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## Putting Medicaid in the Larger Budget Context: An In-Depth Look at Three States in FY 2017 and FY 2018

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Medicaid has long-played an important role in the U.S. healthcare system, accounting for one in every six dollars of all U.S. health care spending while providing health and long-term services and supports coverage to millions of low-income Americans.<sup>1</sup> Medicaid also plays an important role in states budgets as both an expenditure item and the largest source of federal revenue for states.

This year's survey was conducted as Congress debated proposals to repeal major portions of the Affordable Care Act (ACA), including the ACA's Marketplace and Medicaid coverage expansions, as well as other proposals to fundamentally restructure Medicaid's financing structure. States adopted budgets for FY 2018 facing uncertainty about the outcome of the federal legislative debate, some volatility in state revenues and while trying move forward with an array of initiatives to advance Medicaid payment and delivery system reforms and to address emerging public health issues like the opioid epidemic. These policy priorities are playing out in the context of broader state budgets and an economy that varies across states, with some states experiencing steady economic growth and others facing declines in state revenues.

This report provides an in-depth examination of Medicaid program changes in the larger context of state budgets in three states:

- Nevada
- North Carolina
- West Virginia

These case studies build on findings from the 17<sup>th</sup> annual budget survey of Medicaid officials in all 50 states and the District of Columbia conducted by the Kaiser Family Foundation (KFF) and Health Management Associates (HMA). Additional research on budget activity, economic conditions, and other relevant health policy activity was collected to supplement survey responses.

# Nevada

## ECONOMIC AND BUDGET OUTLOOK

### ECONOMY AND STATE REVENUES

While Nevada's recovery from the Great Recession initially lagged behind much of the rest of the country, in recent years, the state's economic growth has outpaced the national average. In 2016, Nevada's Gross Domestic Product (GDP) grew by 2.4 percent to \$147.5 billion compared to the national average of 1.5 percent growth. Finance, insurance, real estate, rental, and leasing are the largest industries in Nevada, followed by the arts, entertainment, recreation, accommodation, and food service industries. While per capita personal income in Nevada was only 88 percent of the national average in 2016,<sup>2</sup> per capita personal income growth in the state (3.9 percent) outpaced the national average 2.9 percent. During the Great Recession, Nevada's unemployment rate peaked at 13.7 percent in September 2010, above the national peak of 10 percent in October 2009. As of August 2017, however, the state has an unemployment rate of 4.9 percent, down from 5.5 percent in August 2016, but still slightly above the August 2017 U.S. average of 4.4 percent.<sup>3</sup>

While Nevada gaming revenues have been affected by the increased availability of gaming throughout the U.S., Las Vegas remains a strong tourist destination, with an estimated 42.3 million visitors in 2016. The Governor's budget for the 2017-2019 biennium notes that "Nevada's tourism industry has diversified its offerings by expanding its amenities beyond gaming with world class entertainment, dining and high-end shopping. In fact, non-gaming revenue now makes up about two thirds of this industry's revenue."<sup>4</sup> At the time of this report, however, the economic impact of the tragic October 1<sup>st</sup> mass shooting in Las Vegas on the tourism sector remains unknown.

### STATE BUDGET

The Nevada legislature meets only in odd-numbered years, when it addresses the full range of legislative issues and must adopt a balanced biennial budget. The enacted budget for FY 2017-18 mirrors actual spending in FY 2015-16 for most budget categories within Medicaid.<sup>5</sup> While the aggregate authorization for Medicaid is 3.5 percent less than actual expenditures in FY 2015-16, the state general fund share is increased by nearly 12 percent, due in large part to the reduction in the federal share of funding for the Medicaid expansion.

## DEMOGRAPHIC CHARACTERISTICS AND MEDICAID'S ROLE

Fewer Nevada residents live in poverty (10 percent in 2016) compared to the national average (13 percent),<sup>6</sup> but Nevada has a low per capita income (\$43,567 in 2016 compared to \$49,246 nationally)<sup>7</sup> that generates a relatively high federal Medicaid matching assistance percentage (FMAP) at 66 percent.<sup>8</sup> [Medicaid plays an important role in the state](#), covering 18 percent of the population in 2016,<sup>9</sup> and Medicaid spending per full-benefit enrollee in Nevada in federal fiscal year 2014 (\$4,003) was lower than that in any other state.<sup>10</sup> While this suggests that the state's program is already relatively efficient, it also means [achieving increased savings in response to a potential future cap on federal Medicaid financing could be particularly difficult in Nevada](#).<sup>11</sup> After expanding Medicaid under the Affordable Care Act (ACA) to all individuals up to 138 percent of the federal poverty level (FPL) in 2014, Nevada experienced the largest percent decline in the nonelderly uninsured rate of any state between 2013 and 2016 (11.8 percent).<sup>12</sup>

While Nevada's population distribution by age as of 2016 is relatively close to the national average,<sup>13</sup> the state has the second highest projected growth rate of its age 85+ population (95 percent) between 2015 and 2030.<sup>14</sup> Because Medicaid is the primary payer for institutional and community-based long-term services and supports, this growth could increase future Medicaid spending levels in the state as the demand for these costlier services increases with age. Nevada is also a relatively diverse state in terms of its racial/ethnic population distribution. Over a quarter of Nevadans (27 percent) are of Hispanic origin, which is the 5<sup>th</sup> largest percentage of any state. Data suggest that Nevada's adoption of the ACA Medicaid expansion has helped reduce longstanding disparities in health coverage faced by Hispanics in Nevada: between 2013 and 2015, the uninsured rate for nonelderly Hispanics in Nevada fell from 34 percent to 19 percent.<sup>15</sup>

[Nevada has been more severely impacted](#) than most states by the HIV and opioid epidemics. The state has an estimated HIV diagnosis rate of 20.1 per 100,000 population compared to a national average of 14.7 per 100,000 population, the 7<sup>th</sup> highest in the country.<sup>16</sup> In addition, Nevada's opioid death rate was 13.8 deaths per 100,000 population in 2015, compared to a national average of 10.4 deaths per 100,000 population.<sup>17</sup> The state is closer to national averages on certain other measures of health status: the percentage of the population that reports poor health status (17.6 percent),<sup>18</sup> reports poor mental health status (34.9 percent),<sup>19</sup> or is overweight or obese (64.7 percent).<sup>20</sup>

## UPDATE ON THE AFFORDABLE CARE ACT AND OTHER ELIGIBILITY CHANGES

Nevada expanded Medicaid coverage to newly eligible groups under the ACA in January 2014. As of August 2017, more than 211,000 people were enrolled in the expansion group, representing nearly one-third of total Nevada Medicaid enrollment.<sup>21</sup> Nevada uses its State General Fund to finance the state share of Medicaid expansion costs.

