NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

November 27, 2018

Ms. Mary Mayhew, Deputy Administrator & Director
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard. Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

Dear Ms. Mayhew:

RE: Section 1115 Demonstration Waiver Application for the Use of Institutions for Mental Diseases in Medicaid Managed Care

The Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care hereby submits the attached Section 1115 Demonstration Waiver Proposal to secure authority to continue utilizing facilities that meet the definition of Institutions for Mental Diseases (IMDs) to provide residential substance use disorder treatment services to Medicaid beneficiaries enrolled in Nebraska's Heritage Health managed care program.

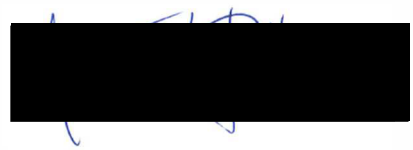
On July 5, 2016, CMS implemented the Medicaid and CHIP Managed Care Final Rule (Final Rule). 42 CFR 438.6(e) as established by the Final Rule stipulates that a state may make a capitation payment to a managed care organization for a Medicaid enrollee age 21-64 receiving inpatient treatment in an IMD for a "short term" stay of no longer than 15 days during the period of the monthly capitation payment.

Prior to the implementation of this provision, Nebraska was among several Medicaid managed care states to include IMD stays (regardless of the length of stay) in rate development for capitation payments utilizing CMS's well-established "in lieu of service" authority. This authority allows states to offer services not covered by the State Plan, provided those services meet certain criteria including medical appropriateness and cost effectiveness. Nebraska utilized "in lieu of service" authority to cover IMD stays in lieu of less appropriate and more costly settings such as emergency departments.

This Section 1115 Demonstration Waiver is being requested to ensure that Medicaid enrollees suffering with substance use disorders can continue to receive treatment in the most appropriate and cost-effective setting.

The Department has worked closely with CMS in the development of this waiver application and appreciates the guidance CMS has provided throughout this process. We look forward to working with CMS in its review of this application.

Sincerely,



Matthew A. Van Patton, DHA, Director
Division of Medicaid and Long-Term Care
Department of Health and Human Services

MVP/tb

Nebraska Medicaid
Section 1115 Substance Use Disorder Demonstration Program

A Member-Centered, Community-Focused Approach to Serving Those with Substance Use Disorders.

November 27, 2018

Table of Contents

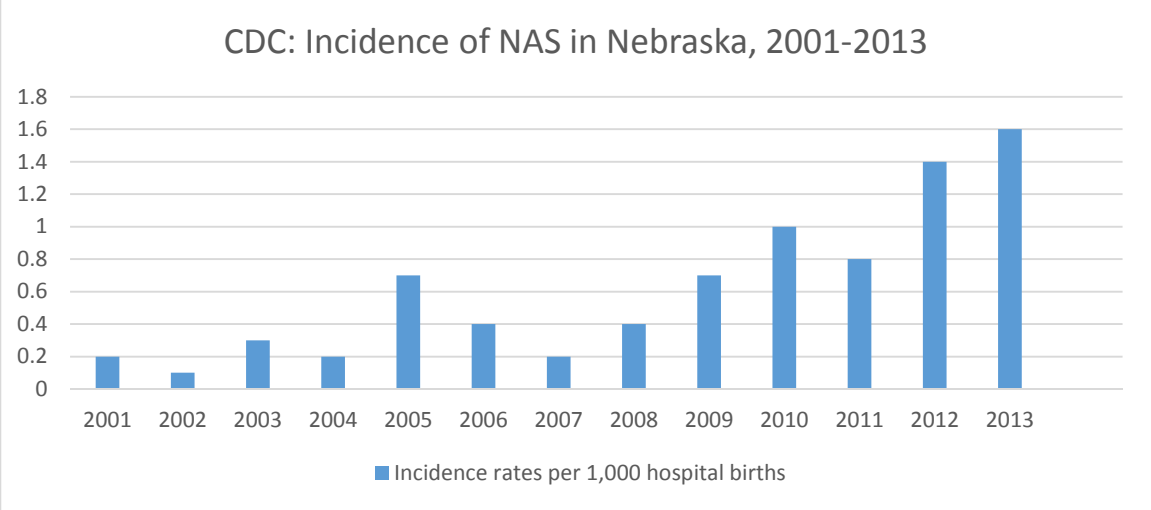
1 NEBRASKA SUBSTANCE USE DISORDER DELIVERY SYSTEM

1.1 OVERVIEW OF OPIOID AND OTHER SUBSTANCE USE DISORDERS

The United States is facing a public health crisis brought on by the abuse of prescription and illicit opioids. According to the National Institutes of Health, more than 90 Americans die from opioid overdoses every day.[1] In 2016, over 63,000 Americans died as a result of drug overdose, 42,200 of which were attributed to opioids.[2] The surge in opioid-related overdose deaths was significant enough to contribute to a decline in overall life expectancy in the U.S. for the second year in a row. This is the first time since the 1960s that U.S. life expectancy has declined over consecutive years.[3]

Nebraska's drug overdose death rate was 8.0 per 100,000 people in 2015, up from 3.6 per 100,000 in 2004. Emergency department visits related to drug overdoses were 128.6 per 100,000 people in 2014, up from 113.5 per 100,000 in 2007.[4] Nebraska is also experiencing an increase in newborns exhibiting drug withdrawal symptoms. Data from the Centers for Disease Control and Prevention (CDC) indicates an increase in Nebraska in the rate of neonatal abstinence syndrome (NAS). As illustrated in Figure 1, incidents of NAS have grown at an annual rate of .1 per 1,000 hospital births from .2 per 1,000 in 2001 to 1.6 per 1,000 in 2013.[5]

Figure 1. Neonatal Abstinence Syndrome (NAS) in Nebraska



[1] National Institutes of Health, Opioid Overdose Crises, January 2018. Available at: https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis#one

[2] Centers for Disease Control and Prevention, Drug Overdose Deaths in the United States, 1999–2016, December 2017. Available at: https://www.cdc.gov/nchs/data/databriefs/db294.pdf

[3] Life Expectancy Drops Again As Opioid Deaths Surge In U.S., National Public Radio, December 21, 2017. Available at: https://www.npr.org/sections/health-shots/2017/12/21/572080314/life-expectancy-drops-again-as-opioid-deaths-surge-in-u-s

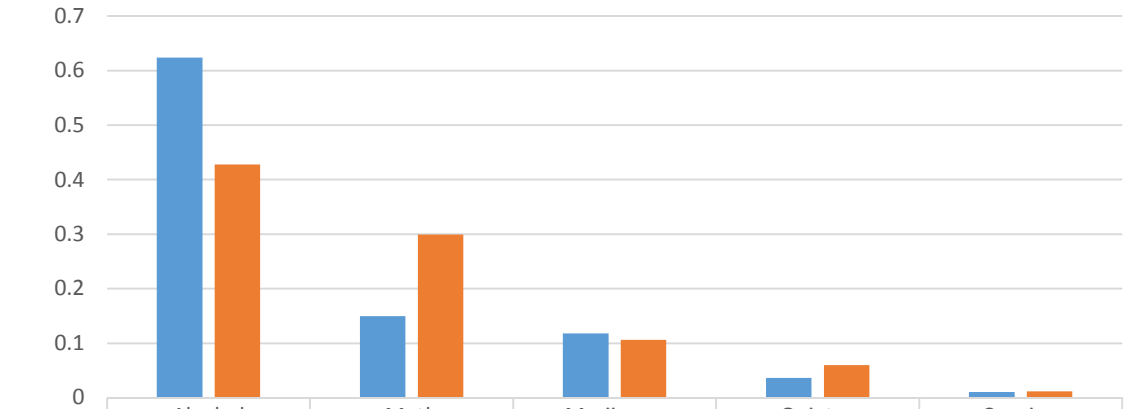
[4] Nebraska DHHS Business Plan July 2017 – June 2018. Pg. 22. Available at: http://dhhs.ne.gov/Documents/BusinessPlan.pdf

[5] Ko JY, Patrick SW, Tong VT, Patel R, Lind JN, Barfield WD. Incidence of Neonatal Abstinence Syndrome — 28 States, 1999–2013. MMWR Morb Mortal Wkly Rep 2016;65:799–802. DOI: http://dx.doi.org/10.15585/mmwr.mm6531a2.

While Nebraska has not experienced the type of public health crisis afflicting other states as a result of prescription and illicit opioid abuse, the state is still feeling the impact of the national epidemic. Opioid overdoses were responsible for 54 deaths in Nebraska in 2015.[6]

Nebraskans, including those participating in the Medicaid program, continue to struggle with a variety of substance use challenges including opioids. Figure 2 illustrates the drug of choice identified by individuals admitted to Substance Abuse Treatment Centers (SATC) in 2016.

Figure 2. Nebraska Primary Drug of Choice



	Alcohol	Meth	Marijuana	Opiates	Cocaine
Male	0.623975912	0.149639381	0.118128983	0.036412016	0.010503466
Female	0.427695139	0.299187241	0.106425395	0.059806778	0.011808005

Note: Excludes admissions in which the drug of choice information was not reported
Source: Centralized Data System, Nebraska Division of Behavioral Health

1.2 DEPARTMENT STRUCTURE

The Division of Medicaid and Long-term Care (MLTC) is the agency responsible for the administration of the Medicaid program in Nebraska. MLTC is one of five divisions that make up the Nebraska Department of Health and Humans Services (DHHS). Other DHHS divisions include:

- The Division of Behavioral Health (DBH) which provides funding, oversight, and technical assistance to the six (6) local behavioral health regions. The regions contract with local programs to provide public inpatient, outpatient, emergency community mental health, and substance use disorder services.

[6] DHHS Working to Combat Opioid Abuse, June 21, 2016. Available at: http://dhhs.ne.gov/Pages/newsroom_2016_june_opioid.aspx

DBH also operates three Regional Centers in Lincoln (LRC), Norfolk (NRC), and Hastings (HRC). Combined, these centers serve about 400 individuals. Services within the Regional Centers include general psychiatric services for those committed by a board of mental health or ordered there by a court (LRC), as well as treatment to sex offenders (NRC, LRC). Additional services also include Psychiatric Residential Treatment Facility treatment for substance use disorders for young men (HRC) and for young men who have sexually harmed (LRC/Whitehall).

- The Division of Public Health (DPH) which is responsible for preventive and community health programs and services. It also regulates and licenses health-related professionals, health care facilities, and services.

  DPH also oversees Nebraska's Prescription Drug Monitoring Program (PDMP).

- The Division of Children and Family Services which administers child welfare, adult protective services, economic support programs, and the youth rehabilitation and treatment centers.

- The Division of Developmental Disabilities which administers publicly funded community-based disability services. The Division also operates several sites that provide services for individuals with developmental disabilities.

1.3 CURRENT DELIVERY SYSTEM

The Nebraska Medicaid Program provides health coverage to approximately 240,000 residents. In any given month, 10 to 12 percent of the state's population is eligible for Medicaid. Over 98 percent of Medicaid enrollees are served through the state's managed care delivery system. As of January 1, 2017, the only populations remaining in the fee-for-service (FFS) delivery system are the following categories:

- Aliens who are eligible for Medicaid for an emergency condition only;
- Beneficiaries who have excess income or who are required to pay a premium, except those who are continuously eligible due to a share of cost obligation to a nursing facility or for HCBS Waiver services;
- Beneficiaries who have received a disenrollment or waiver of enrollment;
- Participants in the Program for All-Inclusive Care for the Elderly; and
- Beneficiaries with Medicare coverage where Medicaid only pays co-insurance and deductibles.

