Attachment A: **TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS**

For projects to be considered for inclusion in the Medicaid Transformation Project List, please provide the information requested in the template. We are looking for summarized information – **2-3 pages maximum per project**.
Please email completed templates by **January 15, 2016,** to MedicaidTransformation@hca.wa.gov with the subject **Medicaid Waiver Project**. Thank you for your interest and support.

Contact Information	*Identify point person, telephone number, e-mail address* *Bradley Finegood, Assistant Division Director, Mental Health Chemical Abuse and Dependency Services Division King County; (206)263-8087; brad.finegood@kingcounty.gov* *Which organizations were involved in developing this project suggestion?* *King County Public Health(Medical Director, HIV / STD Prevention, Jail Health Services); University of Washington- Alcohol and Drug Abuse Institute; King County Department of Community and Human Services, Neighborcare Health*
Project Title	*Title of the project/intervention: Expansion of Opioid Treatment and Overdose Prevention.*

Rationale for the Project

Include:

- *Problem statement – why this project is needed.*

Fatal opioid overdoses in King County are at an all-time high. In addition, the number of people accessing behavioral health services for opioid addiction continues to grow. The greatest increase in use and treatment access is among young adults. Because opioid addiction is a chronic, relapsing condition, the number of people who will need treatment is increasing dramatically in the short and long term. The need for services far outweighs the current capacity to provide effective services on demand. People who are struggling with opioid addiction access safety net services at extremely high frequency; among injectors surveyed at King County Syringe exchanges in 2015 37% had been in jail in the prior year and 29% reported the emergency room was the main place they received medical care. Without treatment and overdose prevention interventions there are many points in the system where opportunities to intervene are missed. The lack of treatment options is often due to the lack of coordination or the lack of system capacity at these touch points. Missed opportunities to intervene lead to increased healthcare costs, increased utilization of safety net services (ER, jail, etc.) and loss of human life. Mobile Health Care, Housing, ER, Primary Care (FQHC, Mobile Medical) Mobile Dental, Needle Exchanges and Jail represent some of the locations where opioid users and families "touch" the system. WA DSHS Research and Data Analysis recently released the report Overdose Deaths among Medicaid Enrollees in Washington State- The Role of Behavioral Health Needs (2015) finding that: "Medicaid enrollees are at high risk for drug-poisoning deaths. Among all persons who died from drug overdose in the 2006 to 2012 time period, 2,211 (35 percent) were enrolled in Medicaid at some point in the 12 months before death. The opioid analgesic overdose death rate for Medicaid enrollees was more than 4 times as high as that for the general state population. With the implementation of expanded adult Medicaid coverage under the Affordable Care Act in January 2014, Medicaid enrollees are likely to account for a significantly higher proportion of overdose deaths than in the time period analyzed in this report." "The risk for drug-overdose deaths among Medicaid enrollees is strongly related to behavioral health risk factors. Medicaid enrollees having mental health service needs and/or substance use disorders had higher risk for death due to drug overdose…"

Because opioid use disorders are a potentially fatal condition the goal of this project is to ensure that two lifesaving medications, naloxone to reverse overdoses and buprenorphine to reduce illicit opioid use, reduce

overdose risk and improve functioning, are easily accessible wherever and whenever those with opioid use disorders present themselves in King County. Communication and care coordination are integral to providing these medications to clients and additional robust recovery support services, professional and peer, need to be readily available. Medical and housing services must also be coordinated.

The proposal is focused on locating peers or other professionals at these touch points, screening all people who interact with the respective systems to identify people who use opioids and then providing naloxone on demand and linking to a coordinated and dedicated system of providers for buprenorphine prescription first and subsequent linkage to other behavioral health, primary care and social service needs. This proposal will also develop the infrastructure to be able to provide Opioid analgesic medication to anyone in need that desires treatment.

- *Supporting research (evidence-based and promising practices) for the value of the proposed project.*[i]

There is an abundance of evidence for both naloxone and buprenorphine. Naloxone has proven effectiveness in saving lives and reducing costs for heroin users with effectiveness having been shown at the population and individual levels(Coffin & Sullivan, 2013; Walley et al., 2013)*. Buprenorphine also has proven effectiveness in reducing ER visits, hospitalizations, mortality and costs for those with opioid dependence*(Clark, Samnaliev, Baxter, & Leung, 2011; Lo-Ciganic et al., 2015).