More recently, in June 2017, the Nevada legislature adopted the Immigrant Children's Health Improvement Act (ICHIA) option to remove the five-year bar on coverage for lawfully-residing immigrant children. If approved by CMS, the plan is estimated to provide coverage to up to 7,500 Nevada children.<sup>22</sup> The legislature also passed the Nevada Care Plan to offer a state-based health coverage plan to uninsured individuals. Approximately 9 percent of Nevadans were uninsured in 2016.<sup>23</sup> Under the Nevada Care Plan, sometimes called "Medicaid for all", individuals would have been able to purchase a product with covered benefits and provider payment rates based on the Nevada Medicaid program. The proposed legislation, which had a proposed implementation date of January 1, 2019, provided a general concept without many details.<sup>24</sup> On June 16, Governor Sandoval vetoed the legislation, indicating that there were too many unanswered questions about how the program would work.<sup>25</sup>

## HEALTH SYSTEM REFORM IN NEVADA

### SECTION 1115 NEVADA COMPREHENSIVE CARE WAIVER

The Nevada Comprehensive Care Waiver (NCCW) was implemented in 2013 to provide care management services for individuals that are not eligible for MCO enrollment and who have at least one qualifying chronic health condition or a complex condition, as well as individuals that are high utilizers of medical services, including those with excessive use of the emergency room.<sup>26</sup>

While 68 percent of Nevada Medicaid enrollees are now served by HMOs,<sup>27</sup> some of the costliest and sickest beneficiaries are in unmanaged fee-for-service.<sup>28</sup> Under the NCCW waiver, up to 41,500 beneficiaries can be enrolled with a Care Management Organization (CMO). The CMO functions are much more extensive than primary care case management. The CMO does not provide direct medical care but it performs beneficiary assessments and works with the beneficiary's health care team to develop, manage, and maintain a care plan. The CMO also coordinates care transitions, referrals to community and social support services.<sup>29</sup> The Health Care Guidance Program is the selected CMO.<sup>30</sup>

## NEVADA MEDICAID DELIVERY MODEL REVIEW

In 2015, the Nevada Legislature passed a bill requiring an impact analysis of the Medicaid managed care program. The Nevada Division of Health Care Financing and Policy (DHCFP) engaged Navigant to perform a comprehensive review of the Nevada Medicaid delivery system and make recommendations for revisions to that model, based on stakeholder input, data about Nevada Medicaid, and Navigant experience with models used in other states.

Navigant delivered a draft report on January 3, 2017 that recommends a phased approach to Medicaid delivery system changes in Nevada. Navigant indicates that the four phases are “designed to address performance, access, and satisfaction issues that exist in the current program, and build upon positive program elements.” The report recommends that DHCFP work on strategies to increase access to care for Medicaid enrollees, build additional capacity to oversee Medicaid MCOs, and work with providers to increase the number of Primary Care Medical Homes and enable value-based payment arrangements. The final phase would be a managed fee-for-service program that would replace the current CMO model and could serve as a pathway to prepare Nevada MCOs to take on full-risk for additional Medicaid populations and services.”<sup>31</sup>

## SECTION 1115 WAIVERS IN DEVELOPMENT

Nevada Medicaid officials reported that two new Section 1115 waivers were under development at the state level as of Summer 2017: one that would extend the CMO demonstration and potentially add some additional features, particularly related to the adult expansion population, and a second that would apply to children in foster care. In 2015, Nevada received a System of Care Implementation Grant from the federal Substance Abuse and Mental Health Services Administration, which the state is using to focus on children's behavioral health care needs.<sup>32</sup> The grant initiative includes development of specific service packages for therapeutic foster care homes for clinical interventions. As a part of that process, the state is exploring a potential Section 1115 waiver that would relate to children with serious emotional disturbances.

## OTHER DELIVERY SYSTEM REFORMS

### PARAMEDICINE INITIATIVE

Nevada implemented Medicaid coverage for medically necessary community paramedicine services as of July 1, 2016 with the goal of increasing access to primary health care services, especially in medically underserved areas. Community paramedicine services are provided by emergency medical technicians (EMTs), advanced EMTs, or paramedics. The services must be part of the care plan ordered by the recipient's primary care provider and provided under the supervision of an ambulance service's Medical Director.<sup>33</sup> While there has

been some success in the cities of Reno and Winnemucca and in Clark County (Las Vegas), rural counties have not taken advantage of this option to the extent the state had hoped would occur.

## CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

Nevada was one of eight states awarded a demonstration grant for Certified Community Behavioral Health Clinics (CCBHC).<sup>34</sup> As of July 1, 2017, there are four organizations with five locations enrolled in Nevada Medicaid to provide services under a prospective payment system (PPS) model for the two-year grant period. The goal of the CCBHC initiative is to support improvement of behavioral health outcomes through integration of primary health care with behavioral health care, and increased access to high quality coordinated care.

## DENTAL CARVE-OUT

Nevada Medicaid provides comprehensive dental care for individuals under age 21 as part of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). For non-pregnant adults, the dental benefit is generally limited to emergency extractions and palliative dental care. Some prosthetic care (dentures or partials) is also covered under certain guidelines and limitations. Through June 30, 2017, the Medicaid MCOs were responsible for these dental services for their child and adult members. Nevada carved the dental benefit out of the MCO benefit package effective July 1, 2017, at which time dental services were covered through the Nevada Medicaid FFS program.<sup>35</sup> The state has now selected a prepaid dental health plan which will be operational on January 1, 2018 and will provide dental care for the MCO population. (Dental services for the FFS population will continue to be managed by the current vendor.) Nevada expects that this change will improve the quality of Medicaid dental care as the dental benefits manager will be accountable for the quality of care.

## ADDRESSING THE OPIOID ABUSE CRISIS

In August 2016 Governor Sandoval convened a drug abuse summit with approximately 500 stakeholders to develop a plan to prevent drug abuse in Nevada. Governor Sandoval continues to chair the Governor's Opioid State Action Accountability Taskforce. One component of the plan developed at the August 2016 summit was a proposal for legislation to further strengthen opioid prescribing policies. The resulting state law<sup>36</sup> includes provisions that limit initial painkiller prescriptions to 14-day supplies, requires that physicians conduct mental health assessments before prescribing certain painkillers for the first time, and includes a new requirement that Medicaid prescribers check the Prescription Drug Monitoring Program before prescribing opioids.