While Medicaid beneficiaries receiving long-term services and supports (LTSS) receive their physical health, behavioral health, and pharmacy services through their managed care plan, their LTSS benefits continue to be delivered through the legacy FFS system.

1.3.1 SUD TREATMENT SYSTEM

1.3.1.1 CURRENT SUD SERVICES

As illustrated in Table 3, Nebraska Medicaid currently provides a range of SUD services. Current Medicaid SUD services address multiple levels of care including outpatient,

intensive outpatient, withdrawal management, and clinically managed residential services at low and high levels of intensity. In June 2017, the state expanded its continuum of community-focused behavioral health services by adding coverage for Peer Support.[7]

Nebraska Medicaid currently offers non-methadone medication-assisted treatment (MAT) including coverage for naloxone delivered as an injectable or spray, buprenorphine, Suboxone (buprenorphine/naloxone), and Vivitrol (naltrexone).[8]

1.3.1.2 DELIVERY INFRASTRUCTURE

Nebraska's publicly funded behavioral health system is anchored by a network of six local regions. The regions contract with local programs to provide public inpatient, outpatient, emergency community mental health, and substance use disorder services. Medicaid managed care plans are required to collaborate with DBH and the local behavioral health regions in the establishment and maintenance of the plans' provider networks.

As of March 2018, Nebraska had just over 20 licensed Mental Health Centers (MHC) with a capacity of nearly 500 licensed beds and approximately 100 licensed SATCs with a capacity of over 800 beds.

The state has over 200 Medicaid-enrolled fully licensed Alcohol and Drug Counselors (LADC) and about 100 Provisionally Licensed Alcohol and Drug Counselors (PLADC).

There are approximately 1,700 Licensed Mental Health Professionals and Licensed Clinical Social Workers enrolled to serve Medicaid beneficiaries.

As of March 2018, there were 46 Medicaid-enrolled providers that had received a waiver to prescribe buprenorphine.

1.3.2 HERITAGE HEALTH

On January 1, 2017, Nebraska Medicaid launched Heritage Health, a new managed care program that integrates physical health, behavioral health, and pharmacy services into a single, statewide, comprehensive delivery system. The objectives of Heritage Health include:

- Improved health outcomes;
- Enhanced integration of services and quality of care;
- Emphasis on person-centered care, including enhanced preventive and care management services;
- Reduced rates of costly and avoidable care; and
- Improved financially sustainable system.

MLTC contracts with three health plans for the administration of the Heritage Health program: Nebraska Total Care (Centene), UnitedHealthCare Community Plan, and WellCare

[7] State Plan Amendment NE-16-0009. Available at: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NE/NE-16-0009.pdf

[8] Nebraska Medicaid Preferred Drug List (PDL). March 1, 2018. Available at: https://nebraska.fhsc.com/downloads/PDL/NE_PDL-20180301.pdf

of Nebraska. Table 1 provides the enrollment distribution of Medicaid beneficiaries across Heritage Health plans.

Table 1: Nebraska Heritage Health Plan Enrollment

Heritage Health Plan	Health Plan Enrollment (August 2018)
Nebraska Total Care	77,090
UnitedHealthcare Community Plan	77,724
WellCare of Nebraska	76,371
Total	**231,185**

A Strong Foundation for Improving SUD Service Delivery and Addressing Co-Occurring Conditions

A driving force behind the creation of Heritage Health was the desire to improve care coordination and simplify service delivery for Medicaid members. Prior to the launch of Heritage Health, a member struggling with substance use, physical health problems, and mental health conditions who also required prescription drugs was forced to navigate three separate programs in order to receive the full array of benefits and services the individual required. Through the integration of Medicaid services, Heritage Health removes barriers to addressing all the health needs of each member with a streamlined, person-centered approach.

In order to facilitate a successful integration of services, MLTC launched the Behavioral Health Integration Advisory Committee (BHIAC). BHIAC was constituted prior to the launch of Heritage Health and has been meeting continuously since May 2016 to address the many challenges and opportunities presented by the transition to an integrated managed care model. The BHIAC provides a platform for MLTC, DBH, Heritage Health plans, behavioral health providers, patient advocates, and other stakeholders to address issues such as provider reimbursement and credentialing, common service definitions, and prior authorization requirements.

Heritage Health's structural improvements and initiatives such as the BHIAC, provide a strong foundation for Nebraska Medicaid to continue its effort to improve SUD service delivery and health outcomes through participation in the SUD demonstration program.

1.4 CURRENT SUD PROGRAMS AND INITIATIVES

1.4.1 MEDICAID PREVENTION AND SAFETY INITIATIVES

On October 1, 2016, MLTC instituted a limit on the number of short-acting opioid doses a Medicaid beneficiary could receive. Medicaid beneficiaries (excluding cancer patients) are

now limited to 150 doses in a 30-day period. Prior to instituting the limits, MLTC had identified approximately 1,700 unique patients whose dosage exceeded the limitation.[6]

MLTC has made a series of additional drug coverage adjustments in order to further enhance abuse prevention and patient safety. These changes include:

- Adding coverage for abuse-deterrent opioids including Butrans (buprenorphine, transdermal) and Hysingla ER (hydrocodone, extended release);
- Removing prior authorization requirements for Suboxone and Vivitrol; and
- Reclassifying methadone as a non-preferred agent for pain management and adding a prior authorization requirement.

1.4.2 HERITAGE HEALTH PERFORMANCE IMPROVEMENT PLANS

For calendar year 2018, all three (3) Heritage Health managed care plans are required to conduct a performance improvement project (PIP) aimed at increasing outpatient follow up treatment for individuals with a primary or secondary diagnosis of substance use disorder or mental illness within seven (7) and 30 days after discharge from an emergency department.

This PIP is designed to reduce avoidable hospital re-admissions for individuals whose mental health or substance use challenges are contributing to potential hospitalizations. Through improved care transition management, the PIP aims to better connect individuals with appropriate outpatient services during a period of time in which these individuals may be at a higher risk of ED readmission, relapse, homelessness, and other associated risks.

1.4.3 PRESCRIPTION DRUG MONITORING PROGRAM

The Nebraska Legislature established the state's Prescription Drug Monitoring Program (PDMP) in 2011. The PDMP is overseen by DPH in coordination with the Nebraska Health Information Initiative. The primary objectives of the PDMP are to prevent the misuse of prescribed controlled substances, allow prescribers and dispensers to monitor the care and treatment of patients for whom such a prescription drug is prescribed, and to ensure that such prescription drugs are used for medically appropriate purposes.

The PDMP program was further strengthened in 2016 with the passage of LB 471 which required that, beginning on January 1, 2017, all dispensed prescriptions for controlled substances must be reported to the PDMP. By January 1, 2018, all prescription information must be reported to the prescription drug monitoring system maintained by the PDMP.[9] On January 1, 2018, Nebraska became the first state to require reporting of all dispensed prescription drugs to the PDMP.[10]

DPH is currently operating a CDC Prescription Drug Overdose Prevention for States (PDO PfS) Grant[11] which provides the state with resources for additional PDMP improvement.

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[9] LB471 (2016). Available at: https://nebraskalegislature.gov/FloorDocs/104/PDF/Slip/LB471.pdf

[10] DHHS Launches Additional Enhancements to Prescription Drug Monitoring Program, January 8, 2018. Available at: http://dhhs.ne.gov/Pages/newsroom_2018_January_PDMP.aspx

[11] CDC Prescription Drug Overdose: Prevention for States. Available at: https://www.cdc.gov/drugoverdose/states/state_prevention.html

Through the PDO PfS grant, DPH is implementing PDMP system enhancements and encouraging increased use of the PDMP through the creation of educational tools for medical providers.

Increased PDMP participation and adherence is a DHHS priority. As part of the Department's 2017-2018 Business Plan (an annual plan that details specific, time-sensitive goals by which DHHS and the Governor's office measure the Department's success), DHHS established participation metrics for the PDMP.[12]

> **GOAL:** The Prescription Drug Monitoring Program (PDMP) will have more than 90 percent of Nebraska's 516 community pharmacies reporting all dispensed substances by the end of June 2018, and will register 30 percent of 22,790 eligible PDMP users (any provider who can prescribe medications and all pharmacists) by March 2018.

1.4.4 STATE TARGETED RESPONSE TO THE OPIOID CRISIS GRANT

In spring of 2017, DBH was awarded a two-year, $2 million grant as part of the Substance Abuse and Mental Health Services Administration's (SAMHSA) State Targeted Response to the Opioid Crisis program. The program aims to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for opioid use disorder (OUD).

Under this program, DBH intends to serve the entire population of the state through training and prevention initiatives, while targeting high burden areas of the state for outreach, training and technical assistance.[13] Goals of the grant program include:

- Increasing the number of clients served by the DBH in the opioid replacement therapy service by 5 percent each year of the program;
- Supplying 1,000 naloxone kits to high-risk clients each year, resulting in 2,000 Nebraskans having access to this life-saving drug; and
- Serving approximately 340 individuals receiving assistance with treatment and in support of their path to recovery by providing funding for medication-assisted treatment through the use of buprenorphine.

[12] Nebraska DHHS Business Plan July 2017 – June 2018. Pg. 22. Available at: http://dhhs.ne.gov/Documents/BusinessPlan.pdf

[13] State Targeted Response (STR) Opioid Crisis Grant, January 5, 2018. Available at: http://dhhs.ne.gov/behavioral_health/Documents/StateTargetedResponsetoOpioidCrisisFactSheet-2018.pdf

1.4.5 NEBRASKA PAIN MANAGEMENT GUIDANCE

In October 2017, DHHS released the Nebraska Pain Management Guidance Document, a comprehensive opioid prescribing resource for providers.[14] This resource was created by a diverse task force including practicing clinicians, medical directors, psychiatrists, emergency department providers, pain medicine specialists, anesthesiologists, and public health professionals.

The goal of the document is to provide "real-world tools and advice to practicing clinicians as they seek to comply with national standards." The guidelines outlined in the document align with the CDC Guidelines for Chronic Pain released March 2016[15] and build off best practices as identified through CDC guidance and similar initiatives in other states.

2 MAINTAINING A MEMBER-CENTERED, COMMUNITY-FOCUSED SYSTEM OF CARE

2.1 DEMONSTRATION GOALS AND OBJECTIVES

DHHS shares the foundational objective of this SUD-focused demonstration program as articulated by CMS to "provide a full continuum of care for people struggling with addiction."

The State believes participation in the demonstration program outlined by CMS will allow the state to build on the recent delivery system reforms and DHHS-wide SUD initiatives identified in Section 1.

Expenditure Authority for Excluded Settings

A critical element in realizing CMS's goals for this demonstration is the ability for Nebraska Medicaid to allow Medicaid-enrolled individuals requiring inpatient SUD treatment to be allowed to complete their medically appropriate length of stay in facilities that meet the regulatory definition of an Institution for Mental Diseases (IMD) as defined in Section 1905(i) of the Social Security Act[16].