- *Relationship to federal objectives for Medicaid*[ii] *with particular attention to how this project benefits Medicaid beneficiaries.*

This proposal addresses all areas of the federal objective for Medicaid. Specifically this proposal provides access to treatment and lifesaving medication for Medicaid and low-income clients that often have other co-morbid conditions. Additionally, this proposal will focus on strengthening a fragmented and sparse set of doctors that are eligible and currently prescribing buprenorphine. Medicaid enrolled clients are at significantly higher risk for dying from opioid overdoses, and represent 35% of all opioid overdose deaths in Washington State. This transformation project is directly tied to the "CMS Dear State Medicaid Director" letter SMD #15-003 on July 27, 2015, Re: New Service Delivery Opportunities for Individuals with a Substance Use Disorder. In that letter CMS Director, Vikki Wachino, advises State Medicaid Directors to use transformation projects in the 1115 waiver. Specifically on p. 10 of the letter it identifies the use of the waiver to focus on Opioid Use Disorders. It specifies three priority areas which this proposal focuses on:

- *Opioid prescribing practices to reduce opioid use disorders and overdose*
- *Expanded use and distribution of naloxone*
- *Expansion of MAT to reduce opioid use disorders and overdose.*

Project Description

Which Medicaid Transformation Goals[iii] *are supported by this project/intervention? Check box(es)*

X Reduce avoidable use of intensive services
X Improve population health, focused on prevention
☐ Accelerate transition to value-based payment
☐ Ensure Medicaid per-capita growth is below national trends

Which Transformation Project Domain(s) are involved? Check box(es)

X Health Systems Capacity Building
X Care Delivery Redesign
X Population Health Improvement – prevention activities

Describe:

- *Region(s) and sub-population(s) impacted by the project. Include a description of the target population (e.g., persons discharged from local jail facilities with serious mental illness and or substance use disorders).*

This project is targeting people with Opioid Use Disorder in any area of the state. This project can be implemented at a statewide level or at a region level. Each region would need to customize location of touch points based upon urban / rural and other regional considerations, but each region has multiple places where opioid dependent people interact and present for a possible intervention. Opioid addiction and overdose has become a statewide and nationwide healthcare issue.

- *Relationship to Washington's Medicaid Transformation goals.*
  This proposal is in line with two of the Washington State Medicaid Transformation goals.

1. Reduce avoidable use of intensive services and settings such as acute care hospitals, nursing facilities, psychiatric hospitals, traditional long term services and supports (LTSS), and jails.

By treating and engaging people with Opioid Use Disorder in medication stabilization treatment services with buprenorphine at different points where they interact with services, individuals will be much less likely to use safety net services (psychiatric hospitalization, jails, emergency rooms and detox). As people engage in recovery and do not use illicit opioids, other long term health costs will be mitigated.

2. Improve population health, with a focus on prevention and management of diabetes, cardiovascular disease, pediatric obesity, smoking, mental illness, substance use disorders, and oral health that is coordinated and whole-person centered.

As previously mentioned buprenorphine treatment is proven an effective treatment modality for people diagnosed with Opioid Use Disorder. Changes in regulation in 2015 allowed for prescribing buprenorphine as an initial intervention without requiring other behavioral interventions as a requisite. This project's proposed engagement strategies aim to initiate people in buprenorphine maintenance in order to engage in a successful recovery. By distributing naloxone at each point the ultimate consequence of opioid abuse, overdose death, will be prevented. Acute and chronic conditions associated with opioid use and injecting drugs, overdose, wounds, infections, will be decreased at the same time providing a necessary medication to manage the chronic disease of addiction.

- *Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.*

  The goals of this project are to increase access to life saving medications for those with Opioid Use Disorders in order to improve quality of life, decrease costs and decrease mortality. To meet these goals the prescribing and administration capacity, the supporting data infrastructure and protocols will need to be established and implemented. Service uptake (increased penetration) by clients will be a main process measure. Outcome measures will include service utilization across systems including medical care in different settings, morbidity and mortality. A cost benefit analysis is expected to yield significant Medicaid savings in healthcare costs along with other cost savings such as reduction in jail and crisis services use. Medicaid enrolled clients are at significantly higher risk for dying from opioid overdoses, and represent 35% of all opioid overdose deaths in Washington State.