Nevada has also adopted the CDC guidelines for opioid policy for its fee-for-service Medicaid program and plans to add a requirement during FY 2018 that Medicaid MCOs follow the guidelines as well. DHCFP revised its quantity limits for opioid prescriptions to require prior authorization for any opioid prescription exceeding a 7-day supply.

DHCFP, in collaboration with the Division of Public and Behavioral Health, was awarded a \$5.7 million Opioid State Target Response (STR) grant from the Substance Abuse and Mental Health Services Administration.<sup>37</sup> Nevada plans to use its grant to reform its Medication Assisted Treatment (MAT) program, including development of criteria for the certification of MAT centers which will then be used for purposes of Medicaid provider enrollment and reimbursement. This project is currently in the planning stages with a goal of implementation for January 1, 2018.

## Nevada Medicaid Policy Changes FY 2017 and FY 2018

### Eligibility Policies

- Nevada made no changes to eligibility policy in FY 2017. In FY 2018, if they receive approval from CMS, Nevada plans to eliminate the five-year bar on Medicaid eligibility for lawfully-residing immigrant children.<sup>38</sup>
- Medicaid outreach or assistance strategies to facilitate enrollment of inmates prior to release were expanded in FY 2018 for both prisons and jails.

### Delivery System and Payment Reforms

- In FY 2018, plan to implement a pilot program encouraging MCOs to provide care coordination and other services to corrections-involved enrollees prior to release from incarceration. Goal is to ensure continuity of care and reduce recidivism.

### Provider Rates and Provider Fees/Taxes

- For FY 2017, provider rates frozen across-the-board, except for rate increases for MCOs and home and community based services (HCBS).
- For FY 2018, rates were cut for outpatient hospital, specialty physicians and dentists, based on budget issues and some realignment with Medicare rates. Inpatient hospital, nursing facility, primary care physician, and HCBS rates are being increased in FY 2018.
- Nevada's only provider tax, for nursing facilities, was unchanged. State legislation requires Nevada Medicaid to work with "other interested facilities" or "personal care services" during FY 2018 to potentially establish new provider taxes.

### Benefits and Pharmacy

- Added coverage for paramedicine services for all coverage groups effective 7/1/2016.
- Reduced hours for Targeted Case Management, from 30 per month to 10 for initial month and 5 for next three consecutive calendar months for non-seriously mentally ill (SMI) adults and non-seriously emotionally disturbed (SED) children as of 2/23/2017.
- Restored coverage for adult podiatry and added coverage for nutritional therapy by registered dieticians for state plan (non-expansion) population as of 01/01/2018
- Added coverage for one-year contraception for both expansion and non-expansion groups as of 7/1/2017.
- Changed several coverage policies as of 7/1/2017 to limit coverage of Private Duty Nursing, hospice, case management, and orthodontia. These changes affected all non-expansion populations.
- Expanded coverage for home health durable medical equipment services 07/01/2017, and for gender reassignment surgery as of 01/01/2018

# North Carolina

## ECONOMIC AND BUDGET OUTLOOK

### ECONOMY AND STATE REVENUES

North Carolina's economy is ranked 10<sup>th</sup> in the nation, with a Gross Domestic Product (GDP) of \$517.9 billion in 2016. Finance, insurance, real estate, rental, and leasing is the dominant industry, followed by government.<sup>39</sup> Compared to the rest of the nation, North Carolina's economy has experienced slower growth since the recession. This is associated with the state's large manufacturing industry, which has experienced a sharp decline over the last several years. Only recently, from 2015 to 2016, is the state's economy showing positive signs of change.<sup>40</sup>

North Carolina's unemployment rate hit a high of 11.3 percent in 2010, following the end of the recession, but has steadily declined since then. The state's unemployment rate was 4.1 percent in August 2017, down from 5.0 percent in August 2016 and below the U.S. average of 4.4 percent.<sup>41,42</sup>

### STATE BUDGET

North Carolina operates under a biennial budget. Cutting taxes and saving for future expenses are priorities for the Republican-led General Assembly. The state started 2017 with a surplus and, as of February, was anticipating moderate, steady economic growth that will yield a 4.5 percent increase in general fund revenues in 2017-18 and another 4.7 percent increase in 2018-19.<sup>43, 44</sup> In 2017, the state's "rainy day" fund exceeded \$1.8 billion.<sup>45</sup>

Since taking control of the North Carolina General Assembly in 2011, Republican legislators have passed sweeping tax reforms that include replacing a progressive income tax with a flat tax and cutting the corporate tax rate by more than half. Proponents of the tax cuts say they are providing a needed boost to North Carolina's economy. Others worry about investments not being made in areas like education and the long-term impact that \$2 billion in lost revenue will have on the state.<sup>46</sup>

The final budget for 2017-19, totaling \$23 billion for FY 2018 and \$23.6 billion for FY 2019, features a new set of controversial tax cuts that will take effect in 2019. The personal income tax rate will drop from 5.499 percent to 5.25 percent and the standard deduction will increase from \$17,500 to \$20,000. The budget also lowers the corporate income tax rate from 3 percent to 2.5 percent. Although Governor Roy Cooper vetoed this Republican-led plan citing fiscal concerns, the General Assembly swiftly overrode his veto.<sup>47</sup>

In the final budget bill, the General Assembly retained a portion of the governor's recommendation for raising teacher's salaries, created a jobs incentives program to encourage new businesses to locate in the state, and provided some of the funding recommended by the governor to expand opioid and substance abuse treatment services.<sup>48</sup>

## DEMOGRAPHIC CHARACTERISTICS AND MEDICAID'S ROLE

The percentage of North Carolinians living in poverty in 2016 (14 percent) was slightly above the national percentage (13 percent).<sup>49</sup> Per capita personal income in the state is \$39,171, the 12<sup>th</sup> lowest among states and

below the national average of \$46,049.<sup>50</sup> Consequently, the state's federal medical assistance percentage (FMAP) is relatively high at 68 percent.<sup>51</sup> In FY 2015, Medicaid accounted for 67 percent of federal funds received by the state, followed by K-12 education accounting for 12 percent of federal funds.<sup>52</sup>

