period, with DY 01 set to begin on July 1, 2019. We have applied 10.5 months of aging to get from the midpoint of the historical data (February 15, 2018) to the midpoint of DY 00 (January 1, 2019).

C. Without-Waiver and With-Waiver Trend Rates, PMPM costs and Member Months

Based on CMS guidance regarding SUD 1115 Waivers, both the WoW and WW scenarios equal one another.

As discussed above, ODM implemented a new SUD service array on January 1, 2018, including SUD treatment at residential facilities. We have projected the SUD facility experience during the five-year Demonstration by applying a trend to both the
member months receiving SUD facility treatment and the corresponding total per member per month (PMPM) cost. The projected PMPM cost trend reflects the President’s budget trend (4.5%). Based on discussions with ODM regarding ramp-up in SUD facility treatment under the behavioral health redesign and new SUD facility providers coming online to provide SUD treatment, we are assuming a 10% annual caseload trend over the five-year Demonstration.

II. Cost Projections for New Populations

Not applicable

III. Disproportionate Share Hospital Expenditure Offset

Not applicable

IV. Summary of Budget Neutrality

Appendix I illustrates the 1115 Waiver budget neutrality spreadsheet, as well as the supplemental SUD budget neutrality spreadsheet, which both include the following applicable tabs:

i. SUD Historical
ii. SUD Without-Waiver
iii. SUD With Waiver
iv. SUD Summary (of Budget Neutrality)
v. SUD Caseloads

V. Additional Information to Demonstrate Budget Neutrality

We do not believe there is any other information necessary for CMS to complete its analysis of the budget neutrality submission.
### SUD Historical Spending Data - 5 Years

#### Historical Years Definition:
- **Calendar Year**

<table>
<thead>
<tr>
<th>SUD Residential Services MEG 1</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>Q1 2018</th>
<th>5-YEARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL EXPENDITURES</td>
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<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>ELIGIBLE MEMBER MONTHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9,760</td>
<td></td>
</tr>
<tr>
<td>PMPM COST</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>$7,719.00</td>
<td></td>
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</table>

#### TREND RATES
- **TOTAL EXPENDITURE**
- **ELIGIBLE MEMBER MONTHS**
- **PMPM COST**

<table>
<thead>
<tr>
<th>SUD Residential Services MEG 2</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>Q1 2018</th>
<th>5-YEARS</th>
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</thead>
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<tr>
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<td>PMPM COST</td>
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<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>$6,533.91</td>
<td></td>
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</table>

#### TREND RATES
- **TOTAL EXPENDITURE**
- **ELIGIBLE MEMBER MONTHS**
- **PMPM COST**
## SUD Without Waiver Costs

<table>
<thead>
<tr>
<th>ELIGIBILITY GROUP</th>
<th>TRENDS</th>
<th>MONTHS OF AGING</th>
<th>BASE YEAR</th>
<th>TRENDS</th>
<th>DEMONSTRATION YEARS (DY)</th>
<th>TOTAL</th>
<th>PB Trend:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RATE 1</td>
<td></td>
<td>RATE 2</td>
<td></td>
<td>DY 00</td>
<td>DY 01</td>
<td>4.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DY 02</td>
<td>DY 03</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DY 03</td>
<td>DY 04</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DY 04</td>
<td>DY 05</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>W.O.W.</td>
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</table>

### SUD Residential Services

#### MEG 1

<table>
<thead>
<tr>
<th>Eligible Member Months</th>
<th>n.a.</th>
<th>10.5</th>
<th>42,435</th>
<th>n.a.</th>
<th>46,679</th>
<th>51,347</th>
<th>56,482</th>
<th>62,130</th>
<th>68,343</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMPM Cost</td>
<td>n.a.</td>
<td>10.5</td>
<td>$8,022</td>
<td>4.5%</td>
<td>$8,383</td>
<td>$8,760</td>
<td>$9,155</td>
<td>$9,566</td>
<td>$9,997</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td></td>
<td></td>
<td>$391,313,853</td>
<td>$449,815,322</td>
<td>$517,062,439</td>
<td>$594,363,007</td>
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#### MEG 2

