Senate Bill 419

Assessment

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WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

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Acknowledgments

West Virginia (WV) stakeholders contributed valuable feedback to the development of this report, including managed care organizations (MCOs), residential treatment centers (RTCs), and state agencies and associations. The West Virginia Department of Health and Human Resources Bureau for Medical Services (BMS) appreciates these stakeholders' time, candidness, and commitment to improving the delivery of substance use disorder (SUD) care services for all West Virginians.

Table 1. Participating Organizations and Entities

Participating Organizations and Entities	
Aetna Better Health of West Virginia	Logan Mingo Area Mental Health
Appalachian Behavioral Health Care	Lotus Recovery Center of Comfort
Ascension Recovery Services	Marshall Health (Project Hope)
Aurora Project Associates, LLC	Mountaineer Behavioral Health
BBC Rehab	Office of Drug Control Policy
Bureau for Medical Services	Ohio Valley Physicians Inc.
Bureau for Behavioral Health	Partnership of African American Churches
Bureau for Public Health	Prestera Center
Charleston Hospitals, Inc./ St. Francis Hospital-Addiction Healing Center	Southern Highlands Community Mental Health Center (CMHC)
Clean & Clear Advantage Recovery	St. Joseph Recovery Center, LLC
FMRS Health Systems, Inc.	Summit BHC West Virginia, LLC
Harmony Ridge Recovery Center, LLC	The Health Plan
Healthways, Inc.	UniCare of West Virginia
Hope Drug Rehabilitation LLC	United Summit Center
Hope for Tomorrow	Valley HealthCare System
Jacob's Ladder at Brookside Farm	West Virginia Behavioral Healthcare Providers Association
Lighthouse Recovery Center	West Virginia University (WVU) Medicine Center for Hope and Healing

Executive Summary

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Introduction

West Virginia (WV) is seeking to establish an innovative, quality-based health care delivery model to improve the long-term outcomes of individuals with a SUD. The West Virginia State Senate passed Senate Bill 419 (SB419)[1] in March 2022. SB419 requires the West Virginia Department of Health and Human Resources, Bureau for Medical Services (BMS) to develop a voluntary, robust[2] post-treatment planning program (the pilot program), promote the use of performance-based payments (PBPs), and evaluate the impact of post-discharge planning and the provision of wraparound services. To prepare for implementation of the pilot program, BMS must also establish an SB419 Advisory Committee; develop requirements and reporting for contracting with WV MCOs to support efforts to improve long-term SUD outcomes; and amend existing federal waiver(s), as needed; and seek approval from the Centers for Medicare & Medicaid Services (CMS).[3]

Assessment Purpose and Activities

BMS engaged Myers and Stauffer to assist with the following activities: 1) perform state and national research on the SUD landscape; 2) conduct stakeholder engagement activities, including the development of the SB419 Advisory Committee and surveys of RTCs to solicit feedback regarding the design, methodology, and implementation of requirements of SB419; and 3) analyze information collected—including West Virginia-specific and national research—to inform a final assessment illustrating next steps for the direction of the pilot program. Milliman, Inc. (Milliman), Myers and Stauffer's subcontracted partner, contributed valuable support in the formation of this assessment, primarily providing actuarial and fiscal impact inputs, and contributions to state-specific and national research related to reimbursement models.

Framework Provided by SB419: Status of SB419 Key Requirements

SB419 provides a framework for West Virginia to use in developing a pilot program to support individuals with SUD to have a successful and effective transition of care from the residential treatment setting to outpatient services and community supports. The current status of SB419 key requirements are provided in Table 2.

[1] https://www.wvlegislature.gov/Bill_Text_HTML/2022_SESSIONS/RS/bills/SB419%20SUB1%20ENR.pdf.
[2] SB419 states that pilot program participants shall, "Develop a robust post-treatment planning program, including, but not limited to, connecting the patient population to community-based supports, otherwise known as wraparound services, to include, but not be limited to, designation of a patient navigator to assist each discharged patient with linkage to medical, substance use, and psychological treatment services; assistance with job placement; weekly communication regarding status for up to three years; and assistance with housing and transportation."
[3] Ibid.

Table 2. Status of SB419 Key Requirements

Status of SB419 Key Requirements			
	Status	BMS Requirement	Progress to Date
↪	***In progress***	***Seek a waiver amendment(s).*** BMS is instructed to seek an amendment to an existing waiver(s) to incorporate programmatic changes resulting from SB419 and seek approval from CMS.	BMS consulted CMS to review SB419 and seek guidance on the federal authority available to support funding of the program. CMS determined the following: • no amendment to the current 1115 SUD waiver was required based on the initial legislation; however, alternative approaches recommended include: • a state directed payment approved under 1.) 42 C.F.R. § 438.6(c) pre-print form for the MCO contract or 2.) quality incentive arrangement. **Next Step**: BMS will continue to explore federal authority options during finalization of program design.
↪	***In progress***	***Enter into contracts with WV MCOs.*** BMS must enter into contracts with WV MCOs, where at a minimum, 15 percent of SUD residential treatment contracts for facilities providing SUD treatment services are paid based on performance-based measures.	There is a need for clarity on what the participation expectations are of the RTCs, WV MCOs, the State and other vested stakeholders for this requirement. **Next Step**: Additional discussions are planned as the State considers program methodology, reporting, governance and fiscal impact prior to initiating the pilot program.
↪	***In progress***	***Appoint a full-time BMS employee.*** BMS must hire an individual to support the Advisory Committee in determining best practices and refinement of the pilot program, actively monitor the SUD RTC compliance with reporting requirements, and provide oversight to contracts associated with the pilot program.	BMS is utilizing contracting staff to fulfill this obligation. **Next Step:** Contracted staff will continue to work on moving the pilot program forward. Example: Contractor is used to facilitate Advisory Committee meetings.
✓	***Complete***	***Operationalize the SB419 Advisory Committee.*** BMS must develop an Advisory Committee responsible for determining the best practices for refinement of the pilot program and establishing performance-based metrics for which payment in the program is based.	BMS has initiated the Advisory Committee who has begun meeting to fulfill their role as detailed in SB419. The Advisory Committee: ♦ Provided constructive feedback on the legislation including areas of potential difficulty such as long-term tracking of patients. ♦ Worked collaboratively to develop a new set of four nationally vetted quality measures as proposed alternatives to the current measures detailed in SB419. These four measures are proposed to be collected in Year 1 of the pilot program.
↪	***In progress***	***Report to the Legislative Oversight Commission on Health and Human Resources Accountability (LOCHHRA).*** BMS should conduct an actuarial analysis	**Next Step:** The actuarial analysis for program year 1 will be limited in scope and will focus on a baseline assessment of costs for the SUD

Status of SB419 Key Requirements			
		of the pilot program annually, submit a detailed report of overall performance of the pilot program, including any performance-based measures added in the fiscal year, and recommendations regarding effectiveness of the program to the LOCHHRA by January 15, 2023 and annually thereafter throughout the term of the pilot program.	population to allow an evaluation of the program impact in future years.
	Status	**RTC Requirement**	**Progress to Date**
↪	***In progress***	***Collect and report performance based measures.*** SB419 requires RTCs participating in the pilot program to collect and report on performance-based measures.	Stakeholder feedback has been collected through detailed surveys of RTC providers. RTC surveys revealed significant operational challenges in collecting and exchanging data. **Next Step**: Include information collected from stakeholder feedback in future discussions as the State considers program methodology, reporting, governance and fiscal impact prior to initiating the pilot program.
↪	***In progress***	***Develop a robust post-treatment planning program.*** SB419 also requires the RTCs to develop a robust post-treatment planning program, including connecting the patient population to community-based supports.	**Next Step:** Additional program planning and design must be finalized prior to initiating the pilot program.
↪	***In progress***	***Report performance based measures.*** The SUD residential treatment facility is required to report the performance-based metrics to the Office of Drug Control Policy (ODCP) on the first of every month over the course of the pilot program.	**Next Step:** Additional program planning and design must be finalized prior to initiating the pilot program.
	Status	**MCO Requirement**	**Progress to Date**
↪	***In progress***	***Enter into contracts with RTCs.*** BMS will enter into contracts with WV MCOs to provide services for the pilot program. WV MCOs then, at a minimum, will contract with 15 percent of SUD RTCs which will be paid based on performance-based measures.[4]	There is a need for clarity on what the participation expectations are of the RTCs, WV MCOs, the state and other vested stakeholders for this requirement. **Next Step**: Additional discussions are planned as the State considers program methodology, reporting, governance and fiscal impact prior to initiating the pilot program.
↪	***In progress***	***(Optional) Transfer risk to RTCs.*** For the three years of implementation of performance-based contracting, the WV MCO may transfer risk for the provision of services to the SUD RTC only to the limited extent necessary to implement a PBP methodology, such as a phased payment for services. The WV MCO may develop a	**Next Step:** Additional program planning and design must be finalized prior to initiating the pilot program.

[4] Ibid

Status of SB419 Key Requirements			
		shared savings methodology through which the participating SUD RTCs shall receive a defined share of any savings that result from improved performance.[5]	
✓	**Complete**	***Membership in advisory committee.*** WV MCOs are to participate as members of the SB419 Advisory Committee.	WV MCOs are members of the SB419 Advisory Committee.

Assessment Results

National Research

During interviews and Advisory Committee meetings, each WV MCO individually expressed having little to no experience in value-based payment (VBP) arrangements with behavioral health and SUD providers in West Virginia. Research was subsequently conducted by Myers and Stauffer and Milliman to present BMS with current strategies in use by other states as they implement similar SUD-focused programs. Key findings/observations from this research include the following:

- ***New York: Managed Care Contract Language***

  For New York, the use of financial incentives has proven successful in engaging Medicaid managed care plans in developing infrastructure, programs, and resources to promote high-quality care.[6] Incorporating financial incentives that tie payment directly to quality is an important approach to improving the quality of care, holds health plans accountable for the care they provide, and rewards those who invest in processes that improve care.[7] Greater detail on New York's approach can be found within this report.

- ***North Dakota: 1915i Program***

  North Dakota's 1915i program includes a care coordinator to perform assessments and reassessments and assist with linkages to services for an individual. This design appears to align with the robust post-treatment planning program sought by SB419 and may be an example for BMS to further explore for the pilot program design.

Stakeholder Engagement

BMS has initiated early involvement of key stakeholders in planning for the pilot program to ensure collection of detailed input and allow for transparency in the process of developing the program. As outlined in the following sections, with support and guidance from BMS, Myers and Stauffer engaged key stakeholders to inform this assessment.

[5] 2019 Quality Incentive Report: A Report on the Quality Incentive Program in New York State," New York State Department of Health, Retrieved from: 2019 NYS Quality Incentive Report.
[6] Ibid, pg. 9.
[7] Alternative Payment Model, APM Framework," Health Care Payment Learning & Action Network, Refreshed in 2017, Retrieved from: Alternative Payment Model (APM) Framework (hcp-lan.org).

SB419 Advisory Committee

SB419 requires the development of an Advisory Committee that is charged with various tasks to develop the pilot program, including development of performance-based measures on which payment in the pilot is based. Comprised of more than 20 respondents, the SB419 Advisory Committee is a multi-disciplinary committee initiated by BMS in May 2022. During the course of Advisory Committee meetings, they reviewed bill requirements including quality metrics as listed in SB419 and national research to develop proposed measures. Table 3 includes these four measures.

Table 3. SB419: Performance-Based Measures

#	Measure Title
1	Continuity of Care After Medically Managed Withdrawal from Alcohol and/or Drugs
2	Continuity of Care after Inpatient or Residential Treatment for SUD
3	SDOH Need Screening and Intervention
4	Follow Up After High-Intensity Care for SUD (FUI)

Residential Treatment Center Provider Surveys

BMS conducted two surveys of RTC providers to understand the technological capabilities, current health information exchange (HIE) efforts, and perceptions of SB419. Twenty-three of the 26 RTC providers in the State completed both surveys. Survey results aim to inform next steps for SB419, and will also serve as valuable data for future BMS initiatives. Key survey topics and associated results include:

- ***Pilot Program Participation***
  - Overwhelmingly, 93 percent of RTCs reported interest in participation in the pilot program.
  - RTCs indicated their top three challenges in the SB419 pilot program participation as administrative considerations (need to train and hire staff), difficulty contacting patients post-discharge, and reimbursement related concerns.
  - RTC surveys revealed significant operational challenges in collecting and exchanging data.
- ***Electronic Health Record (EHR) Adoption***
  - Approximately 19 percent of RTCs reported having no EHR technology or that they are in the process of EHR implementation.
  - Use of paper-based recordkeeping systems may result in delays in patient referrals to community-based supports and required monthly reporting.
- ***Exchanging Patient Data***
  - Nearly half of RTCs report barriers in exchanging patient data with other community providers to coordinate patient care. These barriers include, but are not limited to:
    - Concerns around patient consent and privacy.
    - Exchange of data with community providers that may lack methods to efficiently track services provided to patients (i.e., community-based supportive housing, transportation, or employment agencies).

- ***Difficulties in Contacting Patients Post-Discharge***
  - SB419 requires maintaining contact and communication with patients post-discharge at specified intervals (30 days, six months, one year, two years, and three years). All survey respondents reported increased difficulty in maintaining contact and communication with patients post-discharge in the later intervals.

WV MCO Interviews

BMS and Myers and Stauffer engaged the WV MCOs in one-on-one and group interviews to gain their insights on: 1) the areas of opportunity and potential limitations in the SB419 pilot program design; and 2) the operational requirements for SB419 implementation. The WV MCOs also provided supplementary feedback as members of the SB419 Advisory Committee. Key WV MCO feedback is as follows:

- **Pilot Program Design.** Primary WV MCO concerns regarding SB419 revolved around clarity of the design and methodology outlined in the bill, especially regarding payment structure. For example, one WV MCO suggested SB419 requires performance-based contracting, while others suggested the program must be structured as pay-for-reporting. WV MCOs raised concerns that providers may not voluntarily participate due to the vagueness of the performance-based measures required. WV MCOs also expressed concern the SB419 measures used to evaluate the program may have unintended consequences, such as selection by the RTCs of healthier patients for participation in the pilot program.
- **Measure Collection and Reporting.** The WV MCOs were unanimous in their suggestions to utilize standardized instruments for data collection and reporting. WV MCOs expressed a need for understanding data validation processes and procedures for data collection and reporting by the ODCP.

CMS Engagement

At BMS' request, BerryDunn, a contractor with the State of West Virginia, consulted with CMS to review the requirements of SB419 related to PBP design and provide direction on required federal authority. During these conversations in June and July 2022, CMS determined that no amendment to the current 1115 waiver is required per federal regulations; however, alternative approaches were likely more appropriate for BMS to pursue. At the State's request, CMS offered two options to consider for implementing VBPs in a minimum of 15 percent of SUD residential treatment facilities. At a high level:

- As the State's 1115 waiver has authority for SUD residential services, the State could submit a state-directed payment (SDP) pre-print, pursuant to 42 Code of Federal Regulations (CFR) § 438.6(c), for prior approval and include the payment arrangement in the contract. This authority provides states with the flexibility to implement delivery system and provider payment initiatives under MCO, prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) Medicaid managed care contracts.
- In the alternative, the State may structure the program as a WV MCO quality incentive or withhold the VBP arrangement. This approach would require an amendment to existing WV MCO contracts, as well as subsequent review and approval by CMS.

Actuarial and Fiscal Activities

A comprehensive evaluation of the requirements and provisions within SB419 found that the bill does not provide sufficient information or clarity around the pilot program methodology and approach to provide an estimated fiscal impact for services and associated administrative costs.

SB419 requires an actuarial report due to the Legislative Oversight Commission on Health and Human Resources Accountability by January 15, 2023. Given the pilot program has not yet started and the program design is not yet determined, such a report detailing those outcomes is premature. The actuarial analysis for Program Year (PY) 1 will focus on a baseline assessment of costs for the SUD population to allow an evaluation of the program impact in future years.

Recommendations

West Virginia is committed to building a sustainable health care delivery system for SUD treatment and recovery services. While SB419 is an important step forward for West Virginia, and BMS has made significant strides in initial program planning, the findings from Myers and Stauffer's assessment indicate there is more work ahead in program design to ensure successful program implementation.