Twenty-two percent of the nonelderly population lives in rural areas in North Carolina (compared to a national average of 19 percent), and [research shows](#) that Americans in rural areas often face unique challenges in health care coverage and access, including low density of providers and longer travel times to care, limited access to employer-sponsored coverage, and greater health care needs due to older age and lower income.<sup>53</sup>

Medicaid plays an important role in North Carolina's health system, covering 18 percent of the population in 2016.<sup>54</sup> However, North Carolina is one of 19 states that has chosen not to expand Medicaid up to 138 percent of the federal poverty level (FPL) with enhanced federal funding provided under the ACA. Due to this decision, many adults in the state fall into a "[coverage gap](#)" because their incomes are above Medicaid eligibility limits but below the lower limit (100 percent FPL) for Marketplace insurance premium tax credits. In 2016, North Carolina had the fourth largest number of adults in the coverage gap (219,000) among states, following Texas, Florida, and Georgia.<sup>55</sup> Overall, 11 percent of North Carolina's total population remained uninsured in 2016 (compared to nine percent nationally).<sup>56</sup>

North Carolina performs worse than the national average on a number of health status measures. It had the 13<sup>th</sup> highest percentage of people reporting fair or poor health status in 2015 (19.2 percent)<sup>57</sup> and ranked 32<sup>nd</sup> among states in overall health status in 2016.<sup>58</sup> The state's opioid overdose death rate was higher than the national rate in 2015 (11.9 deaths per 100,000 people compared to 10.4 nationally).<sup>59</sup> The rate of new HIV diagnoses among adults and adolescents was also higher than the national rate in 2015 (15.9 deaths per 100,000 people compared to 14.7 nationally).<sup>60</sup> North Carolina had the eighth highest percentage among states of people reporting not seeing a doctor due to cost in 2015 (15.5 percent, tied with Arkansas and Tennessee),<sup>61</sup> and had the 10<sup>th</sup> highest percentage of adults reporting a serious mental illness in the last year in 2014-2015 (tied with Oregon and Missouri).<sup>62</sup>

## NORTH CAROLINA'S MEDICAID EXPANSION EFFORTS

North Carolina is one of the 19 states that has not expanded Medicaid.<sup>63</sup> Shortly after taking office in January 2017, Governor Cooper announced his intention to take immediate executive action to expand Medicaid under the Affordable Care Act (ACA). He planned to do so by filing an amendment to the state Medicaid plan, seeking approval from the Obama administration in the waning days before the presidential transition.<sup>64</sup> However, on January 13, 2017, Republican legislative leaders in the state House and Senate filed a federal lawsuit challenging the governor's plan to expand without legislative approval<sup>65</sup> and on January 14, 2017, a federal judge issued an order to temporarily suspend Cooper's effort to expand for 14 days or until the court took further action.<sup>66</sup> Given the timing, the temporary suspension prevented the expansion plan from moving forward before the Trump Administration took power.<sup>67</sup>

The lawsuit pointed to a 2013 state law that prohibits the executive branch from expanding Medicaid unilaterally, however, Governor Cooper contended that the statute impinges on the "core executive authority" of the executive branch. Although the state legislators ultimately dropped the lawsuit in July 2017 because the



governor's office never officially submitted an expansion proposal to the Centers for Medicare and Medicaid Services (CMS),<sup>68</sup> the president of the state Senate and speaker of the state House pledged to renew the lawsuit if the governor makes further attempts to expand Medicaid without legislative approval.<sup>69</sup>

In 2017, a group of Republican lawmakers introduced legislation called Carolina Cares. This legislation would increase eligibility for Medicaid up to 138 percent of FPL, impose premiums and co-payments, implement work requirements, and encourage preventive care and wellness activities.<sup>70</sup> If it passes, implementation will occur in coordination with other delivery system transformation activities underway.

## MANAGED CARE IN NORTH CAROLINA TODAY

Community Care of North Carolina (CCNC) is North Carolina's provider-led enhanced primary care case management (PCCM) program. Over 1,800 physician practices participate, and North Carolina's program is often cited as a national model for PCCM. It assigns eligible beneficiaries to a medical home that coordinates their care. It also offers access to local care managers who provide complex case management to high risk beneficiaries and education to help all beneficiaries self-manage their chronic conditions. The model is designed to reduce potentially preventable hospital admissions and readmissions, improve access to primary care, and better manage chronic conditions.

As part of the CCNC model, 14 regional Community Care networks receive a monthly administrative fee in exchange for providing population health management tools, case management, data analysis, and quality improvement support for participating medical homes. Behavioral health services are not included in the PCCM program. They are managed separately by Local Management Entities (LMEs) under 1915(b) and (c) waiver authority.

Many studies have evaluated CCNC's impact and estimate savings ranging from \$105 to \$2,290 annually across different eligibility groups.<sup>71</sup> One study showed that certain measures of health outcomes, such as reduction in hospital admissions and reduction in emergency department visits for asthma, also improved.<sup>72</sup>

## MEDICAID REDESIGN IN NORTH CAROLINA

In 2015, the state General Assembly passed Session Law 2015-245. This legislation requires the state's Medicaid program to transition from the enhanced PCCM model to capitated managed care.<sup>73</sup> Session Law 2015-245 envisions a competitive bid process with participation by commercial plans, which would operate statewide, and regional, provider-led entities licensed by the state Department of Insurance. It requires that cost growth not exceed two percentage points below the national Medicaid spending growth rate and requires submission of a Section 1115 demonstration waiver.

Under Governor Pat McCrory (R), the state crafted a Section 1115 demonstration waiver to implement the statute's reforms. The waiver was submitted to CMS on June 1, 2016. It reflected the vision of the prior administration, and closely tracked the program design established in state statute.

While the waiver was pending, Governor Cooper, a Democrat, took office on January 1, 2017. Waiver negotiations have resumed, and Governor Cooper's administration indicated they plan to submit an amended Section 1115 demonstration waiver request. The Cooper administration's initial plan for implementing

capitated Medicaid managed care was outlined in a program design document recently released by the Department for Health and Human Services (DHHS) for public comment.<sup>74</sup> The main features of the new administration's plan are outlined below.

## **MCO TYPES AND ENROLLMENT REQUIREMENTS**

DHHS's plan calls for participation by both commercial plans and regional, provider-led entities. State law specified three commercial plans would offer products statewide. Additionally, providers with a history of serving Medicaid beneficiaries can own and operate regional risk-based Medicaid managed care plans. Most Medicaid and CHIP beneficiaries will be mandatorily enrolled in capitated managed care. There will be limited exceptions for certain populations.<sup>75</sup> However, specified special populations will be phased into mandatory managed care after program launch, ranging from one year for foster children to four years for dual eligibles and Medicaid-only beneficiaries receiving long-stay nursing home services.