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<th>Eligible Member Months</th>
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<th>n.a.</th>
<th>2,917</th>
<th>3,209</th>
<th>3,530</th>
<th>3,883</th>
<th>4,271</th>
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</thead>
<tbody>
<tr>
<td>PMPM Cost</td>
<td>n.a.</td>
<td>10.5</td>
<td>$6,790</td>
<td>4.5%</td>
<td>$7,096</td>
<td>$7,415</td>
<td>$7,749</td>
<td>$8,098</td>
<td>$8,462</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td></td>
<td></td>
<td>$20,702,232</td>
<td>$23,797,210</td>
<td>$27,354,888</td>
<td>$31,444,455</td>
<td>$36,145,404</td>
<td>$139,444,188</td>
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</table>
### SUD with Waiver Costs

<table>
<thead>
<tr>
<th>ELIGIBILITY GROUP</th>
<th>TRENDS</th>
<th>DEMONSTRATION YEARS (DY)</th>
<th>TOTAL WW</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>DY 00</td>
<td>DY 01</td>
<td>DY 02</td>
</tr>
<tr>
<td></td>
<td>RATE</td>
<td>4.5%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Eligible Member Months</td>
<td></td>
<td>46,679</td>
<td>51,347</td>
</tr>
<tr>
<td>PMPM Cost</td>
<td>$8,022</td>
<td>$8,383</td>
<td>$8,760</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td></td>
<td>$391,313,853</td>
<td>$449,815,322</td>
</tr>
</tbody>
</table>

#### SUD Residential Services MEG 1

| Eligible Member Months | 2,917 | 3,209 | 3,530 | 3,883 | 4,271 |
| PMPM Cost | $6,790 | 7,096 | 7,415 | 7,749 | 8,098 | $8,462 |
| Total Expenditure | 20,702,232 | 23,797,210 | 27,354,888 | 31,444,455 | $36,145,404 | $139,444,188 |

#### SUD Residential Services MEG 2
SUD Residential Supplemental BN
Tests

Without-Waiver Total
Expenditures

<table>
<thead>
<tr>
<th>DEMONSTRATION YEARS (DY)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DY 01</td>
</tr>
<tr>
<td>SUD Residential Services MEG 1</td>
<td>$391,313,853</td>
</tr>
<tr>
<td>SUD Residential Services MEG 2</td>
<td>$20,702,232</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$412,016,084</td>
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</table>

With-Waiver Total Expenditures

<table>
<thead>
<tr>
<th>DEMONSTRATION YEARS (DY)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DY 01</td>
</tr>
<tr>
<td>SUD Residential Services MEG 1</td>
<td>$391,313,853</td>
</tr>
<tr>
<td>SUD Residential Services MEG 2</td>
<td>$20,702,232</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$412,016,084</td>
</tr>
</tbody>
</table>

Net Overspend

| Net Overspend | $0 | $0 | $0 | $0 | $0 | $0 |

Add Trend Rates & PMPMs from Table Below to 'SUD Supplemental Budget Neutrality Test(s)' STC

<table>
<thead>
<tr>
<th>SUD MEG(s)</th>
<th>Trend Rate</th>
<th>DY 01</th>
<th>DY 02</th>
<th>DY 03</th>
<th>DY 04</th>
<th>DY 05</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUD Residential Services MEG 1</td>
<td>4.5%</td>
<td>$8,383</td>
<td>$8,760</td>
<td>$9,155</td>
<td>$9,566</td>
<td>$9,997</td>
</tr>
<tr>
<td>SUD Residential Services MEG 2</td>
<td>4.5%</td>
<td>$7,096</td>
<td>$7,415</td>
<td>$7,749</td>
<td>$8,098</td>
<td>$8,462</td>
</tr>
<tr>
<td>Projected SUD Residential Member Months/Caseloads</td>
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<td></td>
<td></td>
<td></td>
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<tr>
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<td></td>
</tr>
<tr>
<td></td>
<td>Trend Rate</td>
<td>DY 01</td>
<td>DY 02</td>
<td>DY 03</td>
<td>DY 04</td>
<td>DY 05</td>
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<tr>
<td>SUD Residential Services MEG 1</td>
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<td>46,679</td>
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<td>56,482</td>
<td>62,130</td>
<td>68,343</td>
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<tr>
<td>SUD Residential Services MEG 2</td>
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</table>