Program Design

Further development of the pilot program is a multi-step process. The first stage for addressing the requirements of SB419 is developing a comprehensive design of the pilot program. Based on stakeholder feedback and the amount of work to be accomplished, Myers and Stauffer recommends the following:

- **Establish program governance.** The Advisory Committee is currently responsible for determining the best practices for and refinement of the pilot program, developing performance-based metrics, and evaluating the pilot annually to recommend necessary adjustments. While this committee is working diligently to complete its assigned objectives, many detailed foundational questions about the pilot program need to be addressed. Based on this finding, Myers and Stauffer recommends BMS create a project governance plan, modify the role of the Advisory Committee, and create workgroups at the direction of the Advisory Committee to focus on key areas including provider clinical workflows, reimbursement, and quality monitoring and oversight.
- **Expand stakeholder engagement activities.** The Advisory Committee noted the importance of expanding additional stakeholder groups to solicit feedback on program design once it is more fully planned out. Examples cited by the Advisory Committee of engagement to include:
  - **Outreach to Outpatient Providers.** Outpatient providers can provide valuable insights into how they can support key aspects of the pilot such as care coordination.
  - **Engagement of Members.** The committee suggested working with partnership with Medicaid members who have lived experience with SUD to solicit input on the program.
- **Define the program elements.** As BMS continues to develop the pilot program design, we recommend exploring pilot program components that are evidence-based and supported by promising practices in providing services to the SUD patient population. Also, additional consideration is needed for opportunities and challenges of design elements, including:
  - Participant roles and responsibilities.

- Care coordination activities.
- Data collection, reporting, and analysis of results.

Examples of materials to support upcoming Advisory Committee meetings can be found in *Appendix D: National Landscape Research*, and include, but are not limited to recommendations for BMS to consult with states such as California, New York, and North Dakota about the success of their SUD programs, related program design that contributed to that success, and any program outcomes.

- **Understand administrative and financial risk considerations.** As program design progresses, BMS will need to continually consider administrative and financial risks of decisions being made. Below are examples of information to consider:
  - Use of incentives when designing the processes for achieving an incentive payment must take into account several factors, including:
    - Potential for downside risk.
    - Timing of payments.
    - Setting benchmarks.
    - Unintended consequences such as cherry-picking of members, increased administrative burden leads to decrease in time spent with member, etc.
- **Consider federal authority requirements.** Often during program design processes, design elements are considered that require specific federal authority. While CMS has provided input on federal authority based on review of SB419 requirements, additional considerations may be needed as the more comprehensive program design is completed.
- **Consider fiscal impact.** When the proposed program design is finalized, we recommend BMS conduct a fiscal impact analysis.

Upon completion of these steps, the State, with support from its contractors, will finalize a draft pilot program design.

Program Implementation

Myers and Stauffer is defining program implementation as activities that occur after operations begin and members are in the process of being served by the pilot program. Carrying out the planning and goals of the pilot program through implementation includes the following steps that will be performed by BMS and/or their contractor(s):

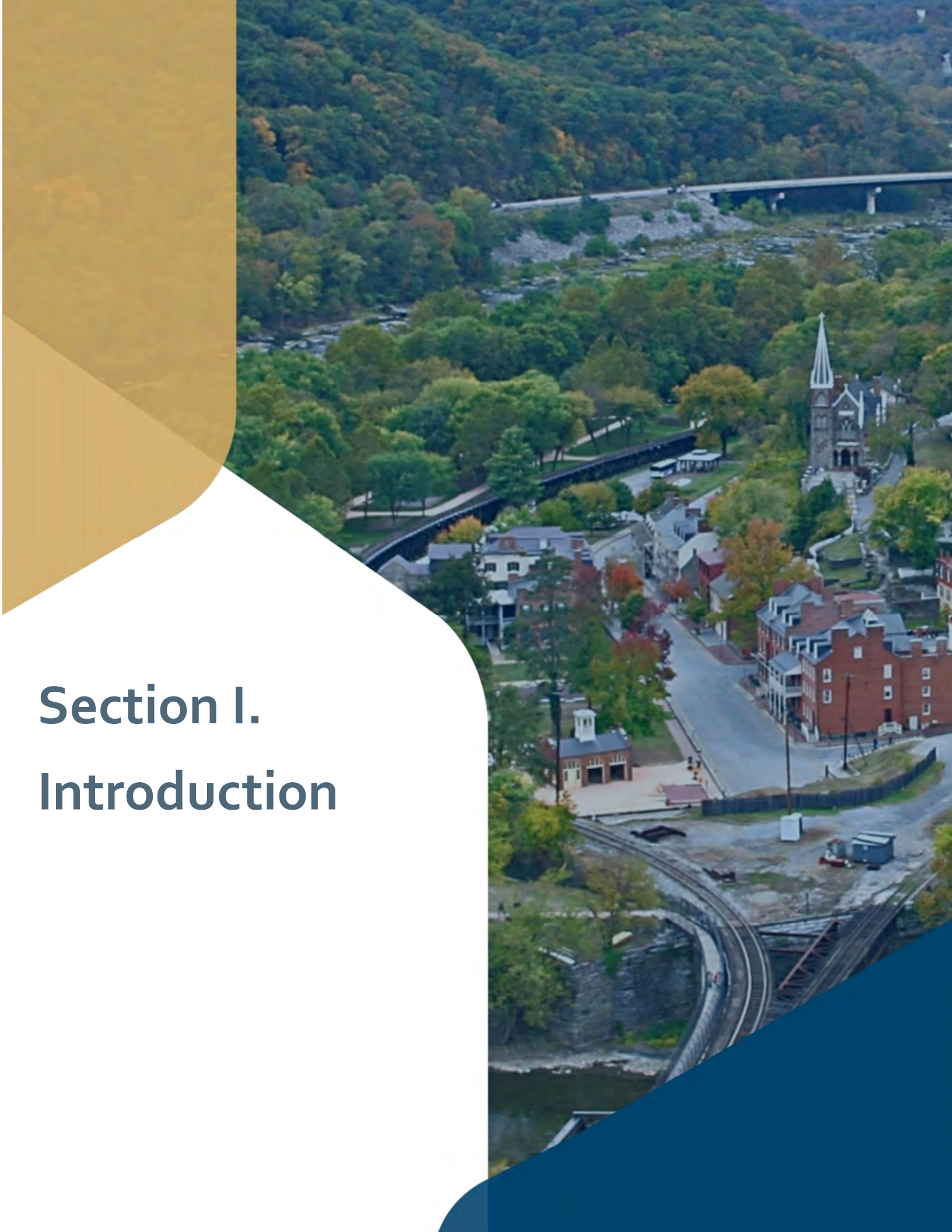
- **Assess the project plan.** Identify and prioritize the tasks that need to be completed. Ensure all stakeholders are aware of their respective roles and responsibilities during implementation.
- **Execute the plan.** Put the plan into action by identifying the pilot program population and working with participants to identify any issues with the program that may exist. Examples of activities to complete include drafting WV MCO contract amendments, obtaining any needed required federal authority, conduct provider trainings, etc.
- **Analyze program data.** The ongoing assessment of the pilot program is an iterative process, designed to inform stakeholders on program outcomes over the course of the program. Data

results will support evaluation of the pilot program. Available data for team members to analyze should include, at a minimum, outcomes-based, actuarial, and fiscal impact data.

- **Gather feedback.** Determine whether the implementation strategies were carried out as planned and if adequate resources were available to carry out the pilot program. Collect feedback from participants in the pilot program to understand early strengths and potential opportunities for improvement.
- **Make changes as needed.** Apply an evaluation-based decision-making model to collectively consider changes to relevant policies, provider education and training, and the payment model as needed. Key performance indicators and stakeholder feedback are just two examples of data collected when considering if changes to the pilot program are needed.

Conclusion

SB419 initiates a well-intended program; however, the pilot program as defined by SB419 presents challenges that must be addressed prior to successful implementation. BMS and stakeholders believe that a thoughtful, transparent process is necessary to develop a comprehensive program design that will have the potential to achieve success. Realization of true outcomes may require several years after program implementation to accomplish.



Section I.

Introduction

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Background

West Virginia has the highest rates of individuals with SUD in the nation.[8] In 2020, there were at least 1,275 confirmed overdose deaths in West Virginia,[9] which was the highest rate of drug overdose deaths per 100,000 population in the nation.[10] The State also faces challenges with a high prevalence of individuals who have multiple chronic conditions and frequent mental distress.[11] In addition, the coronavirus disease 2019 (COVID-19) pandemic impacted West Virginia communities and systems of care, adjusting the way people interact and how society functions.[12] While the situation is distressing, steady progress is underway in West Virginia, as evidenced by a decline in overdose deaths in Calendar Year (CY) 2021[13] for one of the first times in recent years.

West Virginia is seeking to establish an innovative, quality-based health care delivery model to improve the long-term outcomes of individuals with a SUD. In response to this epidemic, the West Virginia State Senate passed SB419[14] on March 7, 2022. SB419 requires the West Virginia Department of Health and Human Resources, BMS to develop a voluntary, robust[15] post-treatment planning program (the pilot program), promote the use of PBPs, and evaluate the impact of post-discharge planning and the provision of wraparound services. To prepare for implementation of the pilot program, BMS must also establish an SB419 Advisory Committee; develop requirements and reporting for contracting with WV MCOs to support efforts to improve long-term SUD outcomes; and amend existing waiver(s) as needed and seek approval from CMS.[16]

Framework Provided by SB419 to Impact SUD

The West Virginia Legislature created and passed SB419 to provide a framework for West Virginia to use in developing a pilot program to ensure individuals with SUD have successful and effective transitions of care from residential treatment to outpatient services and community supports. Below, we provide a brief overview of key pilot program requirements and responsibilities for BMS, the State's RTCs, and the WV MCOs as listed in SB419, as well as a summary table of current status of SB419 requirements to date.

[8] The Centers for Disease Control and Prevention (CDC) reports that in 2020, West Virginia had the highest drug overdose death rate in the country at 81.4 deaths per 100,000. Source: https://www.cdc.gov/nchs/pressroom/states/westvirginia/wv.htm.
[9] "West Virginia Experiences Increase in Overdose Deaths; Health Officials Emphasize resources," West Virginia Department of Health & Human Resources, Retrieved from: https://dhhr.wv.gov/News/2021/Pages/West-Virginia-Experiences-Increase-in-Overdose-Deaths;-Health-Officials-Emphasize-Resources.aspx.
[10] "West Virginia: Ranking Highlights," Commonwealth Fund 2022 Scorecard on State Health System Performance, Retrieved from: https://interactives.commonwealthfund.org/2022/state-scorecard/West_Virginia.pdf.
[11] https://www.americashealthrankings.org/learn/reports/2021-annual-report/state-summaries-west-virginia.
[12] https://www.commonwealthfund.org/publications/scorecard/2022/jun/2022-scorecard-state-health-system-performance.
[13] https://dhhr.wv.gov/News/2022/Pages/West-Virginia-Overdose-Deaths-Trending-Downward.aspx.
[14] https://www.wvlegislature.gov/Bill_Text_HTML/2022_SESSIONS/RS/bills/SB419%20SUB1%20ENR.pdf.
[15] SB419 states that pilot program participants shall, "Develop a robust post-treatment planning program, including, but not limited to, connecting the patient population to community-based supports, otherwise known as wraparound services, to include, but not be limited to, designation of a patient navigator to assist each discharged patient with linkage to medical, substance use, and psychological treatment services; assistance with job placement; weekly communication regarding status for up to three years; and assistance with housing and transportation."
[16] Ibid.

West Virginia Medicaid Agency

As the designated State entity responsible for the administration of the State's Medicaid program, BMS is responsible for providing access to appropriate health care for Medicaid-eligible West Virginians. BMS is charged with leading the efforts to execute the requirements of SB419, including the following activities required by the bill:

- **Seek a waiver amendment(s).** Within three months from the passage of SB419, BMS is instructed to seek an amendment to an existing waiver(s) to incorporate programmatic changes resulting from SB419 and seek approval from CMS.
- **Enter into contracts with WV MCOs.** Within 90 days of CMS approval of the amendment to an existing waiver(s), BMS must enter into contracts with WV MCOs, where at a minimum, 15 percent of SUD residential treatment contracts for facilities providing SUD treatment services are paid based on performance-based measures.
- **Appoint a full-time BMS employee.** BMS must hire an individual to support the Advisory Committee in determining best practices and refinement of the pilot program, actively monitor the SUD RTC compliance with reporting requirements, and provide oversight to contracts associated with the pilot program.
- **Operationalize the SB419 Advisory Committee.** BMS must develop an Advisory Committee responsible for determining the best practices for refinement of the pilot program and establishing performance-based metrics for which payment in the program is based. In addition, the Advisory Committee is tasked with the following:
  - Evaluating the pilot program annually for effectiveness.
  - Adjusting measures as indicated to improve quality outcomes.
  - Assessing the pilot program for continuation.

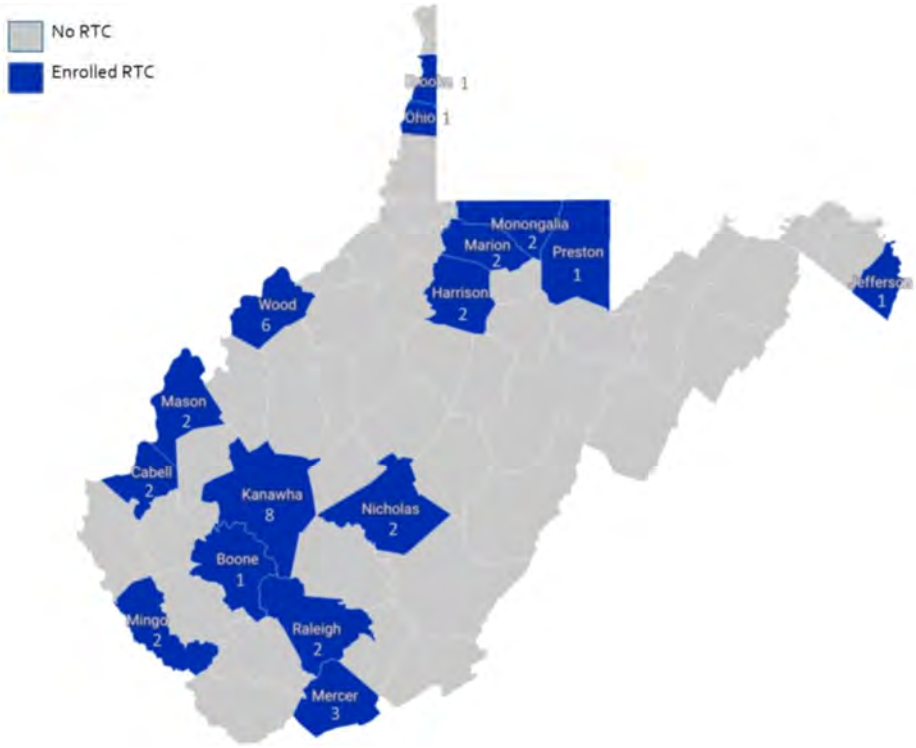
  Furthermore, BMS is tasked to define roles and responsibilities of the Advisory Committee, adhere to a cadence of meetings, and facilitate various strategies to gather Advisory Committee feedback regarding the development of performance-based measures.
- **Report to the Legislative Oversight Commission on Health and Human Resources Accountability (LOCHHRA).** BMS should conduct an actuarial analysis of the pilot program annually, submit a detailed report of overall performance of the pilot program, including any performance-based measures added in the fiscal year, and recommendations regarding effectiveness of the program to the LOCHHRA by January 15, 2023 and annually thereafter throughout the term of the pilot program.

Residential Treatment Centers in West Virginia

RTCs provide a wide range of residential adult substance use treatment services in a facility setting. West Virginia is home to 26 Medicaid-enrolled RTC providers.[17] *Figure 1* illustrates the number of unique RTC locations by county in the State.

[17] BMS Residential Adult Services Report, July 2022.