> **Institution for Mental Diseases (IMD):** The term "institution for mental diseases" means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

On July 5, 2016, CMS implemented the Medicaid and CHIP Managed Care Final Rule (Final Rule). 42 CFR 438.6(e) as established by the Final Rule stipulates that a state may make a capitation payment to a managed care organization (MCO) for a Medicaid enrollee age 21-64 receiving

[14] Nebraska Pain Management Guidance Document. October 1, 2017. Available at: http://dhhs.ne.gov/publichealth/PDMP/Documents/Nebraska%20Pain%20Management%20Guidance%20Document%20v3.2.pdf

[15] CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. Available at: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

[16] Section 1905(i) of the Social Security Act. Available at: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm

inpatient treatment in an IMD for a "short term" stay of no longer than 15 days during the period of the monthly capitation payment.

Prior to the implementation of this provision, Nebraska was among several Medicaid managed care states that included IMD stays (regardless of the length of stay) in rate development for capitation payments utilizing CMS's well established "in lieu of service" authority which allowed states to offer services not covered by the State Plan provided those services met certain criteria including medical appropriateness and cost effectiveness.

Implementing the limitations of the Final Rule has the potential to severely disrupt the treatment plans of some of Nebraska Medicaid's most medically and emotionally fragile adults. The Final Rule limitations strongly incentivize Medicaid health plans and providers to seek treatment for individuals with an SUD in less appropriate and potentially costlier settings as those health plans and providers would anticipate that reimbursement for Medicaid services in IMDs will end after 15 days. In Nebraska, this scenario would almost certainly result in increased utilization of emergency departments as the state's rural profile has historically limited the availability of inpatient behavioral health facilities.

Section 2.7.2 outlines DHHS's request for expenditure authority that would allow the State to continue ensuring that Medicaid enrollees struggling with a SUD and requiring inpatient treatment, receive that treatment in the most appropriate and cost effective setting regardless of whether the facility meets the regulatory definition of an IMD.

2.2 PROGRAM MILESTONES & IMPLEMENTATION PLAN DEVELOPMENT

Table 2 outlines the demonstration program milestones and timeframes identified by CMS. Per CMS's November 1, 2017 guidance, states must submit an Implementation Plan that outlines the initiatives the state will undertake to meet the program milestones. Based on technical guidance provided by CMS, the State understands that the option exists to submit the Implementation Plan after the submission of the demonstration application. Nebraska anticipates submitting its Implementation Plan in January 2019.

Table 2: Milestones for 1115 Demonstrations Addressing Opioids and Other Substances

Milestones	Specifications and Proposed Timeframes
Access to Critical Levels of Care for OUD and other SUDs	Coverage of a) outpatient, b) intensive outpatient services, c) medication-assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state), d) intensive levels of care in residential and inpatient settings, and e) medically supervised withdrawal management *Proposed Timeframe: Within 12 to 24 months of demonstration approval*

Milestones	Specifications and Proposed Timeframes
Use of Evidence-based, SUD-specific Patient Placement Criteria	1. Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines *Proposed Timeframe: Within 12 to 24 months of demonstration approval* 2. Implementation of a utilization management approach such that a) beneficiaries have access to SUD services at the appropriate level of care, b) interventions are appropriate for the diagnosis and level of care, and c) there is an independent process for reviewing placement in residential treatment settings. *Proposed Timeframe: Within 24 months of demonstration approval*
Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities	1. Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria, or other nationally recognized, evidence-based SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings *Proposed Timeframe: Within 12 to 24 months of demonstration approval* 2. Implementation of state process for reviewing residential treatment providers to assure compliance with these standards *Proposed Timeframe: Within 24 months of demonstration approval* 3. Requirement that residential treatment facilities offer MAT on site or facilitate access off site *Proposed Timeframe: Within 12 to 24 months of demonstration approval*
Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD	Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT. *Proposed Timeframe: Within 12 months of demonstration approval*
Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	1. Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse *Proposed Timeframe: Over the course of the demonstration* 2. Expanded coverage of, and access to, naloxone for overdose reversal *Proposed Timeframe: Over the course of the demonstration* 3. Implementation of strategies to increase utilization and improve functionality, of prescription drug monitoring programs *Proposed Timeframe: Over the course of the demonstration*
Improved Care Coordination and Transitions between Levels of Care	Implementation of policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and supports following stays in these facilities. *Proposed Timeframe: Within 12 to 24 months of demonstration approval*

2.3 ELIGIBILITY

Medicaid eligibility requirements will not differ from the approved Medicaid state plan.

2.4 COST-SHARING

Cost sharing requirements under the demonstration will not differ from the approved Medicaid state plan.

2.5 MEDICAID BENEFITS AND THE SUD CONTINUUM OF CARE

Nebraska Medicaid currently offers a range of outpatient and inpatient SUD services. This service continuum reflects MLTC's strategy of investing in community-based services that address the diagnoses most often exhibited by the state's Medicaid population as illustrated by Figure 2 in Section 1.1.

Nebraska's Implementation Plan will include the specific services and service definitions which address the coverage categories identified in Milestone 1: Access to Critical Levels of Care for OUD and other SUDs as detailed in Table 2 of Section 2.2. The benefits and services detailed in the Implementation Plan will not differ from the benefits currently provided to beneficiaries and authorized under the Medicaid state plan and concurrent 1915(b) waiver.

Table 3 illustrates the American Society of Addiction Medicine (ASAM) Levels of Care currently addressed by existing Medicaid SUD services. Services that will be impacted by the expenditure authority allowed under this demonstration waiver include a reference to 1115(a) authority in the Medicaid Service Authority column.

Table 3: Nebraska Medicaid SUD Services by ASAM Level of Care

ASAM Level of Care	ASAM Service Title	ASAM Brief Definition	Current Medicaid Service	New Medicaid Service Under the Waiver	Medicaid Service Authority
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	1915(b)
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	1915(b)
2.5	Partial Hospitalization Services	20 or more hours of service/week for multidimensional instability not requiring 24-hour care	Yes	No	1915(b)
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.	Yes	No	1915(b) and 1115(a)

ASAM Level of Care	ASAM Service Title	ASAM Brief Definition	Current Medicaid Service	New Medicaid Service Under the Waiver	Medicaid Service Authority
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.	Yes	No	1915(b) and 1115(a)
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.	Yes	No	1915(b) and 1115(a)
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.	Yes	No	1915(b)
Other	Peer Support	Peer support services are provided by individuals who have lived experience with Mental Health or Substance Use Disorders (SUD). The core element of this service is the development of a relationship based on shared lived experience and mutuality between the provider and individual.	Yes	No	State Plan

2.6 DELIVERY SYSTEM

The delivery system will continue to be the Heritage Health Medicaid managed care program that utilizes capitated Medicaid MCOs to provide state plan and 1915(b) authorized behavioral health services. Heritage Health will continue to operate as approved in DHHS' 1915(b) waiver.

2.7 LIST OF WAIVER AND EXPENDITURE AUTHORITIES

2.7.1 WAIVER AUTHORITY

Nebraska's current 1915(b) and state plan authority provide sufficient authority for ensuring the delivery of all benefits and services relevant to the objectives of this demonstration waiver. The state will not require additional waiver approval beyond the IMD expenditure authority detailed in Section 2.7.2.

2.7.2 EXPENDITURE AUTHORITY

DHHS is requesting expenditure authority under Section 1115 to claim as medical assistance the costs of services provided to eligible individuals ages 21-64 residing in facilities meeting the regulatory definition of an IMD. The State is requesting expenditure authority to continue to permit Medicaid MCOs to provide enrolled members the appropriate combination of services, in the most appropriate and cost-effective setting, and for the medically appropriate duration without regard to:

1) The 15-day length of stay limit imposed by 42 CFR 438.6(e); and
2) The requirement imposed by 42 CFR 438.6(e) that for purposes of capitation rate setting, that utilization of the substitute services identified in that that section be priced by the state and its contracted actuary at the cost of the same services delivered in state plan settings.

2.8 HYPOTHESIS AND EVALUATION

The Demonstration will test whether the expenditure authority granted under this waiver and the delivery system enhancements identified in the State's Implementation Plan result in increased access to SUD services and better outcomes for Medicaid enrollees struggling with substance abuse.

Per CMS's November 1, 2017, guidance, DHHS will report the initial performance measures identified in Table 4 and will work with CMS to identify additional optional measures of particular relevance to Nebraska's SUD experience.

Table 4: Demonstration Performance Measures

Demonstration/SUD Goals	Performance Measures
Increased Rates of Identification, Initiation and Engagement in Treatment	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (National Committee for Quality Assurance; NQF #0004)* #

Demonstration/SUD Goals	Performance Measures
Improved Adherence to Treatment	1. Continuity of Pharmacotherapy for OUD (RAND; NQF #3175) 2. Follow-up after Discharge from Emergency Department for Mental Health or Alcohol or Other Drug Dependence (National Committee for Quality Assurance; NQF #2605)*# 3. Percentage of beneficiaries with an SUD diagnosis including those with OUD who used the following services per month (multiple rates reported): • Outpatient; • Intensive outpatient services; • Medication-assisted treatment for OUDs and alcohol; • Residential treatment (including average lengths of stay (LOS) in residential treatment aiming for a statewide average LOS of 30 days); and • Medically supervised withdrawal management
Reduction in Overdose Deaths—Particularly Those Due to Opioids	1. Use of Opioids at High Dosage in Persons Without Cancer (Pharmacy Quality Alliance; NQF # 2940)* 2. Number of overdose deaths/ 1,000 Medicaid beneficiaries/month and specifically overdose deaths due to any opioid 3. Number of overdose deaths, and specifically deaths due to overdose of any opioid, among Medicaid beneficiaries in the reporting year
Reduced Utilization of Emergency Department and Inpatient Hospital Settings	1. Emergency department visits for SUD-related diagnoses and specifically for OUD /1,000 member months 2. Inpatient admissions for SUD and specifically OUD among Medicaid beneficiaries/1,000 member months# 3. Baseline and periodic updates on spending on beneficiaries in residential treatment and outpatient settings for SUD treatment and on inpatient and emergency room services for beneficiaries with SUD diagnoses including spending on physical health conditions commonly associated with SUDs
Fewer Readmissions to the Same or Higher Level of Care for OUD and Other SUD Treatment	30-day readmission rate following hospitalization for an SUD-related diagnosis# and specifically for OUD
Improved Access to Care for Co-morbid Physical Health Conditions among Beneficiaries	Percentage of beneficiaries with an SUD diagnosis, and specifically those with OUD, who access physical health care.
* Denotes measures that are part of the Medicaid Adult Core Set of Measures.	

2.9 ESTIMATE OF EXPECTED CHANGE IN ANNUAL ENROLLMENT AND ANNUAL AGGREGATE EXPENDITURES

Medicaid expenditures for State Fiscal Year 2018 (SFY2018) were $1,996,250,946.00 and Medicaid enrollment was approximately 245,000 individuals in its last month (June 2018). MLTC expects that the requested demonstration will not impact expenditure and enrollment figures.

As detailed in Section 2.1, the Department has been utilizing Medicaid managed care in lieu of service authority to include IMD stays in capitation rate development since the transition of behavioral health services to the managed care delivery system in 2013.