## **PLAN TYPES AND BEHAVIORAL HEALTH INTEGRATION**

Pending legislative approval, DHHS intends to allow commercial MCOs and provider-led entities to offer two plan types: standard plans and tailored plans. Standard plans would cover most Medicaid and CHIP beneficiaries and would provide integrated physical health, behavioral health, and pharmacy services. Standard plan enrollees would have access to all state plan behavioral health benefits including inpatient and outpatient behavioral health services and enhanced behavioral health services. Tailored plans would cover special populations with complex health care needs including individuals with serious mental illness (SMI), substance use disorder, or intellectual or developmental disabilities (I/DD)) (and eventually other populations like dual eligibles).<sup>76</sup> Tailored plans would provide integrated physical health, behavioral health, and pharmacy services but would also offer enhanced services, including facility-based crisis services, partial hospitalization ambulatory detoxifications, outpatient opioid treatment, and substance abuse intensive outpatient services.<sup>77</sup>

## **MEDICAL HOMES, VALUE BASED PAYMENT, AND PROVIDER TRANSFORMATION SUPPORT**

DHHS will certify "Advanced Medical Homes," initially based on the state's existing Carolina Access program, which over time must provide expanded care management activities, such as addressing social determinants of health or opioid addiction, to receive additional reimbursement. Health plans will work closely with the providers, and be responsible for monitoring their care management activities and filling in any gaps. They will also be incentivized to adopt value-based payment reimbursement models to improve population health and telehealth initiatives to expand access in rural parts of the state. DHHS will create standardized social needs screening tools and will seek Section 1115 waiver expenditure authority to establish Regional Provider Support Centers. These new centers will provide tools, resources, and other supports to help providers, especially small and rural providers, achieve their care goals.

## **SAFETY NET FUNDING**

DHHS indicates it will develop an alternative payment approach to support safety net providers in compliance with new federal rules as it transitions to managed care.<sup>78</sup>

## REDESIGN NEXT STEPS AND IMPLEMENTATION TIMELINE

For the next two fiscal years, implementing managed care is DHHS' number one priority. It pervades everything the Medicaid program is doing, and requires preparing staff, beneficiaries, and providers for the change. The state is currently working with the state legislature to obtain additional statutory authority required by their revised plan. Later this year the state will seek additional stakeholder input through a Request for Information (RFI) to assess the market's readiness to implement managed care. The state will also need to submit an updated waiver request to CMS, negotiate waiver terms, develop a Request for Proposal (RFP) to select participating commercial and regional provider-led health plans, and conduct readiness reviews. The state has set a target implementation date of July 2019.

## ADDRESSING THE OPIOID ABUSE CRISIS

North Carolina has been hit hard by the nation's opioid abuse crisis. More than 12,000 people have died from opioid-related overdoses since 1999 and from 2013 to 2015 the opioid death rate has grown by 37 percent.<sup>79,80</sup> Opioid-related overdose deaths cost the state \$1.3 billion in 2015. Governor Cooper's goal is to reduce opioid-related deaths by 20 percent. An Opioid Action Plan supports this goal, and includes recommendations for building a coordinated infrastructure, expanding treatment and recovery services, improving access to Naloxone, reducing oversupply and diversion of prescription drugs, and increasing community awareness.<sup>81</sup>

In June 2017, the General Assembly passed the Strengthen Opioid Misuse Prevention (STOP) Act. The STOP Act limits initial opioid prescriptions for acute pain, supports needle exchange programs, and requires prescribers and pharmacies to check the state's prescription drug monitoring system prior to prescribing or filling an opioid prescription. The legislation also expands access to Naloxone through local health departments and law enforcement agencies, and requires electronic prescribing for opioids.<sup>82</sup>

North Carolina's Medicaid program has adopted its own efforts to combat opioid abuse. In FY 2017, it decreased daily dose limits (from 750 morphine milligram equivalents (MMEs) to 120 MMEs); established quantity limits (14-day quantity limit) for initial opioid prescriptions; increased the refill threshold for opioids and benzodiazepines from 75 percent to 85 percent; and made it easier to obtain Naloxone. It also expanded its lock-in program capacity to ensure that all individuals who meet program criteria are enrolled, and extended the required lock-in period from one to two years.<sup>83</sup>

Going forward, DHHS hopes to implement additional initiatives to enhance prevention and treatment. Strategies outlined in DHHS's recently proposed program redesign for Medicaid managed care include:

- Adding low intensity residential services to improve transitions between inpatient and outpatient care
- Establishing behavioral health homes for individuals with SMI, serious emotional disturbance, and substance use disorders
- Using the state's prescription drug monitoring system to issue care alerts to providers when patients have opioid prescriptions through multiple providers
- Offering bundled payments for buprenorphine treatment to support effective care management and medication and counseling services

- Using community pharmacies to help screen, identify, and refer individuals to available resources
- Incorporating opioid prescribing performance metrics into future health plan contracts, and requiring health plans to design and implement an opioid misuse prevention program

### North Carolina Medicaid Policy Changes FY 2017 and FY 2018

#### Provider Rates

- 4 percent rate increase for nursing facilities in FY 2017
- Anticipate targeted provider rate increases in FY 2018 for physician-administered vaccines and contraceptives and personal care services

#### Benefits and Pharmacy

- Implementing new pharmacy utilization controls in FY 2017 and FY 2018
- Planning to adopt Centers for Disease Prevention and Control (CDC) opioid prescribing guidelines in FY 2018
- Strengthening pharmacy benefit management policies to prevent opioid-related harms, decreasing daily dose limits (from 750 MMEs to 120 MMEs); establishing quantity limits (14-day quantity limit) for initial opioid prescriptions; increasing the refill threshold for opioids and benzodiazepines from 75 percent to 85 percent; and making it easier to obtain Naloxone. In FY 2018, North Carolina will further decrease the quantity limit for initial opioid prescriptions to five days for acute pain and seven days for post-operative pain as required by state law.
- Planning to remove prior authorization requirements for SUD treatment (i.e., Suboxone) to ensure immediate access in FY 2018