Figure 1: West Virginia Counties with Medicaid-Enrolled RTC Providers



SB419 requires RTCs participating in the pilot program to collect and report on the following performance-based measures:

- Whether the patient is drug-free 30 days post-discharge, six months post-discharge, one-year post-discharge, two years post-discharge, and three years post-discharge.
- Whether the patient is employed 30 days post-discharge, six months post-discharge, one-year post-discharge, two years post-discharge, and three years post-discharge.
- Whether patient has housing 30 days post-discharge, six months post-discharge, and one-year post discharge.
- Whether SUD residential treatment facility has arranged medical, substance use, psychological services, or other community-based supports for the patient and whether the patient attended, 30 days post-discharge, six months post-discharge, one year post-discharge, two years post-discharge, and three years post-discharge.
- Whether the patient has transportation 30 days post-discharge.
- Whether the patient has relapsed and needed any additional SUD treatment 30 days post-discharge, six months post-discharge, one year post-discharge, two years post-discharge, and three years post-discharge.

SB419 also requires the RTCs to develop a robust post-treatment planning program, including connecting the patient population to community-based supports. This post-treatment planning program includes hiring a patient navigator to assist each discharged patient with the following:

- Linkage to medical, substance use, and psychological treatment services.

- Assistance with job placement.
- Weekly communication regarding status for up to three years (post-discharge).
- Assistance with housing and transportation.

The SUD residential treatment facility is also required to report the performance-based metrics to the ODCP on the first of every month over the course of the pilot program.

Managed Care Organizations

BMS currently contracts with three managed care organizations to provide services to Medicaid members.[18] SB419 states WV MCO roles and responsibilities are as follows:

- **Enter into contracts with RTCs.** BMS will enter into contracts with WV MCOs to provide services for the pilot program. WV MCOs then, at a minimum, will contract with 15 percent of SUD RTCs which will be paid based on performance-based measures.[19]
- **Transfer risk to RTCs.** For the three years of implementation of performance-based contracting, the WV MCO may transfer risk for the provision of services to the SUD RTC only to the limited extent necessary to implement a PBP methodology, such as a phased payment for services. The WV MCO may develop a shared savings methodology through which the participating SUD RTCs shall receive a defined share of any savings that result from improved performance.[20]
- Participate as members of the SB419 Advisory Committee.

Table 4 provides a brief overview and current status of SB419 key pilot program requirements for BMS, the State's RTCs, and the WV MCOs.

Table 4. Status of SB419 Key Requirements

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Status		**BMS Requirement**	**Progress to Date**
↪	***In progress***	***Seek a waiver amendment(s).*** BMS is instructed to seek an amendment to an existing waiver(s) to incorporate programmatic changes resulting from SB419 and seek approval from CMS.	BMS consulted CMS to review SB419 and seek guidance on the federal authority available to support funding of the program. CMS determined the following: • no amendment to the current 1115 SUD waiver was required based on the initial legislation; however, alternative approaches recommended include: • a state directed payment approved under 1.) 42 C.F.R. § 438.6(c) pre-print form for the MCO contract or 2.) quality incentive arrangement.

[18] 'Managed care organization' is not defined in SB419.
[19] Ibid
[20] Ibid

Status of SB419 Key Requirements			
			Next Step: BMS will continue to explore federal authority options during finalization of program design.
↪	***In progress***	***Enter into contracts with WV MCOs.*** BMS must enter into contracts with WV MCOs, where at a minimum, 15 percent of SUD residential treatment contracts for facilities providing SUD treatment services are paid based on performance-based measures.	There is a need for clarity on what the participation expectations are of the RTCs, WV MCOs, the State and other vested stakeholders for this requirement. **Next Step**: Additional discussions are planned as the State considers program methodology, reporting, governance and fiscal impact prior to initiating the pilot program.
↪	***In progress***	***Appoint a full-time BMS employee.*** BMS must hire an individual to support the Advisory Committee in determining best practices and refinement of the pilot program, actively monitor the SUD RTC compliance with reporting requirements, and provide oversight to contracts associated with the pilot program.	BMS is utilizing contracting staff to fulfill this obligation. **Next Step:** Contracted staff will continue to work on moving the pilot program forward. Example: Contractor is used to facilitate Advisory Committee meetings.
✓	***Complete***	***Operationalize the SB419 Advisory Committee.*** BMS must develop an Advisory Committee responsible for determining the best practices for refinement of the pilot program and establishing performance-based metrics for which payment in the program is based.	BMS has initiated the Advisory Committee who has begun meeting to fulfill their role as detailed in SB419. The Advisory Committee: ♦ Provided constructive feedback on the legislation including areas of potential difficulty such as long-term tracking of patients. ♦ Worked collaboratively to develop a new set of four nationally vetted quality measures as proposed alternatives to the current measures detailed in SB419. These four measures are proposed to be collected in Year 1 of the pilot program.
↪	***In progress***	***Report to the Legislative Oversight Commission on Health and Human Resources Accountability (LOCHHRA).*** BMS should conduct an actuarial analysis of the pilot program annually, submit a detailed report of overall performance of the pilot program, including any performance-based measures added in the fiscal year, and recommendations regarding effectiveness of the program to the LOCHHRA by January 15, 2023 and annually thereafter throughout the term of the pilot program.	**Next Step:** The actuarial analysis for program year 1 will be limited in scope and will focus on a baseline assessment of costs for the SUD population to allow an evaluation of the program impact in future years.
	Status	**RTC Requirement**	**Progress to Date**
↪	***In progress***	***Collect and report performance based measures.*** SB419 requires RTCs participating in the pilot program to collect and report on performance-based measures.	Stakeholder feedback has been collected through detailed surveys of RTC providers. RTC surveys revealed significant operational challenges in collecting and exchanging data. **Next Step**: Include information collected from stakeholder feedback in future discussions as the

Status of SB419 Key Requirements			
			State considers program methodology, reporting, governance and fiscal impact prior to initiating the pilot program.
↪	***In progress***	***Develop a robust post-treatment planning program.*** SB419 also requires the RTCs to develop a robust post-treatment planning program, including connecting the patient population to community-based supports.	**Next Step:** Additional program planning and design must be finalized prior to initiating the pilot program.
↪	***In progress***	***Report performance based measures.*** The SUD residential treatment facility is required to report the performance-based metrics to the Office of Drug Control Policy (ODCP) on the first of every month over the course of the pilot program.	**Next Step:** Additional program planning and design must be finalized prior to initiating the pilot program.
	Status	**MCO Requirement**	**Progress to Date**
↪	***In progress***	***Enter into contracts with RTCs.*** BMS will enter into contracts with WV MCOs to provide services for the pilot program. WV MCOs then, at a minimum, will contract with 15 percent of SUD RTCs which will be paid based on performance-based measures.[21]	There is a need for clarity on what the participation expectations are of the RTCs, WV MCOs, the state and other vested stakeholders for this requirement. **Next Step**: Additional discussions are planned as the State considers program methodology, reporting, governance and fiscal impact prior to initiating the pilot program.
↪	***In progress***	***(Optional) Transfer risk to RTCs.*** For the three years of implementation of performance-based contracting, the WV MCO may transfer risk for the provision of services to the SUD RTC only to the limited extent necessary to implement a PBP methodology, such as a phased payment for services. The WV MCO may develop a shared savings methodology through which the participating SUD RTCs shall receive a defined share of any savings that result from improved performance.[22]	**Next Step:** Additional program planning and design must be finalized prior to initiating the pilot program.
✓	***Complete***	***Membership in advisory committee.*** WV MCOs are to participate as members of the SB419 Advisory Committee.	WV MCOs are members of the SB419 Advisory Committee.

Assessment Purpose and Activities

BMS engaged Myers and Stauffer to assist with the following activities: 1) perform state and national research on the SUD landscape; 2) conduct stakeholder engagement activities, including the development of the SB419 Advisory Committee and RTC surveys to solicit feedback regarding the design, methodology, and implementation of requirements of SB419; 3) analyze information collected

[21] Ibid

[22] 2019 Quality Incentive Report: A Report on the Quality Incentive Program in New York State," New York State Department of Health, Retrieved from: 2019 NYS Quality Incentive Report.

along with West Virginia-specific and national research to inform a final assessment illustrating next steps for the direction of the pilot program. Milliman, Myers and Stauffer's subcontracted partner, contributed valuable support in the formation of this assessment, namely providing actuarial and fiscal impact inputs, as well as contributions to state-specific and national research related to reimbursement models.

State-Specific and National Research

Myers and Stauffer and Milliman conducted state-specific and national research to inform our assessment of various requirements of SB419, including:

- Current quality measures used by states.
- Considerations for actuarial and financial impact analysis of the pilot program.
- Approaches and national trends for SUD treatment and recovery services, care coordination, and reimbursement.

Stakeholder Engagement Activities

BMS has initiated early involvement of key stakeholders in planning for the pilot program to ensure collection of detailed input and to allow for transparency in the process of developing the program. With support and guidance from BMS, Myers and Stauffer engaged key stakeholders to inform this assessment, including the SB419 Advisory Committee, RTCs, WV MCOs, and CMS.

RTC Provider Surveys

BMS conducted two surveys of RTC providers to understand the technological capabilities, current HIE efforts, and perceptions of SB419. Of the 26 RTC providers in the State, 23 completed both surveys. Survey results aim to inform next steps for SB419, and will also serve as valuable data for future BMS initiatives.

SB419 Advisory Committee

SB419 requires the development of an Advisory Committee that is charged with various tasks to develop the pilot program, including developing performance-based measures for which payment in the pilot is based. BMS initiated this multi-disciplinary committee of over 20 representatives in May 2022. The Advisory Committee met on a regular basis from May to September and provided constructive feedback on the legislation and expressed support for the intent of the pilot program.

The SB419 Advisory Committee worked collaboratively to:

- Review RTC provider survey results and feedback to support deployment of a second survey.
- Develop a new set of four nationally-vetted quality measures as proposed alternatives to the current measures detailed in SB419. These four measures are proposed to be collected in Year 1 of the pilot program.

Medicaid MCO Interviews

BMS and Myers and Stauffer engaged the WV MCOs in one-on-one and group interviews to gain their insights on: 1) the areas of opportunity and potential limitations in the SB419 pilot program design; and 2) the operational requirements for SB419 implementation. As members of the SB419 Advisory

Committee, the WV MCOs also provided supplementary feedback during committee meetings. WV MCOs were interested in ensuring key provisions of the bill, such as governance, reporting, and fiscal impact were thoroughly considered in the program design process prior to implementation.

CMS

BMS consulted CMS to review SB419 and seek guidance on the federal authorities available to support funding of the program and the potential need for waiver modifications. CMS determined no amendment to the current 1115 SUD waiver is required based on the initial legislation; however, alternative approaches in the form of an SDP pre-print for the MCO contract or quality incentive arrangement were recommended. BMS, in partnership with CMS, will revisit the applicability of federal authority options after finalization of program design.

Actuarial/ Fiscal Activities

The actuarial and fiscal impact activities included a careful examination of SB419 language and discussions with CMS in an attempt to determine SB419 estimated impact on services and administrative costs under the pilot program. Milliman aimed to perform an actuarial analysis of the pilot program.

Financial Assessment Activities

The monetary costs and associated collateral ramifications of SUDs are very high.[23] In CY 2021, West Virginia Medicaid data indicates that for the member population of adults aged 18 years or older, Medicaid-enrolled RTCs[24] treated 27,349 unique Medicaid members.[25] Total spending by the WV MCOs on SUD services in State Fiscal Year (SFY) 2021 was $92.9 million, with over five percent of all managed care members receiving at least one SUD service.

Total Cost of Care

The following information is presented to understand the total cost of care and the potential benefit of focused treatment to the member with SUD. Assuming SUD support will positively affect comorbidities, there is substantial opportunity for statewide benefits related to medical services for those with SUD needs.

The impact of a successful SUD program typically improves individuals' total utilization of health care services. To better understand the potential benefit of a focused treatment investment in individuals with SUD needs, it is important to understand the current spend for those with SUD needs.

Analysis of SFY 2021 managed care encounter data indicates that eight to nine percent of Medicaid adults statewide are receiving SUD services (5.4 percent of all members). The per member per month (PMPM) SUD costs for these members are over $300 PMPM. The non-SUD costs for these members are nearly three times those of members not in need of SUD services, at over $600 PMPM. Additionally, the

[23] "Substance Use Disorders," Medicaid.gov, Retrieved from: Substance Use Disorders | Medicaid.
[24] BMS RTCs are monitored by BMS through a weekly Residential Adult Services Report. Data from July 2022 was used to support this report.
[25] Totals include both FFS claims and Managed Care encounters and may be +/- 5% of actual expenditures based on completeness of the claims data.

southern region of the state[26]experiences the highest needs, where over 10 percent of adults are receiving SUD care.

Key managed care spending metrics for SUD and non-SUD services are shown in the tables below. Statewide data is presented in *Table 5* and individual region data is presented in *Table 6*, *Table 7*, and *Table 8*. Each table includes the percentage of members in the region receiving at least one SUD service through managed care in SFY 2021, along with the total managed care costs for SUD services in millions of dollars and per SUD-receiving member per month (PMPM). Additionally included is a comparison of PMPM non-SUD medical costs for both SUD users and non-SUD users. Note that the opioid treatment program services are provided fee-for-service (FFS) and are, therefore, not currently included in these totals.

Table 5. SUD Managed Care Spending, Statewide

Population	Members receiving SUD services	Total SUD Costs ($mil)	SUD PMPM (users)	Non-SUD PMPM (SUD users)	Non-SUD PMPM (non-users)
Expansion	9.7%	$ 72.8	$340.64	$586.99	$228.63
All Other Adults	8.1%	$ 19.0	$229.15	$635.22	$314.63
All Children	0.1%	$ 1.1	$447.84	$817.85	$138.69
Total	5.4%	$ 92.9	$310.58	$602.26	$203.74

Table 6. SUD Managed Care Spending, North Region

Population	Members receiving SUD services	Total SUD Costs ($mil)	SUD PMPM (users)	Non-SUD PMPM (SUD users)	Non-SUD PMPM (non-users)
Expansion	7.9%	$ 24.8	$405.59	$576.11	$237.60
All Other Adults	6.4%	$ 6.4	$280.71	$599.53	$314.85
All Children	0.1%	$ 0.4	$565.87	$998.72	$144.94
Total	4.4%	$ 31.6	$373.29	$586.39	$210.25

Table 7. SUD Managed Care Spending, East Region

Population	Members receiving SUD services	Total SUD Costs ($mil)	SUD PMPM (users)	Non-SUD PMPM (SUD users)	Non-SUD PMPM (non-users)
Expansion	7.5%	$ 7.0	$305.37	$512.98	$245.87
All Other Adults	7.2%	$ 2.0	$219.73	$567.04	$288.73
All Children	0.1%	$ 0.1	$302.27	$919.25	$123.43

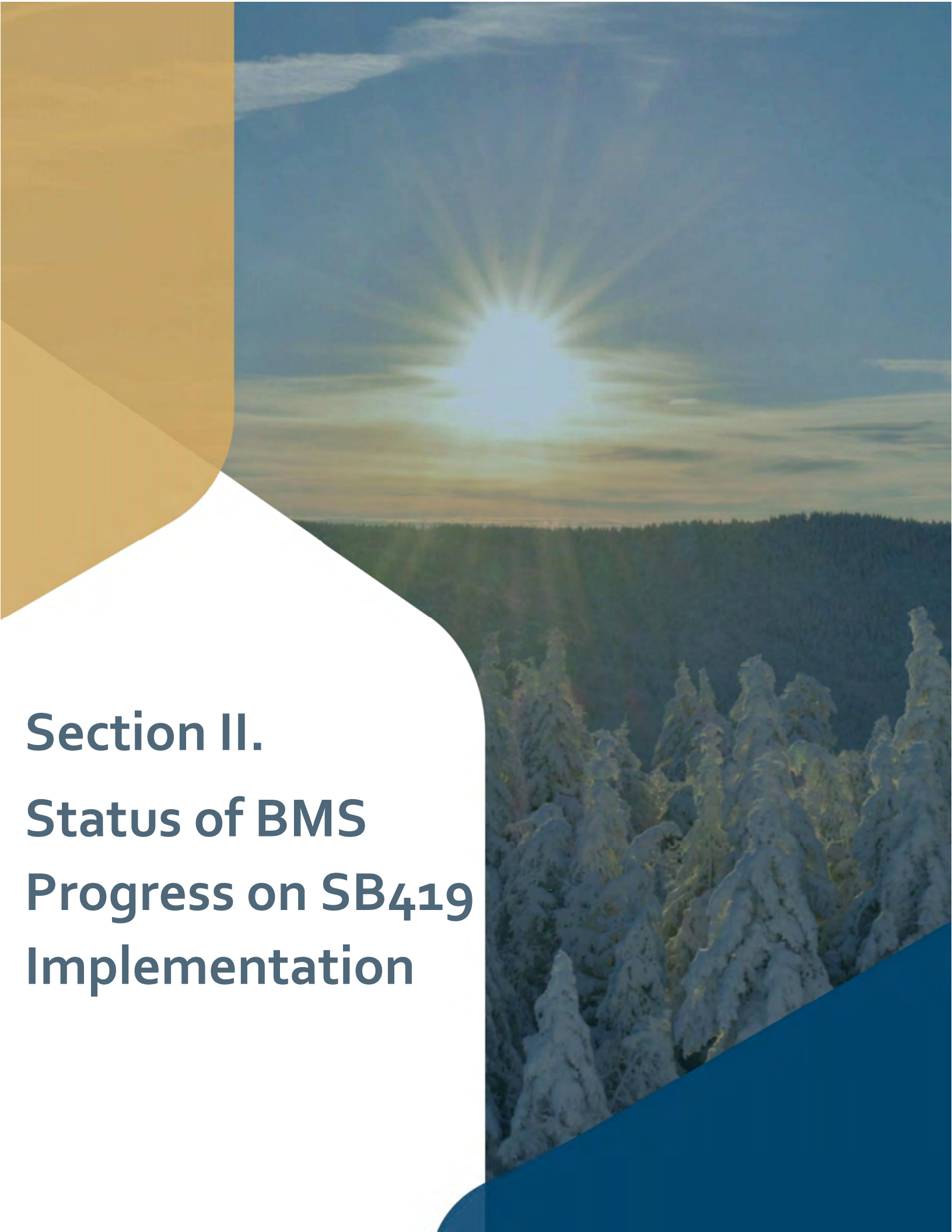
[26] Region definitions are based on those used to define geographic capitation rate differences.