As a result of the Department's current policy towards IMD stays, the Department's approach to the projections for the demonstration years within the budget neutrality analysis is to illustrate the higher cost of care the Department anticipates the Medicaid program would experience if this demonstration waiver were not granted. As was stated in Section 2.1, the Department believes that were the state to be required to implement 42 CFR 438.6(e), it would result in the disruption of treatment plans for some of the state's most medically and emotionally fragile individuals and increase the likelihood that those patients would be forced to receive care in less appropriate and higher costs settings such as emergency departments.

See Budget Neutral Analysis Appendix.

3 PUBLIC NOTICE AND TRIBAL CONSULTATION

3.1 PUBLIC NOTICE PROCESS

The Department posted a notice of the 1115 waiver application on MLTC's dedicated public notice page: http://dhhs.ne.gov/medicaid/Pages/MedicaidPublicNotices.aspx

Public comments on the waiver application were accepted from August 29, 2018, to September 30, 2018.

Comprehensive information on the 1115 waiver application, public comment opportunities, and a copy of the full public notice were made available on the Department's dedicated waiver application webpage: http://dhhs.ne.gov/medicaid/Pages/SubUseDisDemo.aspx

Members of the public could submit written comments electronically at DHHS.SUDWaiver@nebraska.gov or at the following address:

Department of Health and Human Services
Nebraska Medicaid
ATTN: Todd Baustert
301 Centennial Mall South
P.O. Box 95026
Lincoln, Nebraska 68509-5026

The Department hosted two open public hearings where an overview of the 1115 waiver application was presented and public comments accepted. Printed copies of the waiver application and public notice were made available at each public hearing. Both public hearings included toll-free teleconference numbers. Details for the public hearings were posted on the dedicated waiver webpage, in the full public notice, and on the Nebraska State Government's public meeting calendar. The public hearing details are included in Figure 3 and the public hearing notices on the Nebraska State Government public meeting calendar are documented in Figures 4 (a-b).

The agendas for both public hearings were made available through the public calendar links. The meeting agendas are included in Figures 5 (a-b).

Figure 3

Hearing/Meeting Date	Time	Location	Teleconference #
Friday, August 31, 2018 - Behavioral Health Integration Advisory Committee Meeting	8:30AM – 10:00AM	Nebraska State Office Building 301 Centennial Mall South Lower Level Room A (LLA) Lincoln, Nebraska 68509	(888) 820 – 1398 Access Code: 4533256#
Tuesday, September 18, 2018	10:00AM-11:30AM	Omaha State Office Building 1313 Farnam Street Room 226 Omaha, Nebraska 68102	(888) 820 – 1398 Access Code: 4533256#

Figure 4(a)

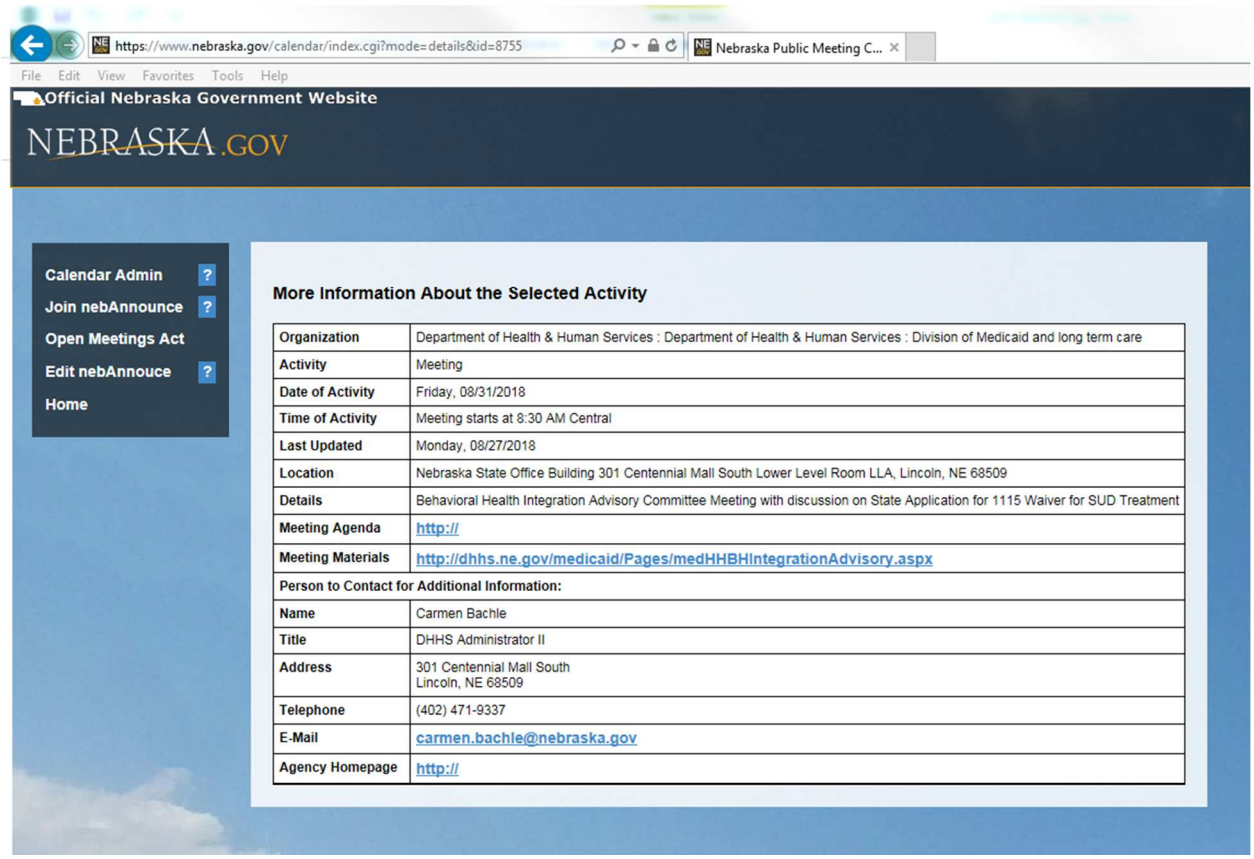
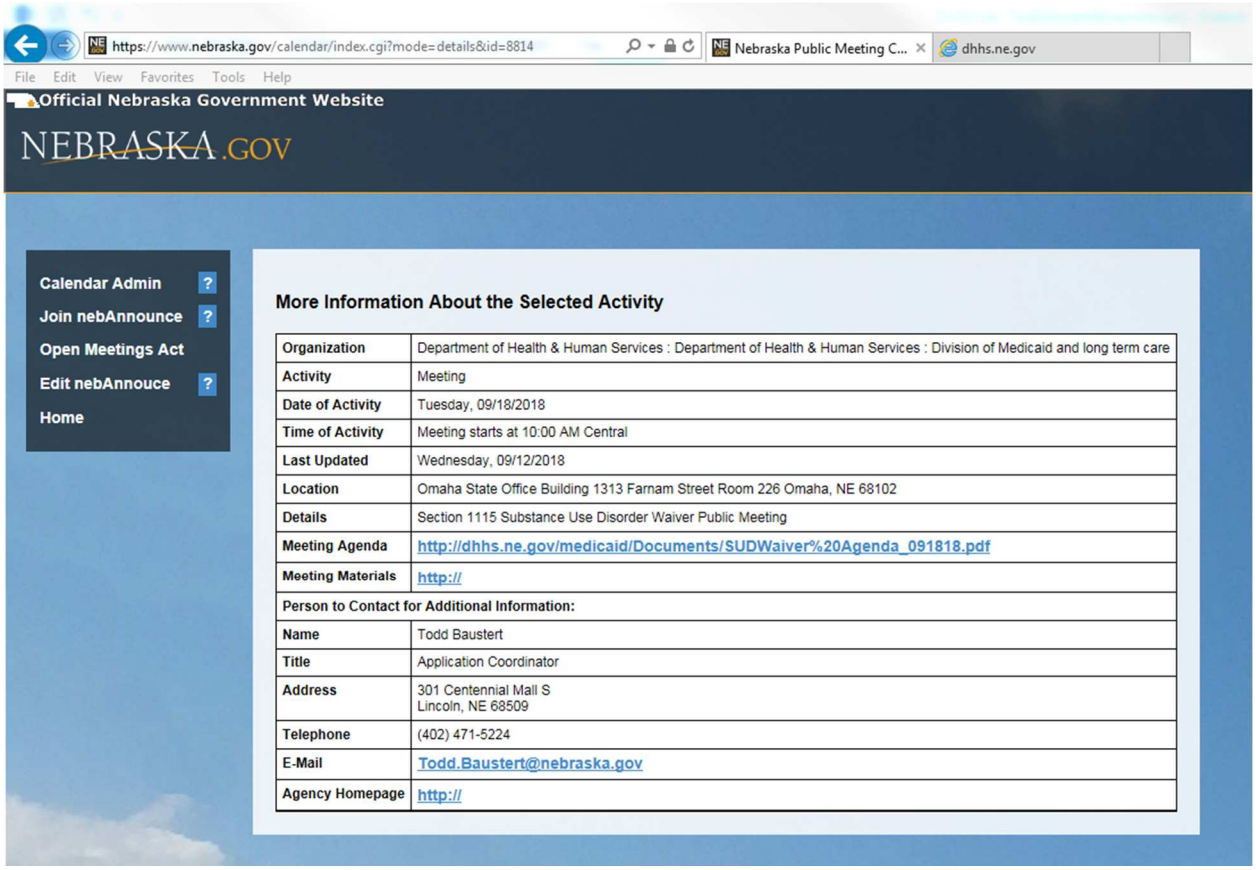


Figure 4(b)


https://www.nebraska.gov/calendar/index.cgi?mode=details&id=8814
Nebraska Public Meeting C...
dhhs.ne.gov
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Official Nebraska Government Website
NEBRASKA.GOV
Calendar Admin
Join nebAnnounce
Open Meetings Act
Edit nebAnnouce
Home
More Information About the Selected Activity
Organization
Department of Health & Human Services : Department of Health & Human Services : Division of Medicaid and long term care
Activity
Meeting
Date of Activity
Tuesday, 09/18/2018
Time of Activity
Meeting starts at 10:00 AM Central
Last Updated
Wednesday, 09/12/2018
Location
Omaha State Office Building 1313 Farnam Street Room 226 Omaha, NE 68102
Details
Section 1115 Substance Use Disorder Waiver Public Meeting
Meeting Agenda
http://dhhs.ne.gov/medicaid/Documents/SUDWaiver%20Agenda_091818.pdf
Meeting Materials
http://
Person to Contact for Additional Information:
Name
Todd Baustert
Title
Application Coordinator
Address
301 Centennial Mall S
Lincoln, NE 68509
Telephone
(402) 471-5224
E-Mail
Todd.Baustert@nebraska.gov
Agency Homepage
http://

Figure 5(a)

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DEPT. OF HEALTH AND HUMAN SERVICES Division of Medicaid and Long-Term Care

HERITAGE HEALTH

Heritage Health Behavioral Health Integration
Advisory Committee Agenda

Meeting Date / Time	**Friday, August 31, 2018; 8:30am – 10:00am**
Meeting Location	Nebraska State Office Building 301 Centennial Mall S. Lower Level Conference Room A Lincoln, NE 68509
Conference Line	(888) 820 – 1398 Access Code : 4533256#