#### Long-term Services and Supports (LTSS) Rebalancing

- Increasing the number of individuals receiving home and community-based services (HCBS) in the community by adding a total of 320 slots to a 1915(c) waiver for adults with disabilities in FY 2018
- Planning to add two new PACE locations in FY 2018
- Renewed the 1915(c) waiver for medically frail children, which includes consumer-directed care, in FY 2017, and increased the number of slots to 4,000
- Increased slots in the intellectual and developmental disabilities (IDD) waiver by 400 in FY 2018

# West Virginia: Medicaid in the Larger Budget Context

## ECONOMIC AND BUDGET OUTLOOK

### ECONOMY AND STATE REVENUES

In 2015, West Virginia fell into an economic recession primarily driven by continued job losses in the coal industry and a slowdown in the natural gas industry.<sup>84</sup> The state continued to struggle economically in 2016 as its real Gross Domestic Product (GDP) shrank by 0.9 percent. West Virginia was one of only seven states with negative GDP growth in 2016, driven, again, by negative growth in the mining sector but also by losses in the construction sector.<sup>85</sup> More recently, however, growth in the mining sector nationwide resulted in economic growth in the state. In the first quarter of 2017, West Virginia had the second-highest GDP growth rate in the nation (3.0 percent), second only to Texas (3.9 percent) and just ahead of New Mexico (2.8 percent) whose economies are also heavily reliant on mining.<sup>86</sup>

Looking ahead, University of West Virginia economists forecast continued moderate growth for the remainder of CY 2017, but warned that economic outcomes vary across the state and that “it will take years to recover all of the jobs that have been lost since early 2012.”<sup>87</sup> The state’s labor force has shrunk by nearly 5 percent since its high in June of 2009, which has contributed to decreasing rates of unemployment.<sup>88</sup> The state’s unemployment rate dropped from 6.0 percent in August 2016 to 5.0 percent in August 2017, the labor force also shrank by 0.5 percent) during that same time period.<sup>89</sup> West Virginia had the lowest work force participation rate among all states at 53.2 percent, presenting “a significant hurdle for long-run economic prosperity.”<sup>90,91</sup>

Except for a one-year state revenue rebound of 8.1 percent in FY 2011, West Virginia state revenue growth has remained low or negative since the onset of the Great Recession with an average annual growth rate of -0.2 percent between FY 2008 and FY 2016.<sup>92</sup> In addition to weak economic growth, a variety of tax cuts since 2007 have also reduced annual state revenues by at least \$415 million.<sup>93</sup> For FY 2017, general revenues were originally projected to grow by 2 percent, but came in \$21 million below target as of June 30, 2017.<sup>94</sup> Improving severance tax collections beginning in March 2017, resulting from natural gas price increases and an increase in coal production, helped the state avoid a larger shortfall predicted to be as high as \$192 million earlier in 2017.<sup>95</sup> Looking ahead, state general revenue collections are projected to grow by a modest 1.4 percent in FY 2018.<sup>96</sup>

### STATE BUDGET

At the start of CY 2017, newly-elected Democratic Governor Jim Justice faced both a current year budget shortfall for FY 2017 of \$123 million and a projected budget gap for FY 2018 of \$497 million.<sup>97</sup> To close the FY 2017 shortfall, the Governor used a combination of midyear spending cuts totaling nearly \$60 million and one-time special revenues, including \$40 million from the state’s Rainy Day reserve.<sup>98,99</sup> In February, he also offered an Executive Budget proposal that included over \$450 million in revenue enhancements to close the projected budget gap for FY 2018 and fund base budget increases for Medicaid, public retirement systems, and classroom teacher raises.<sup>100</sup>

In April 2017, Governor Justice vetoed a state budget passed by the Republican-controlled legislature that did not include the revenue enhancements proposed by the Governor, but did include \$110 million in spending

cuts and a \$90 million transfer from the Rainy Day reserve that the Governor feared would put the state's bond rating at risk.<sup>101</sup> On June 21, 2017, however, the Governor announced that he would allow a subsequent budget passed by the legislature to become law without his signature – despite his objections to its cuts – to avoid a state government shut-down that might otherwise have occurred on July 1, 2017.<sup>102</sup> Compared to FY 2017 appropriation levels, nearly every area of the FY 2018 budget, including Medicaid, was cut with the only significant funding increases for payments to the Teacher's Retirement System Unfunded Liability and the State Police.<sup>103</sup> FY 2018 General Revenue Fund appropriations are slightly below actual FY 2013 spending and, after adjusting for inflation, also less than FY 2008 spending.<sup>104</sup>

Less than seven months into his first term, Governor Justice announced on August 3, 2017, that he was switching parties to become a Republican later saying that his decision was driven by the refusal of legislative Democrats to support his push for tax reform during the budget special session. He also said he made the change because it had given him the ear of President Trump and his Administration to listen and seriously consider plans to bring back coal jobs and allocate federal funds to the state.<sup>105</sup>

## DEMOGRAPHIC CHARACTERISTICS AND MEDICAID'S ROLE

West Virginia has the third highest percentage of people living in poverty among all states (along with New Mexico, 18 percent in 2016),<sup>106</sup> the second lowest personal income per capita among states (\$36,132 in 2014),<sup>107</sup> and the second highest share of its total population enrolled in Medicaid (26 percent in 2016).<sup>108</sup> Due to the state's low per capita income, it has one of the highest federal medical assistance percentages (FMAPs) at 73 percent in fiscal year 2018,<sup>109</sup> and over three-quarters (79 percent) of all federal funds that West Virginia receives are for Medicaid.<sup>110</sup> Nearly half (46 percent) of West Virginia's population resided in rural areas in 2015.<sup>111</sup>

West Virginia's population faces multiple high health needs and limited access to care. The state ranked 43<sup>rd</sup> among states in overall health status in 2016<sup>112</sup> and had the highest percentage among states of people reporting fair or poor health status in 2015 (25.9 percent).<sup>113</sup> In addition to being hit harder than any other state by the opioid epidemic (as described in detail below), West Virginia has the highest obesity rate in the country (71.1 percent in 2015)<sup>114</sup> and the highest percent among states of the non-institutionalized population reporting a disability (19.5 percent in 2015).<sup>115</sup> Access limitations in the state make addressing these serious health needs even more difficult: 30 percent of people in West Virginia lived in a health professional shortage area for primary care and had limited access to the services they need as of December 2016 (the 8<sup>th</sup> highest percentage among states),<sup>116</sup> while 13.8 percent of adults reported not seeing a doctor due to cost in 2015.<sup>117</sup> This range of serious health needs and access challenges coupled with Medicaid's important role in providing necessary services to high-need populations suggest that West Virginia is a state that would be at particularly high risk under potential caps on Medicaid funding.<sup>118</sup>