Total	4.1%	$ 9.2	$280.84	$533.27	$193.50

Table 8. SUD Managed Care Spending, South Region

Population	Members receiving SUD services	Total SUD Costs ($mil)	SUD PMPM (users)	Non-SUD PMPM (SUD users)	Non-SUD PMPM (non-users)
Expansion	11.6%	$ 41.0	$316.32	$605.17	$216.89
All Other Adults	9.6%	$ 10.5	$207.57	$663.89	$321.18
All Children	0.1%	$ 0.5	$418.57	$673.39	$139.06
Total	6.6%	$ 52.1	$286.67	$622.04	$202.00

CY 2022 activities to address SB419 focused on gathering stakeholder feedback and refining a framework for pilot program planning and design. While additional program design and planning must be finalized prior to initiation of the pilot program, BMS has made extensive progress to date on SB419 activities. The goal of CY 2022 has been focused on learning more about requirements to create a successful and sustainable quality program, testing the receptivity of involved stakeholders, and, as part of this final assessment, proposing next steps to further refine program design.



Section II.

Status of BMS Progress on SB419 Implementation

Section II. Status of BMS Progress on SB419 Implementation

Myers and Stauffer conducted state-specific and national research, as well as extensive stakeholder engagement to inform our assessment and the development of an initial quality measure set for the pilot program. We also researched actuarial and financial impact analysis methodologies for the pilot program. Findings from this research are highlighted throughout this report. Additional information related to research and data sources utilized for this assessment are found in *Appendix D: National Landscape Research.*

Myers and Stauffer reviewed documentation to gain an understanding of the current SUD treatment landscape in West Virginia, including:

- **West Virginia Residential Adult Services (RAS) SUD Facility Reports.** These reports produced by BMS provide a comprehensive listing of Medicaid-approved RAS SUD facilities. Reports also include information on RAS SUD facilities by special populations, bed capacity by provider and county, and a list of pending RAS SUD facilities for Medicaid approval.
- **State of West Virginia Quality Information.** These included: West Virginia Managed Care Quality Strategy and the 2020 External Quality Review, Current Performance Improvement Project requirements, select health care effectiveness data and information set, consumer assessment of health care providers and systems, and CMS core measures for the West Virginia MCOs.

National Research

During interviews and Advisory Committee meetings, each MCO individually expressed having little to no experience in VBP arrangements with behavioral health and SUD providers in West Virginia. Research was subsequently conducted by Myers and Stauffer and Milliman to present BMS with strategies currently in use by other states as they implement similar SUD-focused programs. This multi-state research on approaches and national trends for SUD treatment and recovery services, care coordination, and reimbursement can be found in *Appendix D: National Landscape Research.*

Key findings from the research include the following state examples:

State Example: New York Quality Incentive for MCOs

New York emphasizes quality incentives for Medicaid managed care plans.[27] The quality measures included align with the measures selected for the State's VBP arrangements.[28] The use of financial incentives has proven successful in engaging Medicaid managed care plans in developing infrastructure, programs, and resources

[27] 2019 Quality Incentive Report: A Report on the Quality Incentive Program in New York State," New York State Department of Health, Retrieved from: 2019 NYS Quality Incentive Report.
[28] Ibid, pg. 9

to promote high-quality care.[29] Incorporating financial incentives that tie payment directly to quality is an important approach to improving the quality of care, holds health plans accountable for the care they provide, and rewards those who invest in processes that improve care.[30] In 2019, these were the seven behavioral health measures that the Medicaid program in New York focused on for managed care plans that may be replicable for West Virginia:[31]

- Adherence to antipsychotic medications for individuals with schizophrenia.
- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications.
- Follow-up after discharge from the emergency department for alcohol or other drug dependence.
- Follow-up after discharge from the emergency department for mental health.
- Follow-up after hospitalization for mental illness.
- Follow-up for children newly prescribed attention deficit hyperactivity disorder medication.
- Metabolic monitoring for children and adolescents on antipsychotics.

Overall, the managed care plans are assessed on their performance in each of these measurements. If the managed care plans want to receive more incentives, they will have to provide the best possible care for the measurements listed above.

State Example: North Dakota Section 1915(i): An Opportunity to Address Gaps in Care

The 1915(i) State Plan home and community-based services benefit can provide an array of services to a targeted group of individuals in their home and/or community setting. North Dakota may be an example of the specificity needed to create a pilot program that incorporates the vision of SB419. Inclusion of a care coordinator to perform assessments and reassessments and assist with linkages to services for an individual appears to be in alignment with the robust post-treatment planning program sought by SB419.

North Dakota's 1915(i)[32] application provides a multitude of services to individuals with either one or more of the following diagnoses: behavioral health condition, substance abuse disorder, or brain injury. Services can be provided to eligible individuals in their own residence, in provider-owned and controlled residential locations (sober living homes, group homes, foster homes, treatment foster homes, transitional living homes), nonresidential settings, and in the community at large. Services covered under this waiver include: care coordination, training and supports for unpaid caregivers, peer support, family peer support, respite, non-medical transportation, community transition services, benefits planning services, supported education, pre-vocational training, supported employment, and housing supports.

[29] Ibid, pg 9
[30] Ibid, pg 9

[32] https://www.behavioralhealth.nd.gov/sites/www/files/documents/1915i/ND%201915(i)%20Application.pdf

This program offers many services under the care coordination benefit. An individual may be assigned a care coordinator whose responsibilities include the following:

- Perform assessments and reassessments. Example of these activities include, but are not limited to:
  - Collecting information on the individual's data and history.
  - Addressing social determinants of health (SDOH) needs related to economic stability, education, health and health care, neighborhood and built environment,[33] and social and community context.
  - Evaluating with individual his or her overall safety and risk including suicide risk.
- Completion of a crisis assessment and plan.
- Assistance with linkage to services including making appointments for the individual.
- Development of an initial and ongoing person-centered plan of care in collaboration with the individual and the individual's authorized representative if appropriate.

Stakeholder Engagement Results and Accomplishments

Myers and Stauffer developed and implemented a multi-faceted approach to obtain feedback from vested stakeholders on SB419. The purpose of stakeholder engagement was to develop an understanding of stakeholder perceptions of SB419 and to support BMS in development of the pilot program.

With support and guidance from BMS, Myers and Stauffer engaged key stakeholders, including RTC providers, the SB419 Advisory Committee, and WV MCOs. In this section, we present observations and findings from stakeholder engagement activities occurring between May and September 2022.

RTC Survey Methodology

- BMS, in coordination with Myers and Stauffer, developed and conducted two surveys of West Virginia RTCs in June and July 2022. Myers and Stauffer developed the survey questions as a result of preliminary feedback from the SB419 Advisory Committee and BMS. Additionally, the West Virginia Association of Health Plans provided supplemental survey questions. Additional survey methodology can be found in *Appendix E: 2022 RTC Survey Methodology*. Survey findings can be found in *Appendix C*. Key aims of the RTC surveys were to:
  - **Gauge provider interest in participating in the pilot program.** BMS is interested in understanding if RTCs are willing to participate in the pilot program.
  - **Ascertain the ability of RTCs to collect performance-based measures through use of EHR technology.** A key aspect of pilot program success will be the ability to electronically collect and report quality measures. Adoption and utilization of EHRs is significantly less common among SUD versus other mental health treatment facilities.[34]

[33] The built environment includes all of the physical parts of where we live and work (e.g., homes, buildings, streets, open spaces, and infrastructure). Centers for Disease Control and Prevention: https://www.cdc.gov/nceh/publications/factsheets/impactofthebuiltenvironmentonhealth.pdf

[34] Stanislav Spivak, Eric C. Strain, Bernadette Cullen, An Anne E. Ruble, Denis G. Antoine, Ramin Mojtabai,

This survey aimed to understand the number of RTCs that do not have an EHR, are in the process of EHR implementation, or have implemented an EHR that is in use by the majority of staff.

- **Determine the ability of RTCs to connect patients to community-based supports.** SB419 involves the need to coordinate care for patients. The surveys aimed to determine RTC ability and anticipated barriers in connecting patients to community-based supports.
- **Gain insights from stakeholders on who is best positioned to collect and track patient data over a three-year time period.** SB419 requires the RTC to collect patient data for up to three years post-discharge. The survey inquired about the RTCs' ability to 1) collect and report the data; and 2) offer an opinion on the most appropriate party to collect patient data within the first year of the pilot program as well as subsequent years.

RTC Survey Results

Myers and Stauffer analyzed survey data to generate key statistics and identify overarching themes. Twenty-three of the 26 RTC providers in the State completed both surveys. Survey responses of the RTCs revealed significant technological and operational challenges in data collection and reporting. Key findings from the RTC survey are as follows in Table 9.

Table 9. 2022 RTC Survey – Key Findings

Survey Topic	Summary of Findings
Pilot Program Participation	♦ Ninety-three percent of RTCs reported interest in participation in the pilot program. ♦ RTCs indicated their top three challenges in SB419 pilot program participation to be administrative considerations (need to train and hire staff), difficulty contacting patient's post-discharge, and reimbursement-related concerns. ♦ RTC surveys revealed significant operational challenges in collecting and exchanging data.
EHR Adoption	♦ Approximately 19 percent of RTCs reported having no EHR technology or that they are in the process of EHR implementation. ♦ Use of paper-based recordkeeping systems may result in delays in patient referrals to community-based supports and required monthly reporting.
Exchanging Patient Data	♦ The majority of RTCs use facsimile transmission as a primary method of exchanging patient data. ♦ Nearly half of RTCs report barriers in exchanging patient data with other community providers to coordinate patient care. These barriers include, but are not limited to: concerns around patient consent and privacy, and exchanging data with community providers who may not have ways to efficiently track services provided to patients (i.e., community-based supportive housing, transportation, or employment agencies).

Electronic health record adoption among US substance use disorder and other mental health treatment facilities, Drug and Alcohol Dependence, Volume 220,2021.https://doi.org/10.1016/j.drugalcdep.2021.108515.

Survey Topic	Summary of Findings
SDOH	♦ These survey results illustrate that most RTCs are assessing for SDOH conditions and the need for future studies to explore how centers are incorporating SDOH data into the patient's treatment plan.
Difficulties in Contacting Patients Post-Discharge	♦ SB419 requires maintaining contact and communication with patients post-discharge at specified intervals (30 days, six months, one year, two years, and three years). All survey respondents reported maintaining contact and communication with patient's post-discharge increases in difficulty the greater the time period after discharge.
Post-Treatment Planning and Wraparound Services	♦ Robust post-treatment planning, including the ability to track patients for multiple years post-discharge, is difficult or sometimes not able to be achieved.
Responsible Parties to Collect SB419 Measures	♦ RTC providers indicated that they were the most ideal party to collect this data. ♦ RTCs require financial resources to support the hiring of a patient navigator and staff to collect and report measures. ♦ RTC providers note widespread behavioral health workforce shortages exist and are exacerbated by the COVID-19 pandemic.
Accessibility to Outpatient Programs	♦ All RTCs have access to outpatient programs, which will support participation in the pilot program.

This invaluable RTC feedback serves to support the development of the pilot program, as well as any West Virginia future RTC initiatives requiring electronic exchange of patient information and ability to coordinate care. An important next step will be to continue to engage the RTCs in the program design processes.

SB419 Advisory Committee

The SB419 Advisory Committee is a multi-disciplinary committee that BMS initiated in May 2022 and is comprised of over 20 representatives from the following organizations/entities:

- BMS
- Bureau for Behavioral Health
- UniCare Health Plan of West Virginia
- Behavioral Healthcare Provider's Association
- Aurora Project Associates
- Project Hope (Marshall Health)
- Thomas Hospital (WVU Medicine)
- ODCP
- Aetna Better Health of West Virginia
- The Health Plan of West Virginia
- Bureau for Public Health
- Prestera
- Project Hope (Marshall Health),
- Westover Project Associates

Representatives were either recommended for participation by BMS or specifically named in SB419 to participate.

Stakeholder Advisory Committee Feedback

The SB419 Advisory Committee met on a regular basis from May to September 2022. Myers and Stauffer facilitated discussions. During the course of Advisory Committee meetings, particular areas of focus for the committee were:

- Review the SB419 bill requirements and provide feedback for BMS review.
- Evaluate the measures listed in SB419 and propose nationally-vetted quality measures for possible inclusion in the pilot program. Facilitated discussions aimed to capture, discuss, and prioritize SUD-related measures to come to consensus on measures to propose for the pilot program. The proposed initial set of measures was approved by BMS.

Each of these focus areas of the committee is described in greater detail below.

Review SB419 Requirements

The Advisory Committee expressed early in the meetings the need to further understand the level of program participation required for various stakeholders, including the RTCs, WV MCOs, and the ODCP, among others. The Advisory Committee discussed the below select SB419 requirements and generated important questions and comments for consideration.

Table 10. Key Advisory Committee SB419 Feedback

SB419 Requirements and Key Advisory Committee Feedback
"Bureau of Medical Services shall enter into contracts with the MCOs wherein, at a minimum, 15 percent of substance use disorder residential treatment contracts for facilities providing substance use disorder treatment are paid based on performance-based measures."
• What happens if a WV MCO fails to obtain 15% of contracts for this voluntary program? Is there an associated service-level agreement? • Is the expectation that this be a withhold program for provider payments or is this an add-on payment program? If the latter, is there a billing code providers can use for meeting expectations? • *Recommendation from one of the WV MCOs:* Design and implement a program that provides differential increased reimbursement to SUD RTCs that obtain Commission on Accreditation of Rehabilitation Facilities (CARF) certification for ASAM levels of care. The CARF certification standards will require appropriate treatment, discharge planning, and aftercare monitoring of outcomes, engagement, and member satisfaction.
SB419 states that pilot program participants, "[include] the use of programs that are evidence-based, research-based and supported by promising practices, in providing services to patient population, including fidelity and quality assurance provisions."
• Will BMS provide examples of programs it has deemed "high fidelity" as a baseline by which the WV MCO should initiate discussions?
"The substance use disorder residential treatment facility shall develop a robust post-treatment planning program…"[35]

[35] SB419 states that pilot program participants shall, "Develop a robust post-treatment planning program, including, but not limited to, connecting the patient population to community-based supports, otherwise known as wraparound services, to include, but not be limited to, designation of a patient navigator to assist each discharged patient with linkage to medical, substance use, and psychological treatment

SB419 Requirements and Key Advisory Committee Feedback

- Given that the SUD RTC is responsible for employment of a "patient navigator," will the available rate per day be adjusted to allow enhanced payment to offset expenses of the navigator?
- Is it a requirement that all patients be contacted weekly for up to three years regardless of individual patient situations? For example, what if the patient has requested not to be contacted weekly—will the RTC provider be penalized?
- If/when the RTC provider links the patient to an outpatient center and/or primary care provider for additional needed services, is it the expectation that the RTC will still provide all the needed care coordination services?
- What happens if the RTC discharges a patient who later is admitted to another facility—which RTC is responsible for following the patient?