Agenda:

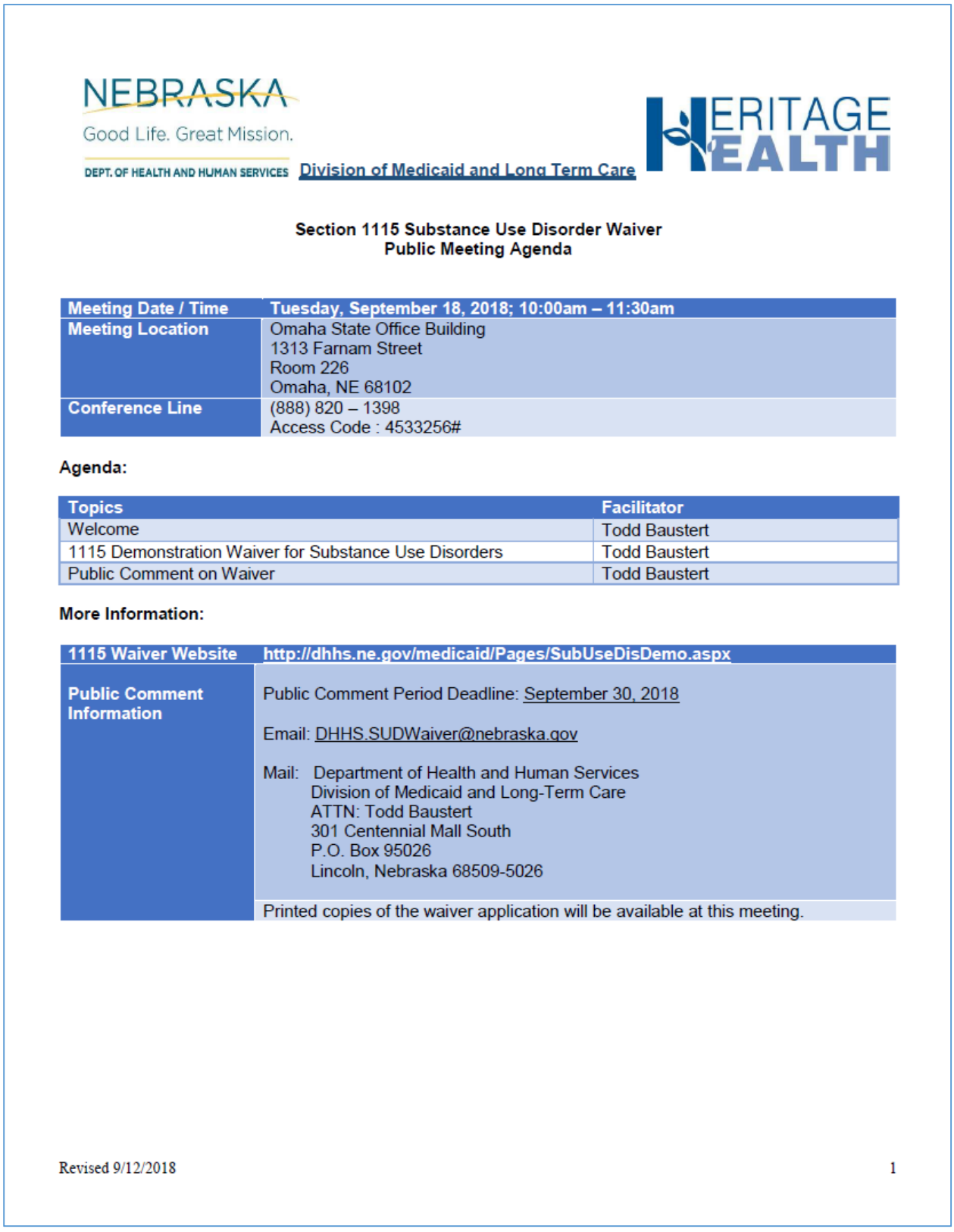
Topics	Facilitator
Welcome and introductions Roll Call Review of Minutes Public Comment on Agenda	Heather Leschinsky
Health Plan Advisory for Therapeutic and Medical Leave Days	Lori Lewis
1115 Demonstration Waiver for Substance Use Disorders	Todd Baustert
Medicaid Behavioral Health Benefit	Lisa Neeman
Roundtable Discussion	Heather Leschinsky
Action item assignments / Closing remarks	
Public Comment Period	
Adjourn	

Next Meeting:

Meeting Date / Time	**Tuesday, October 16, 2018; 2:00 pm – 3:30 pm**
Meeting Location	Nebraska State Office Building 301 Centennial Mall S. Lower Level Conference Room A Lincoln, NE 68509

Revised 8/29/2018 1

Figure 5(b)



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DEPT. OF HEALTH AND HUMAN SERVICES Division of Medicaid and Long Term Care

HERITAGE HEALTH

Section 1115 Substance Use Disorder Waiver
Public Meeting Agenda

Meeting Date / Time	**Tuesday, September 18, 2018; 10:00am – 11:30am**
Meeting Location	Omaha State Office Building 1313 Farnam Street Room 226 Omaha, NE 68102
Conference Line	(888) 820 – 1398 Access Code : 4533256#

Agenda:

Topics	Facilitator
Welcome	Todd Baustert
1115 Demonstration Waiver for Substance Use Disorders	Todd Baustert
Public Comment on Waiver	Todd Baustert

More Information:

1115 Waiver Website	**http://dhhs.ne.gov/medicaid/Pages/SubUseDisDemo.aspx**
Public Comment Information	Public Comment Period Deadline: September 30, 2018 Email: DHHS.SUDWaiver@nebraska.gov Mail: Department of Health and Human Services Division of Medicaid and Long-Term Care ATTN: Todd Baustert 301 Centennial Mall South P.O. Box 95026 Lincoln, Nebraska 68509-5026
	Printed copies of the waiver application will be available at this meeting.

Revised 9/12/2018 1

Stakeholders were notified of the public comment period via email notifications sent to participants on the Heritage Health Behavioral Health Integration Advisory Committee. BHIAC membership includes the Heritage Health managed care plans, providers, provider associations, behavioral health advocacy groups, DBH, DPH, and CFS.

3.2 SUMMARY OF PUBLIC COMMENTS

The Department received verbal comments at its August 31, 2018, public hearing. The comments largely consisted of questions from providers regarding the approach the Department is taking in developing the application and seeking clarification on the scope of the demonstration project. Comments were generally favorable towards the Department's efforts in seeking section 1115 waiver authority but also expressed concerns about the implementation of the IMD stay limit as defined in 42 CFR 438.6(e).

- Commenters encouraged the Department to reach out to other states in addition to receiving technical assistance from CMS.
- Commenters requested that the Department be mindful of the impact on providers and that providers will need adequate guidance as implementation of the demonstration approaches.
- Commenters noted that SUD services are just one piece of the services impacted by 42 CFR 438.6(e) and sought clarification as to what other actions the Department is taking to address other services not addressed in the demonstration waiver application.

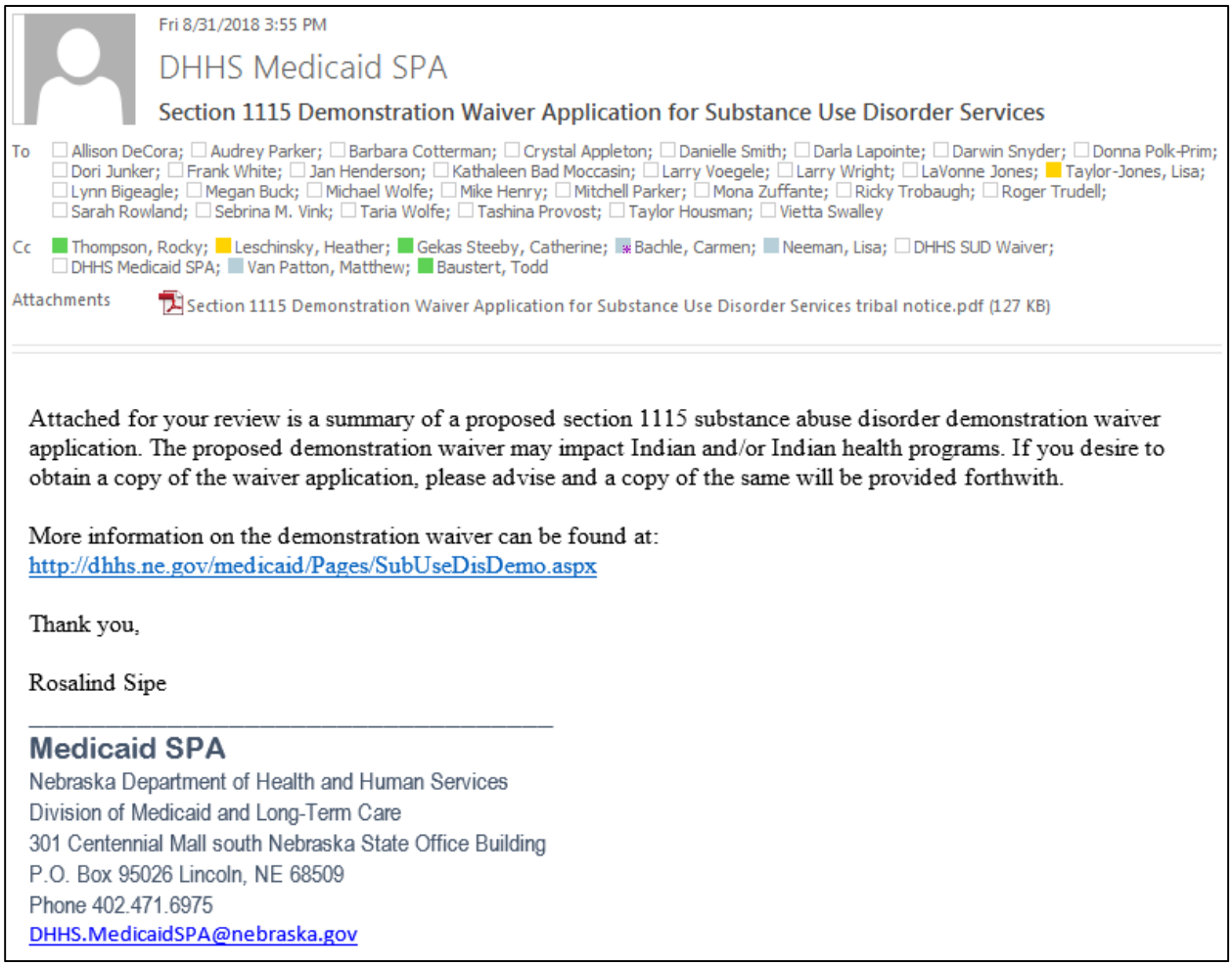
The Department received no written comments. There were no comments offered at the Department's September 18, 2018, public hearing on the waiver application.

3.3 TRIBAL CONSULTATION

On August 31, 2018, the Department sent electronic notification to representatives of the state's federally recognized tribal organizations of the opportunity to review and comment on the demonstration waiver application. Tribal organizations were allowed 30 calendar days to provide comments with a comment deadline of September 30, 2018. Copies of the correspondence and materials are included in Figures 6(a-c).