## UPDATE ON THE AFFORDABLE CARE ACT

### MEDICAID EXPANSION

West Virginia elected to expand Medicaid coverage to newly eligible groups under the Affordable Care Act (ACA) in January 2014, extending coverage to non-disabled childless adults for the first time. While the state's

actuaries had predicted new enrollments in the first year of about 63,000, actual enrollment through the end of June 2014 increased by over 130,000 – more than twice the projected first year increase.<sup>119</sup> As of FY 2016, statewide Medicaid expansion enrollment had grown to over 180,000 and accounted for nearly one-third of total Medicaid enrollment.<sup>120</sup> West Virginia’s expansion enrollment success was partially related to [their implementation of facilitated enrollment \(or “fast track enrollment”\) options](#), including enrolling eligible individuals into coverage using data already available from the state’s Supplemental Nutrition Assistance Program (SNAP) as well as Medicaid enrollment data for children (used to reach eligible parents).<sup>121</sup> According to the Centers for Medicare & Medicaid Services (CMS), total West Virginia Medicaid and Children’s Health Insurance Program (CHIP) enrollments grew by over 57 percent between the third quarter of CY 2013 (prior to the implementation of the ACA and Medicaid coverage expansions) through June 2017.<sup>122</sup>

## MARKETPLACE COVERAGE

The ACA provided states the option of establishing their own Marketplaces or relying on the federally-facilitated Marketplace (FFM), [www.healthcare.gov](http://www.healthcare.gov). West Virginia was one of seven states that chose a “State Partnership Marketplace” model allowing the state to rely on the FFM but retain control over plan management and some consumer assistance activities.<sup>123</sup> In April 2017, however, Governor Justice signed into law HB 2119 that repeals the state law establishing the West Virginia Health Benefit Exchange effective July 4, 2017,<sup>124</sup> likely resulting in the state reverting to the FFM model. The West Virginia Marketplace had just one carrier in 2014 and 2015, but grew to two carriers in 2016 and 2017 and will continue to have two carriers in 2018.<sup>125</sup> During open enrollment for the 2017 plan year, 34,045 West Virginians selected a West Virginia Marketplace plan.<sup>126</sup>

## DELIVERY SYSTEM REFORMS

### MANAGED CARE

West Virginia has operated a risk-based Medicaid managed care program – Mountain Health Trust – since September 1996. Under this program, the state currently contracts with four managed care organizations (MCOs) to provide medically necessary Medicaid services to most Medicaid enrollees statewide, although, school-based services, transplant services, long-term care, personal care and non-emergency medical transportation services are “carved out” of the MCO contracts. As of July 1, 2017, pharmacy services were also carved out of the MCO benefit package.<sup>127</sup> As of September 2017, there were approximately 420,000 members enrolled in Mountain Health Trust.<sup>128</sup>

### ADDRESSING THE SUBSTANCE USE DISORDER CRISIS

The misuse of and addiction to opioids, including prescribed pain relievers, heroin, and synthetic opioids such as fentanyl, is a serious and growing national public health crisis that has hit West Virginia harder than most other states. In 2015, West Virginia had the highest age-adjusted drug overdose death rate (41.5 per 100,000), more than twice the national rate (16.3 per 100,000).<sup>129</sup> Between 2012 and 2015, the drug overdose death count increased by nearly 30 percent, from 558 to 725,<sup>130</sup> and between 2014 and 2016, 37 of every 1,000 births in the state involved a baby born with Neonatal Abstinence Syndrome (NAS) resulting from substance abuse among pregnant women.<sup>131</sup> The state has the second highest rate of prescription drugs filled: 21.8 drugs per capita, compared to 12.7 nationwide.<sup>132</sup> Out of home foster care placements have grown by more than 30

percent over the past three years from 4,366 in April 2014 to 5,772 in April 2017, driven in part by substance abuse by the parents.<sup>133</sup>

Recognizing the substantial public and private harms generated by this crisis, the state has taken numerous steps in recent years to curb the epidemic:<sup>134</sup>

- In 2015:
  - The legislature passed legislation making naloxone (an opioid overdose antidote) available to first responders and to relatives, friends, caregivers or persons in a position to assist someone at risk of experiencing an opiate-related overdose.
  - The state launched its first ever Behavioral Health Referral and Outreach Call Center to provide resources and referral support 24-hours a day (this took place in September 2015).
  - The West Virginia Department of Health and Human Resources (DHHR), Bureau for Children and Families (BCF) launched Safe at Home West Virginia (this took place in October 2015). This program provides wraparound behavioral health and social services to youth ages 12 - 17 years with certain behavioral health needs who are currently in congregate care or at risk of entering congregate care.
- In 2016, the legislature:
  - Authorized pharmacists and pharmacy interns to dispense naloxone without a prescription in accordance with a Board of Pharmacy protocol.
  - Passed the Medication-Assisted Treatment (MAT) bill. MAT combines behavioral therapy and medications to treat substance use disorders (SUDs). Clinics that use MAT must be licensed or registered by the state, provide counseling in conjunction with treatment and test their patients to ensure they are using the medication as intended.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) awarded the state a Cooperative Agreement to Benefit Homeless Individuals in partnership with four Continuum of Care Organizations. This agreement will be used to enhance the state's infrastructure to provide effective, accessible treatment and recovery support services to veterans, nonveterans, families, and youth experiencing homelessness who have mental health and SUDs.

Some cities and towns have also initiated syringe exchange programs to reduce the risk of spreading diseases associated with intravenous drug use, such as hepatitis B, hepatitis C and HIV/AIDS, and in Huntington, a non-profit residential infant recovery center, Lily's Place, has opened to provide short-term medical care to infants suffering from prenatal drug exposure.

### **Adoption of CDC Opioid Prescribing Guidelines**

Building on the Centers for Disease Control (CDC) Opioid Prescribing Guidelines, West Virginia Medicaid initiated a new program on January 17, 2017, to encourage the safe prescribing of opioid medications. This program is designed to help prescribers be aware of the total morphine milligram equivalency (MME) of their patient's opioid prescriptions, especially patients seeing more than one provider for pain management. The Public Employees Insurance Agency (PEIA) implemented the same program in January 2017, and a common prior authorization form was developed for use in both the PEIA and Medicaid Programs.<sup>135</sup> Beginning in July



2017 (the effective date of the carve-out of pharmacy benefits from managed care contracts), these opioid prescribing guidelines are also being phased in for MCO members.<sup>136</sup>

### Section 1115 SUD Waiver

On October 6, 2017, CMS approved West Virginia’s Section 1115 demonstration waiver application to address the state’s SUD crisis with an effective date of January 1, 2018.<sup>137</sup> The purpose of the *Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders* waiver is to promote access to SUD treatment and prevention services and build a comprehensive continuum of care across the state to more effectively prevent and treat SUDs in West Virginia. Features of the waiver include expanded coverage for methadone, naloxone, peer recovery support, withdrawal management and short-term residential services for all Medicaid enrollees.