SB419 states that, "A MCO does not have an obligation to provide any of the information specified (measures A-F) regarding a patient if that patient ceases to be an enrolled member of that particular MCO."

- It is not clear how 'managed care organization' is defined in SB419. An example would be: is Mountain Health Promise membership required to participate?
- If the WV MCO remains obligated to pay for a member post-disenrollment, yet the RTC provider is meeting reporting requirements, are there issues with CFR Part 2 and exchange of protected health information (PHI) with an entity that is no longer responsible for member?

SB419 states that pilot program participants report on SB419 measures A-F (whether the patient is drug-free, has housing, or is employed) as well as measures determined to be appropriate by the Advisory Committee. Certain measures will be collected for a period of time up to three years.

- Is the expectation that the RTCs will follow participants for the entire three-year period or perform a warm hand-off after discharge to an outpatient behavioral health provider?
- How is asking if a patient has housing and employment assessing RTC performance? If the patient answers "No" to not having housing, is this considered not meeting the performance, and therefore, not payable?
- What are the negatives if the provider does not meet the measure benchmark? They would have to bring on more resources to operationalize the new contract requirements. If they do not get anything or a penalty, it would be a substantial cost to the RTC.
- Are RTC providers the most ideal party to collect patient data up to three years post-discharge?
- Once SB419 measures are reported, what is done with the data and how will the data be used?

services; assistance with job placement; weekly communication regarding status for up to three years; and assistance with housing and transportation."

Review and Propose SB419 Quality Measures

SB419 prescribes several performance-based measures.[36] RTC survey respondents were asked to define certain terms used in the SB419 measures, including substance-free, employed, housing, and transportation. The aim of this survey question was to allow RTCs the opportunity to review the terms, supply definitions currently used by RTC providers, and propose a method for collecting information or data related to the terms if not currently being collected. Survey results indicated a wide variability in the definition of SB419 measure terms, as well as multiple methods for collecting data related to the measures.

Preliminary survey results were presented to the Advisory Committee, which agreed that the SB419 measures, as written, are not measureable and may not be suitable to pursue. The committee agreed to explore alternate measures to implement for the pilot program.

Myers and Stauffer performed a comprehensive review of measures related to SUD and developed a draft set of 15 measures to present to the committee (*Appendix A*). To identify this measure set, Myers and Stauffer focused on the following:

- **Current measures collected in West Virginia.** Myers and Stauffer evaluated measures West Virginia currently collects to determine value in adding each measure as a performance indicator for SB419.
- **Claim-based measures.** Myers and Stauffer evaluated measures that can be developed by the State or WV MCOs based on claims data. Claims data can often be more easily available to the State than data extracted from EHRs and can provide valuable insights to the encounters individuals have across the health care continuum. Additionally, measure data available from claims can likely be reported by the WV MCOs, lessening the burden to the RTC providers. This may be appealing to RTCs that may be apprehensive to participate in the pilot program.
- **National Quality Forum (NQF)-endorsed measures.** The benefits of using measures that are endorsed by the NQF is that they have been reviewed against a series of rigorous criteria to ensure they address critical aspects of care, are practical to collect, provide reliable information, and can be used for quality improvement and decision-making.[37] We reviewed and identified NQF-endorsed measures that are applicable to the pilot program.
- **Medicaid adult core behavioral health measures.** The Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act legislation requires, starting in 2024, all State Medicaid programs annually report on the adult core behavioral health measures. As West Virginia will be required to report these measures in the near term, Myers and Stauffer reviewed them to determine if any would be applicable to include for the monitoring and evaluation of the pilot program.
- **Structural, process, outcome, and balancing measures.** The use of a variety of measure types (*Table 11*) for evaluation will better enable BMS to track how the pilot program has impacted

[36] Senate Bill 419," West Virginia Legislature, 2022 Regular Session, Passed March 7, 2022, retrieved from: SB419 SUB1 ENR.pdf (wvlegislature.gov).

[37] https://www.qualityforum.org/Field_Guide/NQF_Endorsement.aspx.

long-term patient outcomes. All the measures listed in SB419 are process-based, meaning they evaluate if a task is completed. While capturing and tracking this data is important, it is also important to understand overall outcomes. To this end, Myers and Stauffer reviewed structural, outcome, and balancing measures to include as proposed measures.

Table 11. Measure Types and Examples

Measure Types and Examples	
Structural	Structural measures assess the capacity, systems, and processes of a single provider, or a system of providers required to provide high-quality care. *Example: The capacity to use electronic medical records to monitor data*.
Process	Process measures review whether a particular action took place to maintain or improve health outcomes based on generally accepted clinical practice guidelines. *Example: The percentage of people receiving SUD services.*
Outcome	Outcome measures evaluate the quality or cost impact of a health care service or intervention. *Example: Increase in individual´s knowledge, skill, and confidence for managing their health and health care.*
Balancing	Balancing measures explore looking at the health care system from different directions or dimensions to ensure changes made in one area do not cause new problems in another.[38] *Example: Readmission rates comparing pre and post a length of stay reduction intervention*.

The selection of the initial SB419 pilot program proposed quality measure set was an iterative, highly collaborative process utilizing extensive stakeholder engagement.

The Advisory Committee determined a focus on outcome measures may be more appropriate for this pilot program than the process-oriented measures outlined in SB419. The committee voted on the 15 identified measures (*Appendix A*) and narrowed the measures to include four recommended measures for pilot program inclusion (*Table 12*). Proposed measures were discussed individually by the committee and required greater than 80 percent of Advisory Committee member votes for inclusion. In addition, the Advisory Committee requested an additional measure(s) in PY 2 be included to focus on connecting a patient with a primary care provider for health care screening and physical health services prior to discharge from residential care.

Table 12. Initial Proposed Measures for SB419 Pilot Program

#	Measure Title	NQF#	Measure Description
1	Continuity of Care After Medically Managed Withdrawal from Alcohol and/or Drugs	3312	Percentage of discharges from a medically managed withdrawal episode for adult Medicaid members, ages 18 to 64, who were followed by a treatment service for SUD (including the prescription or receipt of a medication to treat a SUD [pharmacotherapy]) within seven or 14 days after discharge.
2	Continuity of Care after Inpatient or Residential Treatment for SUD	3453	Percentage of discharges from inpatient or residential treatment for SUD for Medicaid members, ages 18 to 64, which were followed by a treatment service for SUD.

[38] Institute for Healthcare Improvement. Accessed on September 10 from https://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementEstablishingMeasures.aspx.

#	Measure Title	NQF#	Measure Description
3	SDOH Need Screening and Intervention	NA	Percentage of members who were screened, using pre-specified instruments, at least once during the measurement period for SDOH (unmet food, housing, and transportation needs, etc.) and received a corresponding intervention if they screened positive.
4	Follow Up After High-Intensity Care for SUD (FUI)	NA	Percentage of acute inpatient hospitalizations, residential treatment, or detoxification visits for a diagnosis of SUD among members 13 years of age and older that result in a follow-up visit or service for SUD. Two rates are reported: Rate #1: The percentage of visits or discharges for which the member received follow-up for SUD within the 30 days after the visit or discharge. Rate #2: The percentage of visits or discharges for which the member received follow-up for SUD within the seven days after the visit or discharge.

Identified next steps are as follows:

- There is acknowledgement that as the pilot program design is finalized, additional measures will be added, as needed, to the inventory to support comprehensive monitoring and oversight.
- The Advisory Committee needs to determine who will collect and report on the final measure set.

WV MCO Interviews

BMS and Myers and Stauffer engaged the WV MCOs in one-on-one and group interviews to gain their insights on: 1) the areas of opportunity and potential limitations in the SB419 pilot program design; and 2) the operational requirements for SB419 implementation. The WV MCOs also provided supplementary feedback as members of the SB419 Advisory Committee. WV Key MCO feedback is as follows:

- **Pilot Program Design.** Primary WV MCO concerns regarding SB419 revolved around clarity of the design and methodology outlined in the bill, especially regarding payment structure. For example, one WV MCO suggested the program requires performance-based contracting, while others suggested the program must be structured as pay-for-reporting.
- **RTC Participation.** WV MCOs raised concerns that providers may not voluntarily participate solely based on the vague performance-based measures required. WV MCOs discussed the SB419 measures may have unintended consequences such as selection by the RTCs of healthier patients for participation in the pilot program.
- **Measure Collection and Reporting.** The WV MCOs were unanimous in their suggestions to utilize standardized instruments for data collection and reporting. WV MCOs expressed a need for understanding data validation processes and procedures for data collection and reporting by the ODCP.
- **Interaction with Other Programs.** One WV MCO discussed the need for BMS and the Advisory Committee to determine how SB419 measure collection may interact with other models of care,

such as the Center of Excellence for Addiction Medicine model,[39] established by Marshall University.

- **Privacy and Confidentiality.** All WV MCOs noted challenges related to CFR Part 2 and exchange of PHI with entities that are no longer responsible for member care or tracking.

The identified step is as follows:

- The Advisory Committee should revisit WV MCO feedback as they work to develop next steps for program design and implementation.

CMS Engagement

At BMS' request, BerryDunn, a contractor with the State of West Virginia, consulted with CMS to review the requirements of SB419 related to PBP design and provide direction on required federal authority. During these conversations with CMS in June and July 2022, they determined that no amendment to the current 1115 waiver is required per federal regulations; however, alternative approaches were likely more appropriate for BMS to pursue. The CMS Division of Managed Care Policy indicated that CMS supports the State's quality improvement objectives related to the intentions of SB419.[40] At the State's request, CMS offered two options for consideration for implementing VBPs in a minimum of 15 percent of SUD residential treatment facilities. At a high level:

- If the State's 1115 waiver has authority for SUD residential services, the State could submit an SDP pre-print, pursuant to 42 CFR § 438.6(c), for prior approval and include the payment arrangement in the MCO contract. This authority provides States with the flexibility to implement delivery system and provider payment initiatives under Medicaid contracts with MCOs, PIHPs, or PAHPs.
- In the alternative, the State may structure the program as an MCO quality incentive or withhold VBP arrangement. This approach would require an amendment to existing MCO contracts, as well as subsequent review and approval by CMS.

Actuarial and Fiscal Activities

The actuarial and fiscal impact approach included a careful examination of SB419 language and discussions with CMS in an attempt to determine the estimated impact of SB419 on services and administrative costs under the pilot program. SB419 requires an actuarial report due to the LOCHHRA by January 15, 2023. Given the pilot has not yet started and the program design is not yet determined, such a report detailing those outcomes is premature. The actuarial analysis for PY 1 will focus on a baseline assessment of costs for the SUD population to allow an evaluation of the program impact in future years.

After comprehensive evaluation of the requirements and provisions within SB419, the bill does not provide sufficient information or clarity around the pilot program methodology and approach to provide an estimated fiscal impact for services and associated administrative costs. Estimating fiscal impact,

[39] https://www.marshall.edu/coefr/.
[40] CMS Division of Managed Care Policy. Guidance provided to West Virginia on June 14, 2022.

particularly the impact associated with capitation payments to the WV MCOs would require: 1) clearly defined performance-based metrics, targeted metric values, and measurement methods; and 2) applicable populations and services.

The full program design, including the information noted, would inform the additional costs of the program including incentives and required resources by the providers, as well as potential take-up rates for a voluntary program. Successful achievement of the performance metrics would inform potential related offsets, such as reduced medical expenses for members.

Additional considerations in determining the fiscal impact include:

- Near term and future impact for the multiple stakeholder groups including BMS, WV MCOs, and participating providers.
- Tolerance level and burden to WV MCOs and providers (e.g., ability to add new staff or possibility of technological upgrades within the confines of existing budgets).
- Financial resources required by RTCs to support hiring of a patient navigator and staff to collect and report measures.
- Payment reimbursement model impact (if any) on the capitation rates, including provider incentive payments.
- Attribution model design and potential effects on WV MCOs and providers.

In *Table 13* below, we have outlined the known activities and potential cost considerations.

Table 13. SB419 Key Activities and Potential Cost Considerations

Activity	Description	Cost Considerations
Hire full-time BMS employee	Will monitor the SUD residential treatment facility's compliance with required reporting, contracts executed under the SB, and support the Advisory Committee.	Our understanding is that this position is not yet hired.
Hire staff analyst (not addressed in SB 419)	Will support data analysis and reporting.	Our understanding is that this position is not yet hired. This position was recommended to help support analyses, but is not specifically authorized under SB419.
Research and analysis of SUD PBP program	♦ Clinical review of performance and outcome metrics. ♦ Analysis of best practices from other states/payers. ♦ Review of PBP methodology options.	This process is ongoing, but incomplete. Additional work may be required depending on additional legislative direction.
Development of SUD PBP Advisory Committee	♦ Support the configuration of the Advisory Committee and selection of participants. ♦ Development of the governance structure and charter. ♦ Onboarding of participants.	This process is ongoing, but incomplete. Additional work may be required depending on additional legislative direction.
Design SUD PBP	♦ Conduct stakeholder engagement. ♦ Selection of performance measures. ♦ Establish baseline for metrics selected.	This process is ongoing, but incomplete. Additional work may be required

Activity	Description	Cost Considerations
	♦ Assess system(s) to measure performance and appropriateness for implementing the SUD PBP program. ♦ Document program requirements, reporting, processes, etc.	depending on additional legislative direction.
Analyze impact to existing waiver	♦ Assess the alignment of the SUD PBP program with the existing waiver. ♦ Identify any risk to budget neutrality or assessment of the waiver's original intent. ♦ Identify areas of the existing waiver that are impacted and strategy to amend without jeopardizing the existing waiver or federal funds.	At this time, our understanding is that the existing waiver does not need to be amended. However, that may change given additional legislative direction.
Amend existing waiver	Necessary updates to the waiver to support SUD PBP.	At this time, our understanding is that the existing waiver does not need to be amended. However, that may change given additional legislative direction.
Support public transparency process	♦ Draft concept documents. ♦ Support public feedback/response period. ♦ Prepare summary of public input for CMS. ♦ Conduct all activities consistent with federal requirements.	This process is ongoing, but incomplete. Additional work may be required depending on additional legislative direction.
Assess impact on MCO rates and perform actuarial update to rates	♦ Require actuarial assessment, revision of rates, and other considerations.	The impact to rates should include at least the following considerations: ♦ Provider and MCO uptake (i.e., how many providers agree to VBP arrangements with each MCO). ♦ The scope of the arrangements (i.e., the size of the payment and the populations and services covered). ♦ The expected success rate of providers in achieving the benchmarks required to earn the payment. ♦ Expected savings attributable to better management of care achieved through the VBPs. Note that there may be additional costs or savings to BMS that are not covered under managed care. Pharmacy and opioid treatment prevention services, which are covered through FFS, may also be impacted by the SUD VBP program.
Amend MCO contract and negotiate MCO contract	♦ Draft MCO contract update language. ♦ Meet with WV MCOs and negotiate contract language, operational parameters, rates, etc.	The costs associated with MCO contract changes will depend on the recommended measures and the final requirements.

Activity	Description	Cost Considerations
amendment with WV MCOs and CMS	♦ Potential need to develop SDPs with CMS approval required.	
SUD VBP Implementation	♦ Develop provider education on rules of engagement, expectations, etc. ♦ Assess provider, MCO, and State readiness for go-live. ♦ Develop a template for SUD residential treatment facility monthly reporting on performance-based metrics for the ODCP. ♦ Provide technical assistance during implementation and post-implementation period.	The costs associated with implementation will depend on the recommended measures and the final requirements.
Conduct annual assessment and reporting (three assessments; one per year)	Develop annual report including actuarial and operational assessment if the program is meeting its intended outcomes, recommendations for course corrections, and supporting presentation of the report.	The costs associated with the annual report will depend on the recommended measures and the final requirements.