The Department received no written or verbal comments from tribal organizations.

Figure 6(a)



Fri 8/31/2018 3:55 PM

DHHS Medicaid SPA

Section 1115 Demonstration Waiver Application for Substance Use Disorder Services

To Allison DeCora; Audrey Parker; Barbara Cotterman; Crystal Appleton; Danielle Smith; Darla Lapointe; Darwin Snyder; Donna Polk-Prim; Dori Junker; Frank White; Jan Henderson; Kathaleen Bad Moccasin; Larry Voegele; Larry Wright; LaVonne Jones; Taylor-Jones, Lisa; Lynn Bigeagle; Megan Buck; Michael Wolfe; Mike Henry; Mitchell Parker; Mona Zuffante; Ricky Trobaugh; Roger Trudell; Sarah Rowland; Sebrina M. Vink; Taria Wolfe; Tashina Provost; Taylor Housman; Vietta Swalley

Cc Thompson, Rocky; Leschinsky, Heather; Gekas Steeby, Catherine; Bachle, Carmen; Neeman, Lisa; DHHS SUD Waiver; DHHS Medicaid SPA; Van Patton, Matthew; Baustert, Todd

Attachments Section 1115 Demonstration Waiver Application for Substance Use Disorder Services tribal notice.pdf (127 KB)

Attached for your review is a summary of a proposed section 1115 substance abuse disorder demonstration waiver application. The proposed demonstration waiver may impact Indian and/or Indian health programs. If you desire to obtain a copy of the waiver application, please advise and a copy of the same will be provided forthwith.

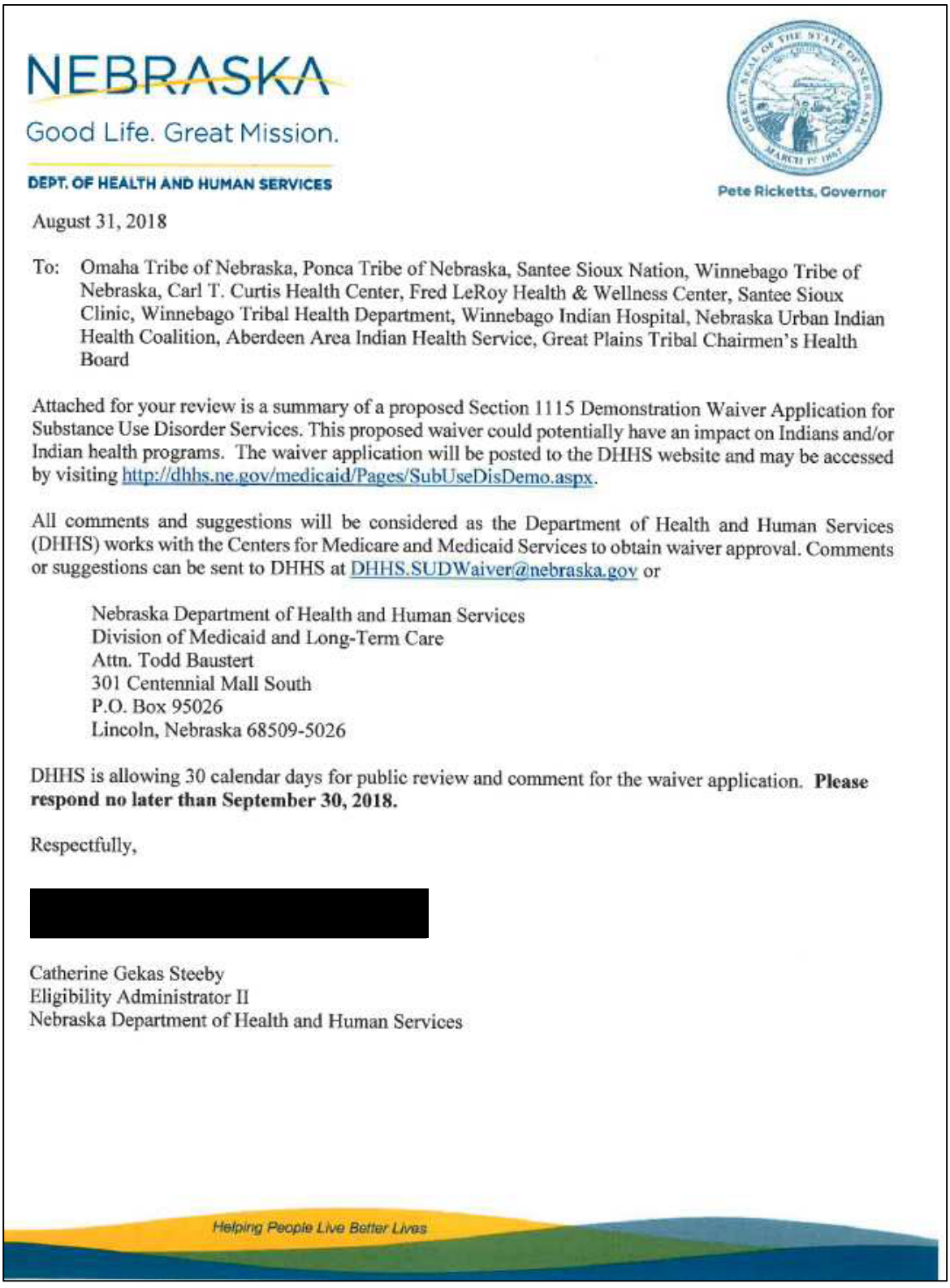
More information on the demonstration waiver can be found at:
http://dhhs.ne.gov/medicaid/Pages/SubUseDisDemo.aspx

Thank you,

Rosalind Sipe

Medicaid SPA
Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care
301 Centennial Mall south Nebraska State Office Building
P.O. Box 95026 Lincoln, NE 68509
Phone 402.471.6975
DHHS.MedicaidSPA@nebraska.gov

Figure 6(b)



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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

August 31, 2018

To: Omaha Tribe of Nebraska, Ponca Tribe of Nebraska, Santee Sioux Nation, Winnebago Tribe of Nebraska, Carl T. Curtis Health Center, Fred LeRoy Health & Wellness Center, Santee Sioux Clinic, Winnebago Tribal Health Department, Winnebago Indian Hospital, Nebraska Urban Indian Health Coalition, Aberdeen Area Indian Health Service, Great Plains Tribal Chairmen's Health Board

Attached for your review is a summary of a proposed Section 1115 Demonstration Waiver Application for Substance Use Disorder Services. This proposed waiver could potentially have an impact on Indians and/or Indian health programs. The waiver application will be posted to the DHHS website and may be accessed by visiting http://dhhs.ne.gov/medicaid/Pages/SubUseDisDemo.aspx.

All comments and suggestions will be considered as the Department of Health and Human Services (DHHS) works with the Centers for Medicare and Medicaid Services to obtain waiver approval. Comments or suggestions can be sent to DHHS at DHHS.SUDWaiver@nebraska.gov or

Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care
Attn. Todd Baustert
301 Centennial Mall South
P.O. Box 95026
Lincoln, Nebraska 68509-5026

DHHS is allowing 30 calendar days for public review and comment for the waiver application. **Please respond no later than September 30, 2018.**

Respectfully,

[redacted]

Catherine Gekas Steeby
Eligibility Administrator II
Nebraska Department of Health and Human Services

Helping People Live Better Lives

Figure 6(c)

Tribal Summary for Section 1115 Substance Use Disorder Demonstration Application

In accordance with 42 CFR 431.408, the Nebraska Department of Health and Human Services (DHHS), Division of Medicaid and Long-Term Care (MLTC) hereby provides notice of MLTC's intent to submit to the Centers for Medicare and Medicaid Services (CMS) an application to implement a Section 1115 Medicaid Demonstration Waiver for Substance Use Disorder Services. This proposed waiver could potentially have an impact on Indians and/or Indian health programs.

MLTC currently allows residential substance use disorder (SUD) services (a combination of substance use treatment services provided to a patient in the facility in which that patient is currently residing) to be provided to Medicaid-enrolled adults ages 21-64 residing in inpatient facilities that meet the federal regulatory definition of an Institution for Mental Diseases (IMD). IMDs are generally defined as inpatient facilities with more than 16 beds that provide behavioral health services to a majority of its patients.

Recently enacted federal Medicaid regulations found in 42 CFR 438.6(e) impose new limitations on MLTC's ability to continue allowing residential SUD services in IMDs for Medicaid-enrolled adults ages 21-64. These limitations have the potential to disrupt treatment programs for some of Nebraska Medicaid's most vulnerable adults, as those individuals may be forced to seek treatment in less appropriate and more costly settings, such as emergency departments.

As a result of these new regulations, MLTC intends to submit an application to CMS to implement a Section 1115 demonstration waiver to continue MLTC's policy of allowing SUD residential services in IMDs for Medicaid-enrolled adults ages 21-64. Implementation of this demonstration program requires CMS approval.

Nebraska SUD IMD 1115 Waiver Budget Neutrality

Background

Nebraska's Department of Health and Human Services (DHHS) is pursuing a waiver of the 15-day monthly maximum on Substance Use Disorder (SUD) Institute for Mental Disease (IMD) utilization for members ages 21-64. Current regulations from the Center for Medicaid and Medicare Services (CMS) cap utilization at 15 days in a month. Research and data analysis indicate that frequently members require more than 15 days of residential treatment, and that an IMD is a more cost-effective setting for members to receive the care they need. DHHS is requesting an exemption from the 15-day maximum to help better serve the needs of their Medicaid enrollees.

Optumas assisted DHHS in modeling the impact of SUD IMD utilization changes and the resulting budget neutrality calculations. The remainder of this document reviews how SUD services and IMD providers were identified, the current utilization of SUD IMDs by the Medicaid population, the estimated impact of enforcing a 15-day maximum, and the cost effectiveness of treating members at an IMD for more than 15 days a month.

Nebraska has not yet enforced a 15-day per month maximum on SUD utilization, so Nebraska Medicaid data serves as a very accurate measure of the true SUD IMD service need that exists within the population. This allowed **Optumas** to use Calendar Year (CY)14 through CY17 Nebraska Medicaid data to evaluate the SUD utilization, identify services over the 15-day per month maximum, and model scenarios showing the impact of capping utilization at 15 days per month. **Optumas** and DHHS chose to use four years of data, rather than five years as requested by CMS, due to major service delivery changes that occurred in Nebraska. Effective September 1, 2013, Nebraska moved all Behavioral Health services into an at-risk capitation arrangement. This drastically changed service utilization patterns and causes CY13 data to be very inconsistent with the subsequent four years of data. **Optumas** and DHHS strongly feel that a four-year base period consisting of data after Behavioral Health services were provided via managed care is more accurate and reasonable when projecting forward SUD IMD expenses. After communicating these observations to CMS, DHHS received instruction from CMS that a four-year base, as opposed to the traditional five-year base, is approvable if appropriately justified. **Optumas** and DHHS feel that the service delivery system change to managed care is appropriate justification to limit the base data to four years instead of five.