- *Links to complementary transformation initiatives - those funded through other local, state or federal authorities (such as the health home program and Early Adopter/Behavioral Health Organization regional purchasing) and/or Medicaid Transformation initiatives # 2 and 3.*
  This project proposal works seamlessly with the Healthier Washington initiative and bringing better health

services to the most vulnerable Medicaid populations. By investing in this project, the State will move closer to purchasing outcomes and value rather than quantity of service. This project also fits with in the King County Health and Human Services Transformation Plan to bring better health and wellbeing at the community and individual level.

- *Potential partners, systems, and organizations (e.g., health and social service providers, ACH participants) needed to be engaged to achieve the results of the proposed project.*
  Members of the ACH including the Physical / Behavioral Health Integration committee and other community providers including managed care plans, FQHCs, current behavioral health providers, Public Health, corrections and jail administration, other primary care settings, emergency rooms, human service agencies, the University of Washington and needle exchanges represent a partial list of potential partners.
  King County and the City of Seattle are in the beginning stages of pulling together a taskforce to address the Opioid issue which this project would work in concert with. A statewide plan to address Opioid abuse and overdoses has participation from this submitting agency and proposal contributors in all four of the workgroups and shall ensure seamless cooperation within the mission of these groups.

Core Investment Components

Describe:

- *Proposed activities and cost estimates ("order of magnitude") for the project.*
  1) *Co-locate peers or other professionals at each touchpoint to help provide comprehensive screening, naloxone distribution and warm handoff to a prescriber.*
     ($90,000 to $100,000 per location depending on region).
  2) *Develop to infrastructure to ensure buprenorphine prescribing is available to enyone in need. (Doctor outreach, training, stigma reduction, clinical care coordination)*
     (Estimated $250,000 to 1 million dollars depending on region).
     Infrastructure to get more waivered doc's and induce and maintain patients
  3) *Coordination with pharmacy for naloxone kit assembly, training and distribution.*
     (Estimated $15.00 per kit outside of current Medicaid reimbursement)
  4) *Regional coordination, administration and data infrastructure development*
     (Estimated $200,000 to $500,000)

- *Best estimate (or ballpark if unknown) for:*
  - How many people you expect to serve, on a monthly or annual basis, when fully implemented.
- At least 2,000 people per year could be on buprenorphine maintenance who are not currently receiving care if easily accessible buprenorphine induction and maintenance were made available in King County. This estimate of utilization is based upon a conservative estimate of 4,689 heroin users not in treatment who expressed interest in decreasing their use or stopping in King County. Estimates of unmet treatment need for heroin users were calculated by Dr. Caleb Banta-Green based upon surveys with syringe exchange clients in 2015. This is based on an estimate of the number of heroin injectors who are not in treatment and expressed interest in reducing their use. These total numbers would be at least double if the entire state of Washington was served with newly expanded buprenorphine access.
- At least 5,536 active heroin users in King County are estimated to not have take-home-naloxone, this is based upon the 2015 syringe exchange survey that found that 40% of heroin users had a take-home-naloxone kit.
- How much you expect the program to cost per person served, on a monthly or annual basis
  - **A rough and conservative estimate, based upon the above projections (at 10 touch point sites and high end of estimate for staffing/ coordination), and 5,536 naloxone kits distributed and 2,000 people accessing buprenorphine. Cost per person for buprenorphine is $466.59 or for buprenorphine is $1,291.52.**
- *How long it will take to fully implement the project within a region where you expect it will have to be phased in. It is anticipated that developing the screening of persons, infrastructure development and distribution network along with training for naloxone kits can be implemented within the first three months. In order to develop a peer or professional network to be hired and stationed at each touch point, engage opioid dependent clients and link a network of eligible buprenorphine prescribers, will take six months to see the first person in service and a year to be fully implemented to project scope.*
- *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.*

An overview of findings on cost offsets and cost effectiveness from the report Medicaid Coverage and Financing of Medications to Treat Alcohol and Opioid Use Disorders prepared by SAMHSA found that:

Medications for treating opioid use disorders have been found to be cost offsetting and cost effective. One study estimated that, over a lifetime, methadone treatment yielded $37.72 in benefits for each $1 in cost (Zarkin, Dunlap, Hicks, & Mamo, 2005). A separate study found that every dollar invested in methadone treatment resulted in a $4.87 offset in health care costs (Hartz et al., 1999).

One study focusing on cost effectiveness estimated that providing long-term, office-based brand

buprenorphine-naloxone treatment for patients with opioid dependence who are clinically stabilized costs $35,100 for every quality-adjusted life year (QALY) saved, and it has a 64 percent probability of being less than the benchmark cost-effectiveness threshold of $100,000/QALY (Schackman, Leff, Polsky, Moore, & Fiellin, 2012).