Section III. Recommendations for Pilot Program

Section III. Recommendations for Pilot Program Development

West Virginia is committed to building a sustainable health care delivery system for SUD treatment and recovery services. This is evidenced by West Virginia's efforts to maintain and expand its 1115 SUD waiver, add medication-assisted treatment to the State Plan in compliance with SUPPORT Act requirements, support ongoing work to design a certified community behavioral health clinic model of care, and recently the passage of SB419. While SB419 is an important step forward for West Virginia, the findings from Myers and Stauffer's assessment indicate there is more work ahead in program design to ensure successful program implementation.

In order to plan, implement, and evaluate an effective pilot program, BMS must have a solid foundation in place to guide its work. The Advisory Committee, with support from BMS, has made significant progress in moving the pilot program forward by analyzing and providing insights on many aspects of the bill, as well as selecting four measures to assess program outcomes. To continue to build on the Advisory Committee's progress, Myers and Stauffer provides the below recommendations for BMS to consider in its planning, implementation, and ongoing evaluation and monitoring for the pilot program. These recommended next steps are based on research of best practices and an understanding of the challenges and opportunities of SB419 as identified by stakeholders. These steps set a foundation for BMS to consider alternative methodologies to achieve the intention of SB419 which is better outcomes for individuals with SUD.

Program Design

Further development of the pilot program is a multi-step process. The first stage for addressing the requirements of SB419 is developing a comprehensive design of the pilot program. While BMS has initiated the Advisory Committee and other program design activities, Myers and Stauffer recommends a more detailed structure moving forward. The items presented below represent the needed future actions to create a shared vision which can provide direction and support of decision makers, identify key stakeholders to perform the activities required by the program, and establish parameters in which the stakeholders must work. Based on stakeholder feedback and the amount of work to be accomplished at hand, Myers and Stauffer recommends the following activities:

- **Establish Program Governance.** The Advisory Committee is currently responsible for determining the best practices for and refinement of the pilot program, developing performance-based metrics, and evaluating the pilot annually to recommend necessary adjustments. While this committee is working diligently to complete its assigned objectives, there are many detailed foundational questions about the pilot program that need to be addressed. Based on this finding, Myers and Stauffer recommends BMS create a project governance plan, modify the role of the Advisory Committee, and create workgroups to focus on key areas, including provider clinical workflows, reimbursement, and quality monitoring and oversight.
- **Create a Project Governance Plan.** The Project Governance Plan should act as the source document for the pilot program development process to document project team members' roles and responsibilities.

- **Program Management.** BMS is responsible for overall program management services including setting the agendas and creating work materials for the Advisory Committee meetings. BMS is also be responsible for producing the draft program design, and creating the project plan.
  - **Develop a project plan.** A project plan should be created by BMS to document and guide the design and implementation process including: objectives required to meet the identified priorities, detailed actions to address the objectives measures to track progress, stakeholders responsible for implementing the program steps, timeline/due dates for completion, creation of key performance indicators (such as quality measures) and potential challenges to completing the plan and how to address them.
- **Modify the Role for the SB419 Advisory Committee.** The Advisory Committee is currently the only working group supporting implementation of SB419. While this group has made gains, additional subject matter expertise is needed to support continued onward momentum. Moving forward, the role of the Advisory Committee should be focused on the following:
  - **Establish the program vision.** The vision statement must be meaningful and set a clear direction on what needs to be accomplished to achieve success. The vision should ideally describe what the State wants to achieve through the pilot program and serve as a point of reference for stakeholders.
  - **Identify goals.** Agreed-upon measureable goals should be created to support the work of assigned workgroups to further establish the objectives, specific strategies, and tactics with action steps.
  - **Develop program design.** The Advisory Committee should be responsible for all designing features of the program that are outside of the expertise of the proposed pilot program planning workgroups (discussed further below). The Advisory Committee would complete this work with support from the CMS contractor and engage stakeholders as needed.
  - **Provide oversight for the planning and implementation for the pilot program.** Responsibility for the global planning and implementation of the pilot program should fall to the Advisory Committee.
  - **Provide updates to executive leadership.** This committee should have decision-making authority for the pilot program and is responsible to make recommendations to BMS.
  - **Create pilot program planning workgroups.** Myers and Stauffer recommends, based on feedback from the Advisory Committee and further evaluation of SB419, creation of workgroups at the direction of the Advisory Committee to focus on key areas including provider clinical workflows, reimbursement, and quality monitoring and oversight. Workgroup recommendations will be presented to the Advisory Committee for review and approval.
- **Perform Stakeholder Engagement Activities.** Workgroups should build upon previous stakeholder engagement activities to further support the development of the pilot program. Stakeholder engagement must occur as the pilot program is further developed and at the direction of the advisory committee. Activities include:

- **Outreach to and include members and member advocates.** This stakeholder group can provide invaluable insights on pilot program design to be relevant to the culture of the members and their families. The Advisory Committee felt that when the program is more fully designed to solicit member input on the following:
  - What services would members like to receive?
  - Where would members like to receive treatment?
  - How would members like to access treatment? Is treatment available in the member's area?
  - What does culturally and linguistically competent treatment look like?
- **Outreach to and include outpatient SUD providers.** These providers have a wealth of knowledge and experience in the long-term management, including care coordination, of individuals with SUD. Consideration should be given to engaging these providers to share in best practices and lessons learned once a strong menu of program interventions have been proposed for further evaluation.
- **Expand outreach to the RTC provider community.** The Advisory Committee currently does not include all RTC providers such as representatives from small, medium, and large-sized facilities located in rural and urban regions. Thought should be given regarding how to appropriately engage this provider group moving forward. Potential avenues include, but may not be limited to, regular email communications, town hall discussions, committee membership, and additional surveys.
- **Assess provider participation willingness.** As indicated earlier within this report, outreach has been conducted with RTC providers to assess their willingness to participate in SB419. Further outreach will be conducted with SUD providers once program scope is clearly defined to assess for specific barriers to participation in the pilot program.

- **Define the Program Elements.** Further assess the current design of the pilot program to determine where there are opportunities and challenges including:
  - **Participant roles and responsibilities.** Stakeholder engagement efforts concluded that participant roles and responsibilities can be further clarified as part of program design. For example, determinations need to be made as to what entities (the RTC or MCO) would be responsible for measure collection and reporting.
  - **Care coordination activities.** Based on the current plan, RTCs assume all ownership in providing care coordination services. As this is not a current day-to-day responsibility for RTCs, further discussions by the workgroups must include:
    - Role for CMHCs and other behavioral health providers in the pilot.
    - Expectations for the level of services required to be offered. As care coordination services are the cornerstone of the pilot program, they must be concretely defined.

- **Review of SUD VBP strategies occurring within the national health care landscape.** BMS should explore including pilot program components that are evidence-based and supported by promising practices in providing services to the SUD patient population. Examples of materials to support upcoming Advisory Committee meetings can be found in *Appendix D: National Landscape Research*, which includes, but is not limited to recommendations, such as opportunities for BMS to consult with the states of California, New York, North Dakota and others to determine the success of their SUD programs and learn of any outcome available as a result of these efforts.
- **Understand administrative and financial risk considerations.** As program design progresses, BMS will need to continually consider administrative and financial risks of decisions being made.
    - **Use of incentives.** The roles and responsibilities of all invested stakeholders in the incentive payment process should be well-defined and understood. When designing the processes for achieving an incentive payment, workgroups must take into account several factors, including:
        - Potential for downside risk.
        - Timing of payments.
        - Setting benchmarks.
        - Unintended consequences such as cherry-picking of members, increased administrative burden leads to decrease in time spent with member, etc.
- **Data collection, reporting, and analysis of results.** Workgroups determine the appropriateness of who will be responsible to collect, report, and analyze data. In determining these roles, workgroups must be well-informed on each stakeholder's capacity to perform these tasks.
- **Consider federal authority requirements.** Often during program design processes, design elements are considered that require specific federal authority. While CMS has provided input on federal authority based on review of SB419 requirements, additional considerations may be needed as the more comprehensive program design is completed.
- **Consider fiscal impact(s).** Following completion of the program design, the reimbursement workgroup (with support from the State's contractor) should document and determine understood near-term and future impact for the multiple stakeholder groups including BMS, WV MCOs, and participating providers including:
    - Tolerance level and potential financial burden (hiring of a patient navigator and staff to collect and report measures) for providers.
    - Payment reimbursement model impact (if any) on capitation rates.
    - Attribution model design and potential effects on WV MCOs and providers.
- **Evaluation.** Planning for evaluation should be part of the design process by developing a framework that includes rigorous fidelity and quality assurance provisions.

Upon completion of these steps and once all feedback has been incorporated, the State, with support from its contractors, will finalize a draft pilot program design.

Program Implementation

For the purposes of this report, Myers and Stauffer is defining program implementation as activities that occur after operations begin and members are in the process of being served by the pilot program. Carrying out the planning and goals of the pilot program through implementation includes the following steps that will performed by BMS and/or their contractor(s). BMS will also ensure vested stakeholders are made aware of progress during program implementation.

- **Assess the project plan.** Identify and prioritize the tasks that need to be completed. Ensure all stakeholders are aware of their respective roles and responsibilities during implementation.
- **Execute the plan.** Put the plan into action by identifying the pilot program population and working with participants to identify any issues with the program that may exist.
- **Analyze program data.** The ongoing assessment of the pilot program is an iterative process, designed to inform stakeholders on program outcomes over the course of the program. Data results will support evaluation of the pilot program. Available data for team members to analyze should include, at a minimum, outcomes-based, actuarial, and fiscal impact data.
- **Gather feedback.** Determine whether the implementation strategies were carried out as planned, and if adequate resources were available to carry out the pilot program. Collect feedback from participants in the pilot program to understand where early strengths and opportunities lay.
- **Make changes as needed.** BMS will apply an evaluation-based decision-making model to collectively consider changes to relevant policies, provider education and training, and the payment model as needed. Key performance indicators and stakeholder feedback are just two examples of data collected when considering if changes to the pilot program are needed.

Section IV: Conclusion

Section IV: Conclusion

The SB419 final assessment may be used as a resource for West Virginia BMS in developing an understanding of RTC ability to collect and report on quality measures as the State works to make advancements in SUD community-based recovery supports. As detailed in this document, SB419 initiates a well-intended program; however, the pilot presents challenges that must be addressed prior to successful implementation. BMS and stakeholders believe that a thoughtful, transparent process is necessary to develop a comprehensive program design that will have the potential to achieve success. Realization of true outcomes may require several years after program implementation to accomplish.

Appendices

Appendices

Appendix A: Senate Bill 419 Advisory Committee Members

The Senate Bill (SB) 419 Advisory Committee is comprised of over 20 representatives from the Bureau for Medical Services (BMS), the Office of Drug Control Policy, the Bureau for Behavioral Health, Aetna Better Health of West Virginia, UniCare Health Plan of West Virginia, the Health Plan of West Virginia, the West Virginia Bureau for Public Health, West Virginia Behavioral Healthcare Providers Association, and several residential treatment center (RTC) provider organizations, including: Aurora Project Associates, Prestera, Project Hope (Marshall Health), St. Joseph Recovery Center, Thomas Hospital (West Virginia University [WVU] Medicine), and Westover Project Associates. Table 14 lists the organization and representative information.

Table 14. SB419 Advisory Committee Members

SB419 Advisory Committee Member		
Name	**Organization**	**Title**
Keith King, Chair	Bureau for Medical Services	Program Manager, 1115 Waiver
Cynthia Parsons	Bureau for Medical Services	Program Manager, Behavioral Health
Keli Mallory	Bureau for Medical Services	Grants Manager
Susan Hall	Bureau for Medical Services	Chief, Medicaid Managed Care
Designee: Anita Ferguson	Bureau for Medical Services	Operations Director, Medicaid Managed Care
Mandy Carpenter	Bureau for Medical Services	Chief Financial Officer
Dr. Matthew Christiansen	Office of Drug Control Policy (ODCP)	Director, Office of Drug Control Policy
David Didden	Bureau for Public Health	Medical Director of Overdose Prevention
Alex Alston	Bureau for Behavioral Health	Director, Behavioral Health Services
David Sanders	Bureau for Behavioral Health	State of WV Interstate Compact Coordinator Recovery Supports Advisor
Lora Dunn-Miller	MCO, Aetna Better Health of West Virginia	Behavioral Health Clinical Program Consultant
Designee: Todd White	MCO, Aetna Better Health of West Virginia	Chief Executive Officer
Sheila Kelly	MCO, The Health Plan	Clinical Psychologist
Designee: Jeff Wiseman	MCO, The Health Plan	Director, MHT Compliance and Outreach
Dr. Jorge Cortina	MCO, UniCare of West Virginia	Medical Director for Behavioral Health
Designee: Tanya Ford	MCO, UniCare of West Virginia	WV UM Manager
Mark Drennen	West Virginia Behavioral Healthcare Providers Association	Chief Executive Officer

SB419 Advisory Committee Member		
Name	**Organization**	**Title**
Designee: Joe Deegan	West Virginia Behavioral Healthcare Providers Association	President Elect; Business Development Liaison at Thomas Health
Beth Welsh	Project Hope (Marshall)	Associate Director of Operations, Division of Addiction Sciences Department of Family & Community Health
Amy Miller	Thomas Hospital	Director for Behavioral Health
Lisa Zappia	Prestera	President and CEO
Donna Meadows	St. Joseph Recovery Center	Chief Executive Officer
Designee: Jordan Granus	St. Joseph Recovery Center	Program Director
Kathryn Sullivan	Ascension, RS	Regional Director of Operations
Designee: Jason Batten	Ascension, RS	Regulatory Compliance Manager

Appendix B: Measurement Polling Results

The SB419 Advisory Committee was created to establish performance-based measures for which RTC payments are based in the pilot program. The Advisory Committee discussed many quality measures that may be applicable to the pilot program between May and September 2022. On September 1, 2022, the committee voted on 15 proposed measures indicated in Table 15.

Polling results in Table 15 include the 15 initial measures discussed by the committee for inclusion in Year 1 of the pilot program. For reference, the National Quality Forum[41] (NQF) number (if applicable) is provided, followed by a brief measure description, and the Advisory Committee member voting percentage. Highlighted in green are voting percentages greater than 80 percent. Highlighted in yellow are measures resulting in less than half of the voting members selecting the measure. Members selecting overwhelmingly no to measure inclusion are highlighted in red.

After deliberation during the September 8, 2022 Advisory Committee meeting, the committee selected four proposed measures to be collected in Year 1 of the pilot program. The final list of Year 1 pilot program proposed quality measures is presented on page 31.

Table 15. Proposed Quality Measures for Year 1 of the SB419 Pilot Program

#	Measure Title	NQF#	Measure Description	Percentage Voting Yes
1	Initiation and Engagement of Substance Use Disorder (SUD) Treatment (IET)	0004	This measure assesses the degree to which the organization initiates and engages members identified with a need for SUD services and the degree to which members initiate and continue treatment once the need has been identified.	81.82%
2	Follow-Up After Emergency Department (ED) Visit for Substance Use	3488	The percentage of ED visits for members 13 years of age and older with a principal diagnosis of SUD, who had a follow-up visit for SUD.	63.64%
3	Use of Pharmacotherapy for Opioid Use Disorder (OUD)	3400	The percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or dispensed a Food and Drug Administration (FDA)-approved medication for the disorder during the measure year.	72.73%
4	Depression Assessment with Patient Health Questionnaire (PHQ)-9/ PHQ – 9M	0712	Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during the four month measurement period. The PHQ-9 tool is a widely accepted, standardized tool that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress.	0.00%

[41] The National Quality Forum sets standards and endorses measures considered to be the highest standard for healthcare measurement in the United States. For additional information, visit: https://www.qualityforum.org/what_we_do.aspx.