When populating data into the SUD IMD Budget Neutrality template, **Optumas** used a Demonstration Year (DY) 00 period of January 1, 2018 – December 31, 2018 (CY18), which corresponds to a five-year demonstration period of CY19 through CY23. **Optumas** cross-walked DHHS' Medicaid Eligibility Groups (MEGs) to the three listed in the template by assigning ABD to MEG 1, Dual to MEG 2, and Family to MEG 3, limited to members age 21-64.

Provider and Service Identification

Optumas used service definitions and provider rosters submitted by DHHS to identify SUD IMD services inherent in the historical data. The data included encounters from DHHS' Behavioral Health-only managed care program as well as DHHS' Integrated Care managed care program, Heritage Health. As

mentioned previously, **Optumas** reviewed data going back to pre-managed care experience but felt that a four-year base data period, consisting only of managed care data, was the most reasonable base data for projection of future expenditures.

The following Healthcare Common Procedure Coding System (HCPCS) codes and modifiers were used to identify SUD services that could be provided via an IMD: H2034; H0018 HF; H0018 HH; H0019; H0019 TT. IMD providers were identified using a provider roster supplied by DHHS. The provider roster was reviewed using Provider ID, Provider Tax Identification Number, and National Provider ID to ensure consistent provider identification across the two managed care programs that operate during the four-year base data period.

Once SUD IMD stays were identified, **Optumas** used the range of dates on the IMD admission to capture all non-SUD or non-IMD services provided to the member during the IMD admission span. These services were separately flagged so they could be itemized as a separate component of the total IMD utilizer cost, as required by the Budget Neutrality templates. Finally, **Optumas** identified the length of each IMD admission per month, allowing for a review of SUD IMD stays that exceed the 15-days per month regulatory maximum.

Modeling Service Delivery Changes

After all services occurring during admission to an SUD IMD were identified, **Optumas** adjusted the experience to be consistent with the Budget Neutrality templates. This required two primary changes: adjustment of all SUD IMD utilization exceeding 15 days per month, and projection of expenditures to the anticipated waiver effective date.

The adjustment of SUD IMD utilization reflects an estimate of what may occur if the 15-day per month maximum was enforced. A review of the data from CY14 through CY17 indicates that around 1,500 SUD IMD days per year exceed the 15-day per month maximum. Our discussions with DHHS, their clinical support teams, and our own internal clinician indicate that there are five potential outcomes if members were removed from the SUD IMD once they reach 15 days:

1. The member could be discharged and prescribed Substance Use Day Treatment services
    a. This is estimated to happen for 25% of the SUD IMD utilization over the 15-day per month maxium
2. The member could be discharged and prescribed Intensive Outpatient services
    a. This is estimated to happen for 35% of the SUD IMD utilization over the 15-day per month maximum
3. The member could relapse after discharge and require Inpatient Hospital services
    a. This is estimated to happen for 25% of the SUD IMD utilization over the 15-day per month maximum
4. The member could relapse after discharge and require Emergency Room detox services
    a. This is estimated to happen for 5% of the SUD IMD utilization over the 15-day per month maximum
5. The member could be discharged into the community and no longer need any care
    a. This is estimated to happen for the remaining 10% of the SUD IMD utilization over the 15-day per month maximum

It is not anticipated that a member will be able to transition to a non-IMD setting to receive continued residential treatment. This is due to the current capacity of non-IMD facilities as well as the anticipated changes when Nebraska expands Medicaid eligibility to 138% of the federal poverty line. Service costs for the possible member transitions are as follows:

1. If the member transitions to Day Treatment, the expected reimbursement is $86.48 per day. This is anticipated to be a lower bound estimate since it only reflects 2 hours of treatment a day, while the member's acuity suggests they require residential treatment.
2. If the member transitions to Intensive Outpatient treatment the expected cost is $10 per day. This is based on the cost per day of individuals currently receiving intensive outpatient treatment. This cost would actually be multiple visits spread out over weeks, but for the purpose of the hypothetical cost modeling it was converted to a per-diem so it could be substituted for IMD days.
3. If the member transitions to an Inpatient Hospital setting, the service is priced out assuming the DRG reimbursement policy in place in Nebraska. **Optumas** reviewed Substance Use DRGs and the prevalence of the Severity of Illness (SOI) associated with each Substance Use admission. Based on this review, a per diem of $1,100 is used for Inpatient Hospital services.
4. If a member requires Emergency Room services (without a corresponding Inpatient Hospital admission), the cost is assumed to be $521. This is based on the cost for Emergency Room visits for similar populations in Nebraska Medicaid.
5. The final component of individuals no longer needing any care has no associated cost.

Optumas feels both the utilization and reimbursement assumptions are reasonable yet err on the side of understating hypothetical costs, as the population acuity indicates even more Inpatient Hospital admissions might occur and some might require a higher Severity of Illness. Further, the Intensive Outpatient and Day Treatment services are likely to be required for weeks or months after IMD discharge, but have only been modeled as lasting for the same duration as the original IMD utilization span. Finally, the average length of stay for an SUD IMD admission that exceeds 15 days in a month is 23 days. This speaks to the high level of need for this population, as individuals that go past 15 days require an additional 8 days of care on average. These are not individuals who are close to fully treated and could potentially receive fewer days of care with no negative repercussions. These are high-need individuals who would be severely, negatively impacted if forced to discharge 8 days prior to the end of their treatment program. For these reasons **Optumas** feels our estimate of a hypothetical cost increase if the 15-day per month maximum was enforced is a reasonable, yet conservative, estimate of the likely outcome.

In order to project the estimated expenditures to the anticipated waiver effective date, **Optumas** projected expenditures forward to DY00 using the President's Budget trend of 4.9%. The President's Budget trend is used due to the selection of Scenario 2 in the Budget Neutrality template, which uses hypothetical cost development. The absence of actual cost information for the Without Waiver scenario necessitates the use of the President's Budget trend per the template instructions: "in the absence of historical data, CMS will apply the President's Budget trend". This is consistent with our review of other 1115 SUD IMD Waiver submissions.

A 2% membership growth assumption is applied to convert the trended PMPMs to total expenditures. While the 2% growth is consistent with both experience and expectations moving forward, Budget

Neutrality is tied to the PMPM amounts submitted in the template, so deviations in enrollment growth are not anticipated to impact Budget Neutrality.

Template Submission

The updated SUD 1115 Waiver Budget Neutrality Template accompanies this narrative. The SUD Summary table has been pasted in Appendix I for reference.

Appendix I

SUD IMD Supplemental BN Tests

IMD Cost Limit

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
SUD IMD Services MEG 1	$271,660	$290,671	$311,012	$332,777	$356,065	$1,562,185
SUD IMD Services MEG 2	$386,755	$413,820	$442,779	$473,765	$506,919	$2,224,038
SUD IMD Services MEG 3	$706,746	$756,204	$809,124	$865,747	$926,331	$4,064,152
TOTAL	$1,365,161	$1,460,695	$1,562,915	$1,672,288	$1,789,315	$7,850,374

With-Waiver Total Expenditures

	DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL
SUD IMD Services MEG 1	$271,660	$290,671	$311,012	$332,777	$356,065	$1,562,185
SUD IMD Services MEG 2	$386,755	$413,820	$442,779	$473,765	$506,919	$2,224,038
SUD IMD Services MEG 3	$706,746	$756,204	$809,124	$865,747	$926,331	$4,064,152
TOTAL	$1,365,161	$1,460,695	$1,562,915	$1,672,288	$1,789,315	$7,850,374
Net Overspend	$0	$0	$0	$0	$0	**$0**

How To Use This Spreadsheet:

Consult the tables below for a high-level overview of the IMD Cost Limit and SUD Hypothetical CNOM Services Limit in Scenario 1 and Scenario 2. The tables provide basic concepts for establishment of the budget neutrality limits, and reporting requirements for monitoring. The notes below the table provide additional information related to allowable SUD IMD medical assistance services, estimation of the various budget neutrality limits, trend rates and other details of estimation. (see glossary below table for definition of abbreviations)

Scenario 1

Situation: Demonstration CNOM is limited to expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are residents in facilities that meet the definition of an IMD (i.e., IMD exclusion related MA).	**IMD Cost Limit**	**SUD IMD Hypothetical CNOM Services Limit**
Without Waiver (i.e., budget neutrality limit)	PMPM Cost - Estimated average of all MA - Est. total MA cost in IMD MMs x Member Months - IMD MM: Any whole month during which a Medicaid-eligible is 8% Expenditure Limit - PMPM cost x IMD MMs	
With Waiver	Expenditures Subject to Limit - All MA costs with dates of Reportine Requirements State must be able to identify and report: - IMD MMs separate from other MA costs during IMD MMs	

Scenario 2

Situation: Demonstration CNOM include both CNOM for IMD exclusion related MA to-and CNOM for additional hypothetical services that can be provided outside the IMD.	**IMD Cost Limit**	**SUD IMD Hypothetical CNOM Services Limit**
Without Waiver (i.e., budget neutrality limit)	PMPM Cost - Estimated average of all MA costs incurred during IMD MMs - Est. total MA cost in IMD MMs x Member Months - IMD MM: Any whole month during which a Medicaid-eligible is - Can exclude months with ≤ 15 IMD inpatient days under managed 8% Expenditure Limit - PMPM cost x IMD MMs	PMPM Cost - Estimate of average SUD CNOM service cost during Non-IMD MMs - Est. total SUD CNOM service - SUD CNOM service cost can include capitated cost of IMD services Member Months - Non-IMD MM: Any month of Medicaid eligibility in which a person 8% Expenditure Limit - PMPM cost x Non-IMD MMs
With Waiver	Expenditures Subject to Limit - All MA costs with dates of service during IMD MMs Reportine Requirements State must be able to identify and report: - IMD MMs separate from other MA costs during IMD MMs	Expenditures Subject to Limit - All SUD CNOM service costs with dates of service during Non-IMD Reportine Requirements State must be able to identify and report: - Non-IMD MMs separate from SUD CNOM costs separate from

Glossary of Abbreviations

CNOM = expenditure authority (cost not otherwise matchable)
Hypo = hypothetical, i.e., optional services that could be included in the state plan but are instead being authorized in the 1115 using CNOM
IMD = institution for mental diseases
MA = medical assistance
MM = member month
SUD = substance abuse disorder

Notes

1. Date of service for capitation payments is the month of coverage for which the the capitation is paid.
2. The IMD Cost Limit and SUD Hypothetical CNOM Services Limit are intended to be two distinct budget neutrality tests separately and independently enforced.
3. SUD IMD Services may include all approved services provided to Medicaid beneficiaries while residine in an IMD: however, *they may not include costs associated with room and board payments* in those facilities unless they qualify as inpatient facilities under section 1905(a) of the Social Security Act.

Estimation for the IMD Cost Limit

The IMD Cost Limit represents the projected cost of medical assistance during months in which Medicaid eligible are patients at the IMD. These are the acceptable ways for the state to determine the PMPMs for the IMD Cost Limit.