### HEALTH HOMES

In July 2014, the West Virginia Department of Health and Human Resources, Bureau for Medical Services implemented a Health Homes initiative (authorized under ACA Section 2703) focused on members in a six-county region who suffer from bipolar disorder and who may have hepatitis B or C (Health Home I). In April 2017, this initiative was expanded statewide (Health Home II), and a second Health Home pilot (Health Home III), targeting diabetes and obesity, was launched in 14 counties.<sup>138</sup>

The state’s Health Home model focuses on the member’s entire condition, behavioral health, physical health, and social needs. By addressing all member needs, the Health Home model is designed to reduce emergency room (ER) visits and inpatient admissions for both physical and behavioral health issues, and improve the member’s overall quality of life. Results from the Health Home I implementation demonstrated success in reducing ER utilization, inpatient admissions, and overall costs, which led the state to initiate the Health Homes II statewide expansion and the new Health Homes III pilot.

Additional policy actions the state either implemented in FY 2017 or planned to implement in FY 2018 are described in the table below.

West Virginia Medicaid Policy Changes FY 2017 and FY 2018 <sup>139</sup>	
<b>Provider Rates</b>	
FY 2017:	<ul style="list-style-type: none"> <li>Increased MCO rates and nursing facility rates.</li> <li>All other rates were flat.</li> </ul>
FY 2018:	<ul style="list-style-type: none"> <li>Plan to increase MCO rates and nursing facility rates.</li> <li>Plan to hold all other rates flat.</li> </ul>
<b>Benefit Changes</b>	
FY 2017:	<ul style="list-style-type: none"> <li>Liberalized medical necessity criteria for hepatitis C antiviral agents.</li> </ul>
FY 2018:	<ul style="list-style-type: none"> <li>Through Section 1115 waiver authority, the state will expand substance use disorder (SUD) treatment coverage to create a continuum of care for Medicaid enrollees with SUD issues. New SUD treatment services and supports will include:</li> </ul>

- Statewide adoption of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) method to ensure a consistent and effective enrollment process for the waiver
- Expanded coverage of withdrawal management in regionally identified settings
- Short term, residential SUD treatment
- Enhanced access to outpatient SUD treatment as appropriate when residential treatment is not required
- Coverage of methadone and methadone administration
- Comprehensive initiative for distributing naloxone and cross-training staff on administration of naloxone
- Coverage of clinical and peer recovery support services and recovery housing supports.

### Copayment Changes

FY 2018:

- Changing the pharmacy copayment requirements from a tiered approach (\$0.50 - \$3) based on drug price to a flat rate of \$1 for generics and \$3 for brands. The change is expected to be cost-neutral to the state.

### Pharmacy Changes

FY 2017:

- Hepatitis C antivirals carved out of managed care contracts effective April 1, 2017.
- New pharmacy utilization controls applied.
- New provider education/profiling initiative implemented.
- CDC Opioid Prescribing Guidelines adopted for fee-for-service enrollees.

FY 2018:

- Pharmacy benefit carved out of managed care contracts effective July 1, 2017.
- Following pharmacy managed care carve-out, plan to enhance rebate collection efforts and further reduce ingredient cost reimbursement.
- Will expand pharmacy utilization controls.
- Will expand provider education/profiling initiative.
- CDC Opioid Prescribing Guidelines will be implemented, on a phased-in basis, for MCO members beginning July 1, 2017.

### Managed Care and Delivery System and Payment Reforms

FY 2017:

- Non-dual, non-LTSS SSI members enrolled into managed care on a mandatory basis.
- Health Homes for persons with bipolar disorder and who have or are at risk of having hepatitis B or C expanded statewide (April 2017).
- New Health Home pilot targeting diabetes and obesity implemented (April 2017).

FY 2018:

- Quality withhold eliminated from managed care contracts.
- Requirement added to MCO contract requiring 10 percent of the plan's enrollees to be part of an Alternative Provider Payment Model. Plans allowed to determine model(s) used.

### Long Term Services and Supports Rebalancing

FY 2018:

- Planning to expand the number of persons served in the Individuals with Developmental Disabilities Waiver.

# Endnotes

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- <sup>76</sup> The state envisions phasing tailored plans in. At program launch, beneficiaries with more serious behavioral health or I/DD needs would continue to receive care via FFS and LME-MCO.
- <sup>77</sup> Enhanced care management through behavioral health and I/DD health homes is also under consideration.
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- <sup>134</sup> West Virginia Department of Health and Human Resources, Bureau for Medical Services, Provider Newsletter, Quarter 4, 2016, accessed at <http://www.dhhr.wv.gov/bms/BMSPUB/Documents/4QTRProvidernewsletter2016-rev.pdf>.
- <sup>135</sup> When an opioid prescription is submitted for a member in the fee-for-service delivery system, the member’s medication profile is evaluated to determine the patient’s average MME dose for the past 90 days. An average does that equals or exceeds 50 MME will trigger further review through the prior authorization process and the patient will be locked into one pharmacy of their choice for prescriptions for controlled substances so their therapy can be more carefully managed. Ibid.
- <sup>136</sup> West Virginia response to the 2017 Medicaid Budget Survey for State Fiscal Years 2017 and 2018, Kaiser Commission on Medicaid and the Uninsured.
- <sup>137</sup> CMS, West Virginia “Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders” Section 1115 Waiver Demonstration Approval, accessed at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wv/wv-creating-continuum-care-medicaid-enrollees-substance-ca.pdf>.
- <sup>138</sup> West Virginia Department of Health and Human Resources, Bureau for Medical Services, Provider Newsletter, Quarter 1, 2017, accessed at <http://www.dhhr.wv.gov/bms/BMSPUB/Documents/1Quarter2017FinalApproved.pdf>.
- <sup>139</sup> West Virginia response to the 2017 Medicaid Budget Survey for State Fiscal Years 2017 and 2018, Kaiser Family Foundation.