#	Measure Title	NQF#	Measure Description	Percentage Voting Yes
5	Depression Remission at Six Months	0711	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score >9 who demonstrate remission at six months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly-diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at six months (+/- 30 days) are also included in the denominator.	27.27%
6	Depression Remission at 12 Months	0710e	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score >9 who demonstrate remission at 12 months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at 12 months (+/- 30 days) are also included in the denominator.	18.18%
7	Depression Response at Six Months – Progress Towards Remission	1884	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score >9 who demonstrate a response to treatment at six months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score.	45.45%
8	Depression Response at 12 Months – Progress Towards Remission	1885	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score >9 who demonstrate a response to treatment at 12 months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score.	54.55%
9	Gains in Patient Activation Measure (PAM)® Scores at 12 Months	2483	The PAM is a 10 or 13 item questionnaire that assesses an individual´s knowledge, skill, and confidence for managing their health and health care.	54.55%
10	Use of Opioids from Multiple Providers and At a High Dosage in Persons Without Cancer	2951	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose for 90 consecutive days or longer, AND who received opioid prescriptions from four or more prescribers AND four or more pharmacies.	45.45%

#	Measure Title	NQF#	Measure Description	Percentage Voting Yes
11	Continuity of Care After Medically-Managed Withdrawal from Alcohol and/or Drugs	3312	Percentage of discharges from a medically-managed withdrawal episode for adult Medicaid beneficiaries, ages 18 to 64, that were followed by a treatment service for SUD (including the prescription or receipt of a medication to treat a SUD [pharmacotherapy]) within seven to 14 days after discharge.	90.91%
12	Continuity of Care after Inpatient or Residential Treatment for SUD	3453	Percentage of discharges from inpatient or residential treatment for SUD for Medicaid beneficiaries, ages 18 to 64, which were followed by a treatment service for SUD.	81.82%
13	Depression Screening and Follow-Up for Adolescents and Adults	This measure is adapted from a provider-level measure developed by Quality Insights of Pennsylvania (NQF #0418, CMS2).	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.	64.64%
14	Social Determinants of Health (SDOH) Need Screening and Intervention	NA	The percentage of members who were screened, using pre-specified instruments, at least once during the measurement period for SDOH (unmet food, housing, and transportation needs etc.) and received a corresponding intervention if they screened positive.	90.91%
15	Follow Up After High-Intensity Care for SUD	NA	The percentage of acute inpatient hospitalizations, residential treatment, or detoxification visits for a diagnosis of SUD among members 13 years of age and older that result in a follow-up visit or service for SUD. Two rates are reported: Rate #1: The percentage of visits or discharges for which the member received follow-up for SUD within 30 days after the visit or discharge. Rate #2: The percentage of visits or discharges for which the member received follow-up for SUD within seven days after the visit or discharge.	90.91%

Appendix C: 2022 RTC Survey Results

BMS, in coordination with Myers and Stauffer, developed and conducted two surveys of West Virginia RTCs in June and July 2022 to gain an understanding of the capabilities of the RTCs to participate in the SB419 pilot program. A total of 23 out of 26 providers (88 percent) completed both the June and July RTC surveys.

Myers and Stauffer analyzed RTC survey data to generate key statistics and identify overarching themes. Eight key focus areas emerged as a result of the survey and are further detailed in the narrative below:

1. Electronic Health Record (EHR) Technology Adoption and Implementation.
2. Use of Health Information Exchange (HIE).
3. SDOH.
4. Difficulty in Contacting Patients Post-Discharge.
5. Post-Treatment Planning and Wraparound Services.
6. Responsible Parties to Collect SB419 Measures.
7. Accessibility to Outpatient Programs.
8. Pilot Program Participation.

The SB419 Advisory Committee also reviewed RTC survey results in an attempt to shape their understanding of RTC ability to collect and report on required quality measures. The Advisory Committee feedback is presented where applicable, in this Appendix.

This invaluable feedback from the RTCs provides insight into RTC ability to participate in the pilot program and serves as a foundation for the development of future RTC initiatives requiring electronic exchange of patient information and ability to coordinate care.

1. Electronic Health Record Technology Adoption and Implementation

A key aspect of pilot program success is the ability to electronically collect and report quality measures. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users. EHR systems are often built to go beyond standard clinical data and include a broader view of patient care, including but not limited to: billing, quality management, outcome reporting, and public health surveillance.[42] Though previous federal funding to adopt EHRs was available for certain provider types, the opportunity excluded most mental and behavioral health and other types of providers and treatment facilities from participating.[43] Data from 2021 shows that

RTC Perspective

"We don't have electronic records at this time. Possibly in the next year.

– *RTC Provider with two centers, ASAM 3.5 levels of care*

[42] *What is an electronic health record (EHR)?* HealthIT.gov. (2019, September 10). Retrieved July 26, 2022, from https://www.healthit.gov/faq/what-electronic-health-record-ehr.

[43] Medicaid and CHIP Payment Access Commission (MACPAC) June 2021 Report to Congress on Medicaid and CHIP, Chapter 4: Integrating Clinical Care through Greater Use of Electronic Health Records for Behavioral Health. Accessed on August 2, 2022. Retrieved from: https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-4-Integrating-Clinical-Care-through-Greater-Use-of-Electronic-Health-Records-for-Behavioral-Health.pdf.

adoption and utilization of EHRs is significantly less common among SUD versus other mental health treatment facilities.[44]

The RTC survey aimed to understand the number of RTCs that do not have an EHR, are in the process of EHR implementation, or have implemented an EHR that is in use by the majority of staff. RTC survey results indicate that of 23 RTC providers, 18 RTC providers have implemented an EHR and the technology is in use by the majority of staff. Conversely, five RTC providers, or 19 percent[45] do not have an EHR or are in the process of implementation (Table 15).These five RTC providers treated over 1,500 members in calendar year 2021, presumably with paper-based recordkeeping or other non-electronic recordkeeping systems.[46] RTCs located in rural counties are more likely to be in the process of EHR implementation or do not have plans to implement in the near future.

Table 16. RTCs with Limited Adoption of EHR Technology

RTCs with Limited Adoption of EHR Technology			
	RTC Provider	**Center Name and ASAM Level**	**EHR Status**
1	Appalachian Behavioral Health Care	Appalachian Behavioral Health Care – 3.5	EHR Implementation In Progress
2	BBC Rehab	BBC Rehab – 3.7	No EHR
	BBC Rehab	BBC Rehab – 3.5	No EHR
3	Healthways, Inc.	Miracles Happen Center – 3.5	EHR Implementation In Progress
4	Lighthouse Recovery Center	Serenity Pointe – 3.1	EHR Implementation In Progress
	Lighthouse Recovery Center	Serenity Pointe – 3.5	EHR Implementation In Progress
	Lighthouse Recovery Center	Serenity Pointe – 3.7	EHR Implementation In Progress
5	Logan Mingo Area Mental Health	Anchor Point Men's – 3.5	No EHR
	Logan Mingo Area Mental Health	Anchor Point Women's – 3.5	No EHR

The June 2022 RTC survey asked respondents to rank the top three barriers to EHR adoption and implementation. Among the 23 respondents, the top barriers were cost (48 percent), finding a suitable system (41 percent), and level of effort to implement and train staff (32 percent). Internet access (16 percent) and technology issues (11 percent) were also noted as barriers to EHR adoption, which is expected in a largely rural state.

[44] Stanislav Spivak, Eric C. Strain, Bernadette Cullen, An Anne E. Ruble, Denis G. Antoine, Ramin Mojtabai. Electronic health record adoption among US substance use disorder and other mental health treatment facilities, Drug and Alcohol Dependence, Volume 220,2021.https://doi.org/10.1016/j.drugalcdep.2021.108515.

[45] Survey results indicate N=5 RTC providers representing multiple ASAM level of care either in the same physical location or multiple physical locations.

[46] Totals include both FFS claims and Managed Care encounters and may be +/- 5% of actual expenditures based on completeness of the claims data in CY2021.

Key Takeaway – EHR Adoption

- The five providers that report no EHR or are in the process of EHR implementation will experience difficulty in measurement collection and reporting using paper-based or other non-electronic recordkeeping systems.

2. Use of Health Information Exchange

June 2022 RTC provider survey results indicate opportunities to encourage use of HIE(s) among RTC providers to support finding, sending, receiving, and integrating information relevant to a patient's health.

The primary method of RTC patient health data exchange is overwhelmingly facsimile transmission (76 percent), followed by secure email (24 percent). RTCs in rural counties reported use of secure email rather than facsimile transmission or other methods. This survey question featured other methods for exchanging patient health data, including West Virginia Health Information Network, phone call, or other; however, none of these options were selected by respondents.

Respondents were asked to identify the top three challenges related to exchanging patient data. Among the 23 RTC providers, the top three barriers were as follows:

- **Managing consent and privacy concerns (63 percent).** Managing the privacy of health information and patient consent in sharing of health information is a challenge, especially for behavioral health providers due to 42 Code of Federal Regulations part 2, which serves to protect patient records created by federally-assisted programs for the treatment of SUD. While Part 2 has been revised[47] to facilitate care coordination in response to the opioid epidemic, the rule continues to restrict the disclosure of SUD treatment records without patient consent.[48]
- **Providers that RTCs refers patients to, or receive patients from, do not use electronic data sharing (46 percent).** This is a critical area to address as one of the greatest impediments to sustained recovery for patients is that various programs and treatment settings operate in isolation from one other with limitations in referrals and/or requisite information sharing with other key parties.[49]
- **Time and effort (35 percent).** It takes a greater amount of time to prepare facsimile transmissions when exchanging patient records. RTCs stated time and effort as a barrier to exchanging patient data.

Notably, 19 percent of respondents indicated no barriers in exchanging patient data, half of which do not have an EHR or are in the process of EHR implementation. This may speak to the need for increased provider education and awareness of HIE services available in West Virginia.

[47] SAMSHA Substance Abuse Confidentiality Regulations. Accessed on August 8, 2022. Retrieved from: https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs.
[48] SAMSHA 42 CFR Part 2 Revised Rule Fact Sheet. Accessed on August 4, 2022. Retrieved from: https://www.samhsa.gov/newsroom/press-announcements/202007131330.
[49] A. McLellan, D. Carise and H. Kleber, "Can the national addiction treatment infrastructure support the public's demand for quality care?," Journal of Substance Abuse Treatment, vol. 25, pp 117-121, 2003.

Key Takeaway – HIE:

- SB419 involves the need to coordinate care for patients. As 74 percent of RTCs use facsimile transmission as a primary method of exchanging patient data and 46 percent of RTCs reported barriers in exchanging patient data with other providers to coordinate patient care, RTCs may face difficulty with coordination. Use of non-electronic care coordination tools (such as fax or referrals made by phone call), are not the most efficient methods available for tracking patient information.

3. Social Determinants of Health

SDOH is defined as the conditions in the places where people live, learn, work, and plan that affect a wide range of health and quality of life risks and outcomes.[50] Examples of SDOH include but are not limited to: economic stability, education, health and health care, neighborhood and environment, and social and community context. Collection and use of SDOH data can help health care and social service providers maximize the effectiveness of interventions to support individual health. SB419 pilot program participation will require RTCs to track SDOH-related data for their patient population after patient discharge.

SB419 measures involve RTC communication with a variety of community-based organizations to support non-medical factors that influence patient health outcomes. The RTC survey inquired whether or not RTCs assess patients for issues related to SDOH. Among RTC providers, 87 percent assess patients for issues related to SDOH. Among providers conducting SDOH assessments, nearly half are either paper-based or use a combination of paper and electronic methods.

Respondents were asked how the RTC currently refers patients to community-based organizations or other external organizations to help address identified SDOH needs. The following were identified by RTCs as top referral organizations to assist patients with SDOH needs:

- Help for West Virginia (988) (48 percent).
- 211 directory (13 percent).
- Phone calls to other referral organizations (13 percent).

Once a referral is made, providers can utilize a closed-loop referral system (CLRS) to electronically refer patients and send patient information to community-based organizations that can help serve a client's needs that fall outside of the clinical workflow. CLRS in West Virginia mentioned by survey respondents include the UniteUs platform, although others also exist. The CLRS allows the referral sending organization (in this case the RTC) to determine what happened to the patient after referral. Among RTCs, 13 percent of respondents use a CLRS. This is a salient point as the inability to refer patients electronically and close the loop on whether or not a patient received care from a community-based

[50] Centers for Disease Control and Prevention. Social Determinants of Health: Know What Affects Health. Accessed on August 3, 2022. Retrieved from: https://www.cdc.gov/socialdeterminants/index.htm

organization is a significant challenge for pilot program participation. SB419 measure D[51] specifically requires RTCs to track whether the RTC has arranged and whether the patient received care from other community-based supports.

Respondents were additionally asked to select the most significant challenges and/or barriers to providing referrals to community-based organizations or other external organizations to address SDOH needs. The top barriers in referring patients to organizations for SDOH needs are as follows:

- Limited organizations to refer patients for help with SDOH issues (53 percent).
- Inability to close the loop with organizations to which the RTC refers patients (the RTC make a referral, but do not hear back if the patient used the service) (31 percent).
- Lack of awareness of local referral resources for specific social challenges (20 percent).

Key Takeaways – SDOH

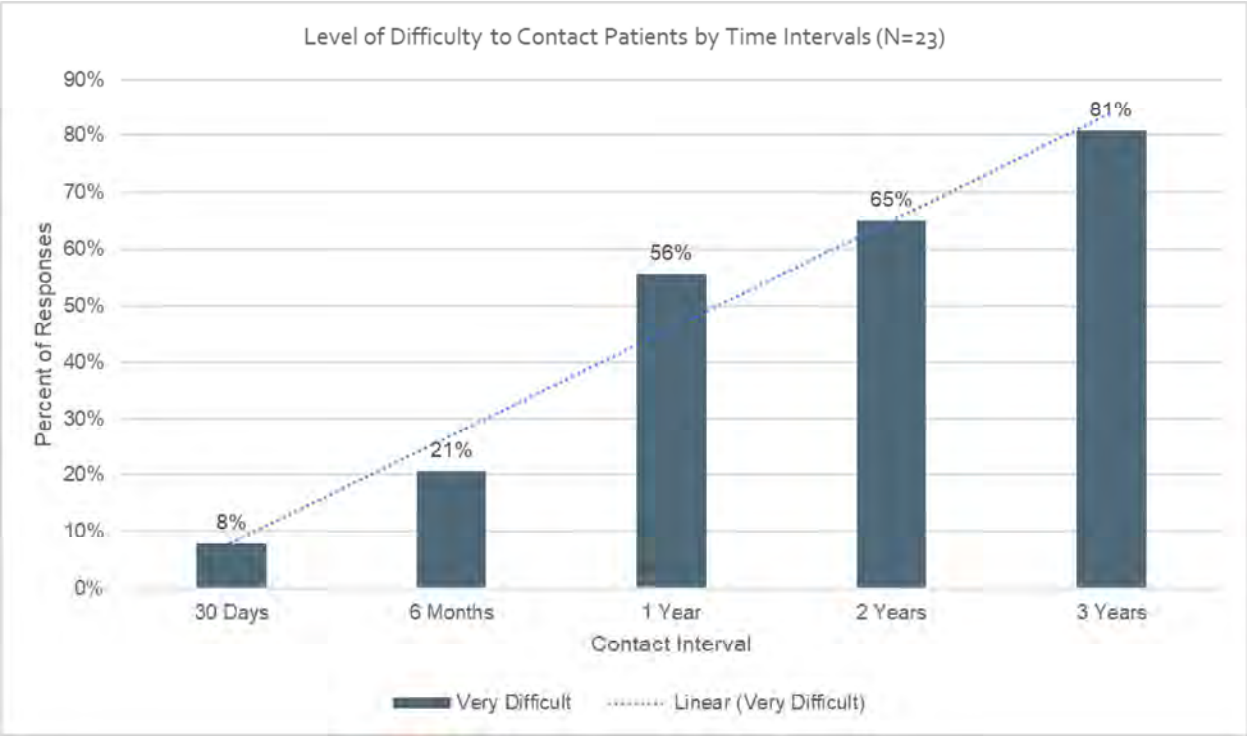
- Eighty-seven percent of RTCs assess patients for issues related to SDOH. However, nearly half of the assessments are either paper-based or a combination of paper and electronic methods.
- Only 13 percent of respondents reported use of a CLRS to coordinate care with community-based providers.
- These survey results illustrate that most RTCs are assessing for SDOH conditions and the need for future studies to explore how centers are incorporating SDOH data into the patient's treatment plan.

4. Difficulty in Contacting Patients Post-Discharge

SB419 outlines specific timeframes for RTCs to follow up with patients over the course of a three-year period. Timeframes include 30 days, one year, two years, and three years post-discharge. All respondents (N=23) reported maintaining contact and communication with patients post-discharge increases in difficulty the greater the time period (Figure 2).

[51] SB419 Measure D: "Whether the substance use disorder residential treatment facility has arranged medical, substance use, psychological services or other community-based supports for the patient and whether the patient attended, 30 days post discharge, six months post-discharge, one-year post discharge, two years post-discharge and three years post-discharge."