- States should present 5 years of historical data on overall MA costs for individuals with a SUD diagnosis (or proxy) who received inpatient treatment for SUD (or could have received inpatient treatment if such services were available), to determine average MA cost per user of SUD inpatient services for each historical year. The per user per month costs are then projected forward using the lower of historical per user month cost trend or the President's Budget PMPM cost trend. The projected per user per month costs will become the PMPMs for the IMD Cost Limit.
- If the state has an existing comprehensive Medicaid demonstration with already calculated without waiver PMPMs, the state should incorporate those PMPMs in the IMD Cost Limit PMPMs (see Historical tab).
- State can top off IMD Cost Limit PMPMs with an additional estimated amount representing any additional CNOM services that affected individuals may also receive during IMD months.
- State may use Alternate PMPM Development in Historical tab for estimating expenditures to be included in the PMPM(s)/IMD Cost Limit (see 'Supplemental Methodology Document' requirement below).

Estimation of the SUD Hypothetical CNOM Services Limit

The SUD Hypothetical CNOM Services Limit represents the projected average PMPM cost of additional expenditure authority services for the population eligible to receive them. This can include the estimated average cost of IMD services, if these costs are being averaged out across an entire covered population through inclusion in capitated payment rates to Medicaid managed care plans.

- Since states are unlikely to have actually covered these services in the past, they will not have historical data for projecting future costs.
- The PMPM cost estimate should be an average expected cost of hypothetical additional expenditure authority services for individuals who are eligible to receive those services. It should not be a cost per month of service use.

Supplemental Methodology Document

- The 'Historical Spending Data' and/or 'Alternate PMPM Development' in the SUD Historical tab must be accompanied by a supplemental methodology and data sources document that fully describes, for each MEG, a full breakout of all SUD services - with descriptions of accompanying expenditures and caseloads. There should also be sections/headings in the methodology document which describe all other state data inputs (see 'State Data Inputs' below).

Trends

PMPM trends should be the lower of the state's historical trend and the smoothed trend from the 2018 President's Budget (in the absence of historical data, CMS will apply the President's Budget trend). The President's Budget trends should be for the eligibility groups that are participating in the SUD demonstration. Most often, these will be the Current Adults, New Adults, or a blend of Current Adults and New Adults.

Multiple MEGs

There should be one set of MEGs for the current Medicaid state plan IMD Cost Limit(s) with associated PMPMs and member months. and one for the SUD Hypothetical CNOM Services Limit (and non -Hypothetical CNOM). as applicable.

Member Month Non-Duplication

IMD Cost Limit member month must be non-duplicative of SUD Hypothetical CNOM Services Limit member months, and must also be non-duplicative of general comprehensive demonstration budget neutrality limit member months. This means that month of Medicaid eligibility for an individual cannot appear as both an IMD Cost Limit member month and a SUD Hypothetical CNOM Services Limit member month; it has to be one or the other, and likewise for IMD Cost Limit member month and general comprehensive demonstration budget neutrality limit member months. SUD Hypothetical CNOM Services Limit member months can be duplicative of general comprehensive demonstration budget neutrality limit member months.

State Data Inputs

States must add their data to the yellow highlighted cells for CMS review and discussion - and choose the appropriate drop-downs corresponding to their data inputs. CMS will provide template instructions with this spreadsheet.

SUD Historical Spending Data - 5 Years

	Historical Years Definition:		State Fiscal Year			
SUD IMD Services MEG 1	**2012**	**2013**	**2014**	**2015**	**2016**	**5-YEARS**
TOTAL EXPENDITURES						
ELIGIBLE MEMBER MONTHS						
PMPM COST	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
TREND RATES						
TOTAL EXPENDITURE		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
ELIGIBLE MEMBER MONTHS		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

SUD IMD Services MEG 2

TOTAL EXPENDITURES						
ELIGIBLE MEMBER MONTHS						
PMPM COST	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
TREND RATES						
TOTAL EXPENDITURE		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
ELIGIBLE MEMBER MONTHS		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

SUD IMD Services MEG 3

TOTAL EXPENDITURES						
ELIGIBLE MEMBER MONTHS						
PMPM COST	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
TREND RATES						
TOTAL EXPENDITURE		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
ELIGIBLE MEMBER MONTHS		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Alternate SUD IMD MEG PMPM Development & CNOMs		**Non-SUD/IMD Title XIX PMPM:** $2,730.29			**Choose "Included" from Drop-Down(s) to Link Services with MEG(s)**				
					CURRENT State Plan Service(s)			**NOT CURRENT State Plan Svc(s)**	
SUD IMD Services	**Estimated Total Expenditures for SUD Medical Assistance Provided in an IMD**	**Estimated Total Expenditures for All Other non-SUD/IMD Title XIX State Plan Medical Assistance**	**Estimated Eligible Member Months for All Medical Assistance Provided in an IMD**	**Estimated PMPM Cost**	**SUD IMD Services MEG 1**	**SUD IMD Services MEG 2**	**SUD IMD Services MEG 3**	**SUD IMD Hypothetical Services CNOM MEG**	**SUD IMD Non-Hypothetical Services CNOM MEG**
Service 1	$519,260	$603,395	221	$5,079.89	Included				
Service 2	$536,398	$627,968	230	$5,062.46		Included			
Service 3	$1,332,265	$1,509,853	553	$5,139.45			Included		
Service 4		$0		#DIV/0!					
Service 5		$0		#DIV/0!					
Service 6		$0		#DIV/0!					
Service 7		$0		#DIV/0!					
Service 8		$0		#DIV/0!					
Service 9		$0		#DIV/0!					
Service 10		$0		#DIV/0!					
Service 11		$0		#DIV/0!					
Service 12		$0		#DIV/0!					
Add additional services, as necessary		$0		#DIV/0!					
Totals					**$5,079.89**	**$5,062.46**	**$5,139.45**	**$0.00**	**$0.00**

			PB Trend:	4.9%						
ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY)					TOTAL WOW
					DY 01	DY 02	DY 03	DY 04	DY 05	
SUD IMD Services MEG 1										
Eligible Member Months	n.a.	n.a.	0	n.a.	51	52	53	54	55	
PMPM Cost	n.a.	30	$5,079.89	4.9%	$5,329	$5,590	$5,864	$6,151	$6,453	
Total Expenditure					$271,660	$290,671	$311,012	$332,777	$356,065	$1,562,185
SUD IMD Services MEG 2										
Eligible Member Months	n.a.	n.a.	0	n.a.	73	74	76	77	79	
PMPM Cost	n.a.	30	$5,062.46	4.9%	$5,311	$5,571	$5,844	$6,130	$6,430	
Total Expenditure					$386,755	$413,820	$442,779	$473,765	$506,919	$2,224,038
SUD IMD Services MEG 3										
Eligible Member Months	n.a.	n.a.	0	n.a.	131	134	136	139	142	
PMPM Cost	n.a.	30	$5,139.45	4.9%	$5,391	$5,655	$5,933	$6,223	$6,528	
Total Expenditure					$706,746	$756,204	$809,124	$865,747	$926,331	$4,064,152
SUD IMD Hypothetical Services CNOM MEG										
Eligible Member Months	n.a.	n.a.	n.a.	n.a.	0	0	0	0	0	
PMPM Cost	n.a.		$0.00	4.9%	$0	$0	$0	$0	$0	
Total Expenditure					$0	$0	$0	$0	$0	$0

ELIGIBILITY GROUP	DY 00	TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 01	DY 02	DY 03	DY 04	DY 05	
SUD IMD Services MEG 1								
Eligible Member Months			51	52	53	54	55	
PMPM Cost	$5,080	4.9%	$5,329	$5,590	$5,864	$6,151	$6,453	
Total Expenditure			$271,660	$290,671	$311,012	$332,777	$356,065	$1,562,185
SUD IMD Services MEG 2								
Eligible Member Months			73	74	76	77	79	
PMPM Cost	$5,062	4.9%	5,311	5,571	5,844	6,130	$6,430	
Total Expenditure			386,755	413,820	442,779	473,765	$506,919	$2,224,038
SUD IMD Services MEG 3								
Eligible Member Months			131	134	136	139	142	
PMPM Cost	$5,139	4.9%	5,391	5,655	5,933	6,223	6,528	
Total Expenditure			706,746	756,204	809,124	865,747	926,331	$4,064,152
SUD IMD Hypothetical Services CNOM MEG								
Eligible Member Months	n.a.		0	0	0	0	0	
PMPM Cost	$0	4.9%	0	0	0	0	0	
Total Expenditure			0	0	0	0	0	$0
SUD IMD Non-Hypothetical Services CNOM MEG								
Eligible Member Months			0	0	0	0	0	
PMPM Cost	$0	4.9%	$0	$0	$0	$0	$0	
Total Expenditure			$0	$0	$0	$0	$0	$0

SUD IMD Supplemental BN Tests

IMD Cost Limit

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
SUD IMD Services MEG 1	$271,660	$290,671	$311,012	$332,777	$356,065	$1,562,185
SUD IMD Services MEG 2	$386,755	$413,820	$442,779	$473,765	$506,919	$2,224,038
SUD IMD Services MEG 3	$706,746	$756,204	$809,124	$865,747	$926,331	$4,064,152
TOTAL	$1,365,161	$1,460,695	$1,562,915	$1,672,288	$1,789,315	$7,850,374

With-Waiver Total Expenditures

	DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL
SUD IMD Services MEG 1	$271,660	$290,671	$311,012	$332,777	$356,065	$1,562,185
SUD IMD Services MEG 2	$386,755	$413,820	$442,779	$473,765	$506,919	$2,224,038
SUD IMD Services MEG 3	$706,746	$756,204	$809,124	$865,747	$926,331	$4,064,152
TOTAL	$1,365,161	$1,460,695	$1,562,915	$1,672,288	$1,789,315	$7,850,374
Net Overspend	$0	$0	$0	$0	$0	$0

SUD IMD Hypothetical CNOM Services Limit

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
SUD IMD Hypothetical Services CNOM MEG	$0	$0	$0	$0	$0	$0
TOTAL	$0	$0	$0	$0	$0	$0

With-Waiver Total Expenditures

	DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL
SUD IMD Hypothetical Services CNOM MEG	$0	$0	$0	$0	$0	$0
TOTAL	$0	$0	$0	$0	$0	$0
Net Overspend	$0	$0	$0	$0	$0	$0

SUD IMD Non-Hypothetical Services Limit

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
SUD IMD Non-Hypothetical Services CNOM MEG	$0	$0	$0	$0	$0	$0
TOTAL	$0	$0	$0	$0	$0	$0

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

SUD MEG(s)	Trend Rate	DY 01	DY 02	DY 03	DY 04	DY 05
SUD IMD Services MEG 1	4.9%	$5,329	$5,590	$5,864	$6,151	$6,453
SUD IMD Services MEG 2	4.9%	$5,311	$5,571	$5,844	$6,130	$6,430
SUD IMD Services MEG 3	4.9%	$5,391	$5,655	$5,933	$6,223	$6,528
SUD IMD Hypothetical Services CNOM MEG	4.9%	$0	$0	$0	$0	$0

Projected SUD IMD Member Months/Caseloads		DEMONSTRATION YEARS (DY)				
	Trend Rate	DY 01	DY 02	DY 03	DY 04	DY 05
SUD IMD Services MEG 1	2.0%	51	52	53	54	55
SUD IMD Services MEG 2	2.0%	73	74	76	77	79
SUD IMD Services MEG 3	2.0%	131	134	136	139	142
SUD IMD Hypothetical Services CNOM MEG			0	0	0	0
SUD IMD Non-Hypothetical Services CNOM MEG			0	0	0	0