An analysis of the cost effectiveness of distributing naloxone to heroin users found an incremental cost-effectiveness ratio of $438 (CI, $48 to $1706). This ICER was based upon a lifetime estimate of cost effectiveness, however given the high annual rates of having an opioid overdose (23% self-reported in 2015 King County syringe exchange survey) and an estimated 1% annual rate among heroin users of dying from an opiate overdose (Darke et al., 2003).

Project Metrics

The state will monitor implementation of transformation projects at regional and statewide levels through process and outcome measures. Each project will require clearly defined outcomes that relate to the goals and specific process steps.
Wherever possible describe:

- Key process and outcome measures (and specific benchmark performance data if known) against which the performance of the project would be measured. Include priority measures sets described in the Waiver application http://www.hca.wa.gov/hw/Documents/waiverappl.pdf pages 46-47[iv].

  It is anticipated that this project will yield positive outcomes in all four of the behavioral health outcomes included as priority benchmarks by the State. The two primary SUD benchmarks, increased a*lcohol and drug treatment penetration and retention* are the primary focus of this project. The goal is to identify Medicaid individuals who are not in treatment and engage them in low barrier, medication first, treatment services. With the appropriate medication opiate cravings will be satisfied and people will be able to be retained in treatment rather than feel the need to abort treatment to use.

  It is also anticipated that the two mental health metrics will be positively impacted. In King County 1,688 people 16 or older who had open MH outpatient benefits anytime from 10/1/2014 through 9/30/2015 had an opioid abuse or dependence diagnosis that was reported. Therefore, stabilizing people in substance abuse treatment and identifying a possible undiagnosed mental health disorder will be able to *increase penetration*, while stabilization of behavioral health symptoms will stave off escalation of mental health acuity and *decrease hospitalizations.*

  Other outcome measure as previously mentioned are decreased use of safety net services (jail, ED, detox, etc.), decrease in medical complications associated with intravenous drug use, improved quality of life, decrease costs and decrease mortality. Process indicators include reduction in amount of time for treatment initiation; naloxone kits distributed; overdose reversals; Medical Director's engaged in prescribing suboxone.

- *If no specific benchmark performance data are currently available*, *what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*? N/A

[i] The Washington State Institute for Public Policy, http://www.wsipp.gov, has identified "evidence-based" policies that can lead to better outcomes; Behavioral health research reports developed by the Research and Data Administration are available at: https://www.dshs.wa.gov/bhsia/division-behavioral-health-and-recovery/decision-support-and-evaluation

[ii] Medicaid objectives as stated in GAO report 15-239, April 2015, http://www.gao.gov/products/GAO-15-239:

- Increase and strengthen coverage of low income individuals.
- Increase access to, stabilize, and strengthen provider networks available to serve Medicaid and low-income populations.
- Improve health outcomes for Medicaid and low-income populations.
- Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.
- Criteria established for specific demonstrations described through an informational bulletin or State Medicaid Director's Letter – available at: http://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html.

[iii] Transformation goals as stated in Washington's Medicaid Transformation waiver, http://www.hca.wa.gov/hw/Documents/waiverappl.pdf:

- Reduce avoidable use of intensive services and settings such as acute care hospitals, nursing facilities, psychiatric hospitals, traditional LTSS and jails.
- Improve population health, with a focus on prevention and management of diabetes, cardiovascular disease, pediatric obesity, smoking, mental illness, substance use disorders and oral health; that is coordinated and whole-person centered.
- Accelerate the transition to value-based payment, while ensuring that access to specialty and community services outside the Indian Health system are maintained for Washington's tribal members.
- Ensure that Medicaid per-capita cost growth is two percentage points below national trends.

[iv] This includes the statewide common measure set for tracking health care quality and cost across multi-payer public and private health delivery systems: http://www.hca.wa.gov/hw/Documents/pmcc_final_core_measure_set_approved_121714.pdf and the subset of 2016 Medicaid contract common performance metrics. It also includes priority measures for critical behavioral health and community support services recommended by the 5732/1519 Steering Committee and reported to the Legislature in "*Service Coordination Organizations – Accountability Measures Implementation Status*", (page 36) at: http://www.hca.wa.gov/documents_legislative/ServiceCoordinationOrgAccountability.pdf.