Figure 2. Level of Difficulty to Contact Patients by Time Intervals (N=23)



Anecdotal evidence from one RTC suggests an approximate 20 percent contact rate when conducting 90-day follow-up calls with patients post-discharge. Another RTC suggested use of social media to stay in communication with patients post-discharge and provided the caveat that the greater the length of time after discharge the more unlikely it is to maintain communication. Additionally, Advisory Committee members supported survey findings that suggest the ability to contact patients post-discharge is challenging.

Key Takeaway – Difficulties in Contacting Patients Post-Discharge

- RTC providers reported that maintaining contact and communication with patients post-discharge increases in difficulty the greater the time period. Meeting the required timeframes in SB419 will be challenging.

STAKEHOLDER PERSPECTIVE

Regarding SB419 timeline for contacting patients post-discharge:

"Anything beyond about 30 days is extremely difficult with a largely transient population and unless there is a shared database at the state level, this is a largely impossible task."

– *Advisory Committee Member and RTC Provider (ASAM levels of care 3.1 and 3.5)*

5. Post-Treatment Planning and Wraparound Services

SB419 states the pilot program will evaluate the impact that post-discharge planning and the provision of wraparound services, otherwise known as community-based supports, has on SUD outcomes in three years post-SUD residential treatment. The bill further states that the RTC will develop a robust post-treatment planning program, including, but not limited to, connecting the patient population to community-based supports to include, but not be limited to, designation of a patient navigator to assist

each discharged patient with linkage to medical, substance use, and psychological treatment services; assistance with job placement; weekly communication regarding status for up to three years; and assistance with housing and transportation.

The July 2022 RTC survey respondents were asked to identify the level of difficulty (via a rating scale of very easy, easy, neutral, difficult, or very difficult) in providing components of a robust post-treatment planning program as outlined in SB419. Results indicate that RTCs would have the greatest difficulty in achieving the following:

- Hiring a patient navigator (26 percent).
- Assistance with job placement (13 percent).
- Assistance with transportation (nine percent).

Additionally, 69 percent of respondents find discharging a patient with linkage to outpatient medical, substance use, and psychological treatment services to be very easy (17 percent) or easy (52 percent). Advisory Committee feedback contradicted these findings, suggesting that ease in linking a patient to outpatient medical, substance use, and psychological treatment services is related to the geographic area where the RTC provides services. In the event that RTCs discharge patients to areas of the State not geographically close to the RTC location, this linkage becomes more difficult.

Key Takeaway – Post-Treatment Planning and Wraparound Services

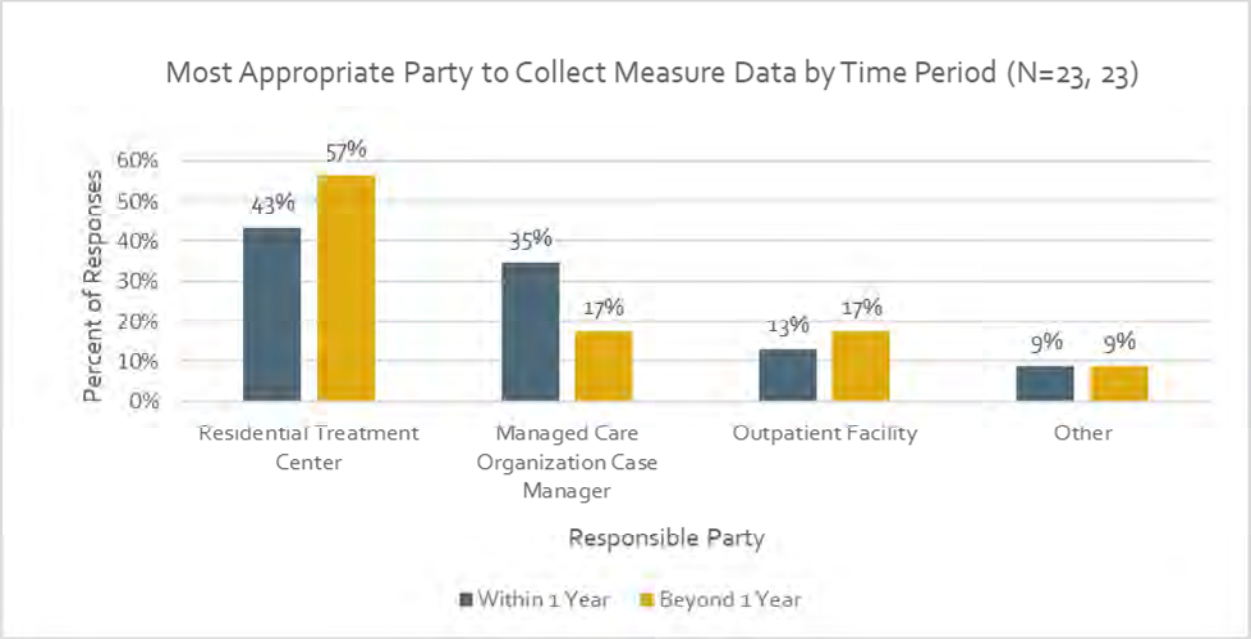
- Robust post-treatment planning, including the ability to track patients for multiple years post-discharge, is difficult or sometimes not able to be achieved.

6. Responsible Parties to Collect Data on SB419 Measures

Advisory Committee members discussed the need to determine the most appropriate party to collect data for the measures outlined in SB419. While most members agreed an MCO case manager would be an ideal representative to ensure coordination of care between facilities, survey results suggest RTC facilities identify internal resources as best to collect data for and report on measures. July 2022 RTC survey respondents were asked in review of SB419 measures, who they believe to be the most appropriate party to collect required patient data within the first year (30 days, six months, one year) (Figure 3).

This question was added to the survey at the request of the Advisory Committee, who suggested that the RTC may not be the most appropriate party to conduct patient outreach in the years that follow discharge from their facilities. The majority of respondents indicated data collection would be most appropriate by an RTC in year 1 and subsequent years. Additional comments included the need to involve multiple parties in collection of measure data, the need for funding to support data collection as RTCs expressed limitations in their workforce as a result of the recent COVID-19 pandemic, and reiterating the difficulty of contacting patients post-discharge. Survey results also suggested RTCs are experiencing issues with staffing shortages, are working to recruit and retain qualified staff, and noted that the COVID-19 pandemic impacted their workforce. Advisory Committee members noted the effort for RTCs to track measures would create additional burdens on an already taxed RTC workforce.

Figure 3. Most Appropriate Party to Collect Measure Data by Time Period (N=23, 23)



Key Takeaways – Responsible Parties to Collect SB419 Measures

- RTC providers' responses indicated the RTC providers are the most appropriate parties to collect patient information up to three years post-discharge.
- Advisory Committee members suggest that RTC providers may not be the most ideal party to collect patient information up to three years post-discharge.
- RTCs require financial resources to support the hiring of a patient navigator and staff to collect and report measures.
- RTC providers and Advisory Committee members note widespread behavioral health workforce shortages exist and are exacerbated by the COVID-19 pandemic.

7. Accessibility to Outpatient Programs

One of the most critical elements of promoting integrated treatment and recovery for patients is found in creating and managing a care continuum.[52] Alongside the criticality of management, there is also the associated discharge planning and care transitions that ensure a patient assimilates into the subsequent environment.[53] Advisory Committee members discussed an important component of quality care is successful linkage to outpatient treatment. There is compelling research suggesting that patients who have an outpatient appointment scheduled prior to discharge are significantly more likely to attend outpatient mental health services.[54] Advisory Committee members suggested the ability to have a

[52] Addiction Recovery Medical Home Alternative Payment Model Consensus Learning Model White Paper, 2019.
[53] Ibid.
[54] Smith TE, Haselden M, Corbeil T, Wall MM, Tang F, Essock SM, Frimpong E, Goldman ML, Mascayano F, Radigan M, Schneider M, Wang R, Dixon LB, Olfson M. Effect of Scheduling a Post-Discharge Outpatient Mental Health Appointment on the Likelihood of Successful Transition From Hospital to Community-Based Care. J Clin Psychiatry. 2020 Sep 15; 81(5):20m13344. doi: 10.4088/JCP.20m13344. PMID: 32936543. Accessed on August 8, 2022. Retrieved from: https://pubmed.ncbi.nlm.nih.gov/32936543/.

successful transition of care could be a focus area for WV MCOs and treatment providers to work together to ensure an individual transitioning from American Society of Addiction Medicine (ASAM) level 3.1 was provided services for a successful long-term recovery. Advisory Committee members also suggested that individuals with SUD generally experience better outcomes if they are engaged in care long term, and that they are able to achieve success in their home environments and recommended keeping patients engaged in outpatient services and supports could be a good metric of long-term recovery. Advisory Committee members further expressed the need for RTCs located in urban areas be equipped to serve individuals living in rural areas.

The July 2022 RTC survey asked RTCs about their access to outpatient programs in which to discharge members. RTC survey respondents indicated most providers (70 percent) currently have an outpatient program within their organization in which to discharge members. Of those RTCs that do not have an outpatient program within their organization (26 percent), the majority have outpatient programs to which patients are referred (83 percent). The following organizations were listed by RTCs as outpatient programs to which they refer patients:

- Cabin Creek Health Systems.
- Prestera.
- WVU Behavioral Medicine.
- Family Care.
- Various Suboxone Clinics.
- UHC Family Medicine.
- Bridgeport Behavioral Clinic.
- Community Care.
- Whole Brain Solutions.
- Other organizations based on patient-specific needs.

Key Takeaway – Accessibility to Outpatient Programs

- Most RTCs have access to outpatient programs, which will support participation in the pilot program.
- However, two RTCs reported no outpatient programs to discharge members prior to care. Both RTCs provide ASAM 3.1 level of care services, meaning these RTCs should have outpatient

programs available to discharge members. Participation in the pilot program will be challenging for these RTCs unless they are able to establish referral relationships with outpatient programs.

8. Pilot Program Participation

Overwhelmingly, 93 percent of RTC providers indicated they were willing to participate in the pilot program; however, many respondents noted challenges. July 2022 survey respondents indicated the top three challenges in SB419 pilot program participation as follows:

- Administrative considerations (65 percent).
- Difficulty contacting patients (61 percent).
- Reimbursement (48 percent).

STAKEHOLDER PERSPECTIVE

This [pilot program] would require additional staff and costs that are not sustainable within our budget. These staff would not be reimbursed and the reimbursement rates for West Virginia Medicaid cannot support additional non-reimbursed staff."

– *RTC provider, center levels 3.1, 3.5, and 3.7.*

In alignment with survey results, Advisory Committee members discussed an additional burden on RTCs, WV MCOs, and other parties to collect data for and report SB419 measures.

Appendix D: National Landscape Research

During interviews and Advisory Committee meetings, each MCO individually expressed having little to no experience in VBP arrangements with behavioral health and SUD providers in West Virginia. Research was subsequently conducted by Myers and Stauffer and Milliman to present BMS with additional strategies currently in use by other states as they implement similar SUD-focused programs. Presented in the tables below is multi-state research on approaches and national trends for SUD treatment and recovery services, care coordination, and reimbursement. As program design is finalized and MCO responsibilities are fleshed out, BMS and the Advisory Committee can revisit applicability of funding mechanisms. While other funding mechanisms exist to support pilot programs such as SB419, this appendix: (1) provides background on how state Medicaid agencies can work toward tying health care payments to quality and value using a resource such as the health care payment learning and action network (HCP LAN); and (2) highlights salient health care innovation for SUD services being performed by other State Medicaid agencies through various mechanisms including, but not limited to, managed care contracts, waivers (1115 and 1915(i)), and alternative payment models (APMs).

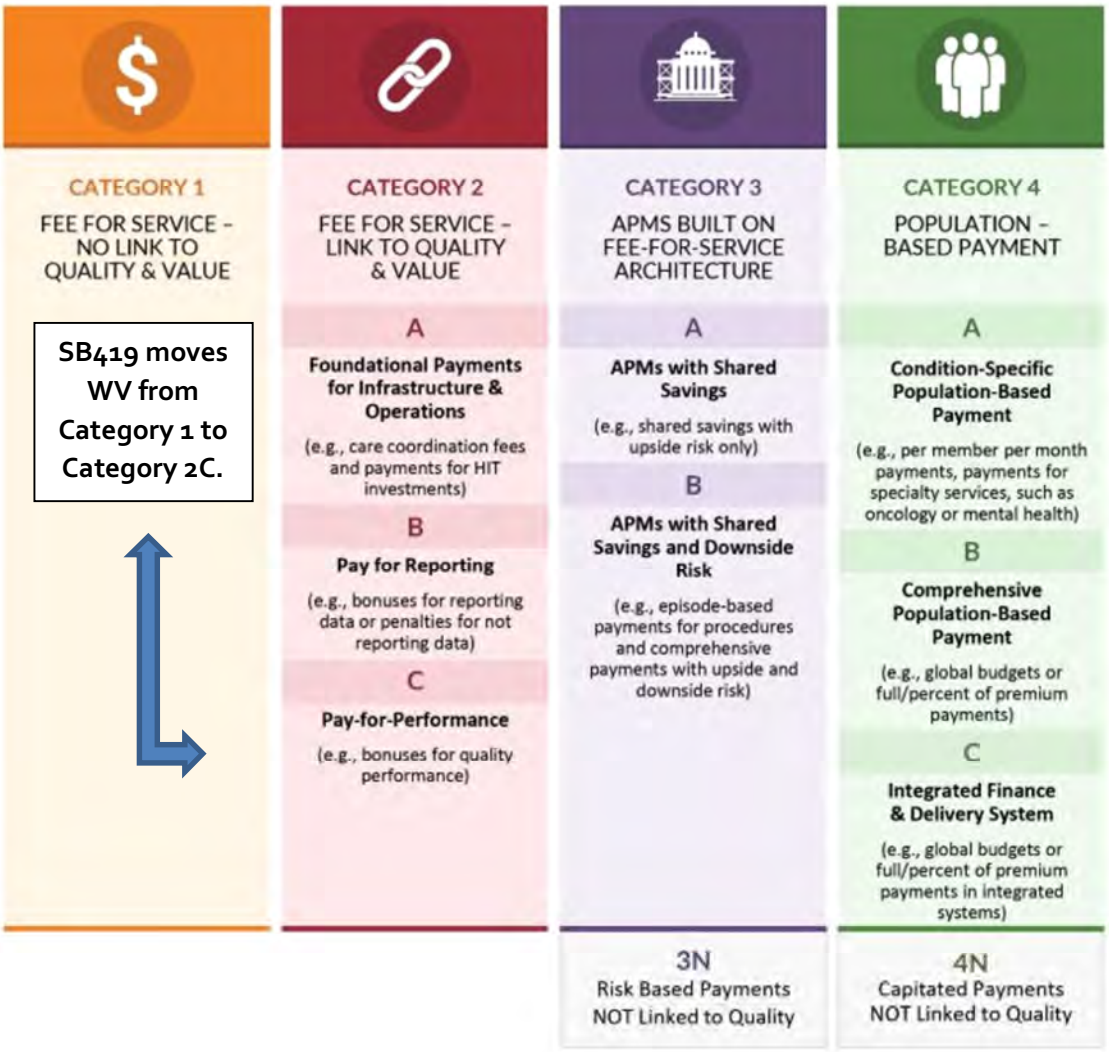
Health Care Payment Learning and Action Network

The HCP LAN set a goal to have APMs account for 50 percent of all Medicaid payments tied to quality and value through the adoption of two-sided risk APMs by 2025.[55] The goal of HCP LAN is to move away from FFS and volume-based payment systems to one that pays for high-quality care and improved health.[56] The HCP LAN created an APM framework in 2017,[57] which has four categories (*Figure 4*). As SB419 requires West Virginia to move from a Category 1 FFS to Category 2C pay-for-performance (P4P), it is important to understand that multiple steps are recommended to ensure a successful transition from FFS to payment tied to quality. Additional steps with recommended timeframes for BMS consideration including are:

- 2A: Establish infrastructure and operational needs. Allow payments to RTCs to establish infrastructure and operational needs. **Timeframe – one year (2023).**
- 2B: Pay-for-reporting. Allow RTCs to receive payment for the reporting of data results only. Payment is not yet based on performance. **Timeframe – one to two years (2024 – 2025).**
- 2C: P4P. **Timeframe: – three-plus years (2025 and beyond).**

[55] "Health Care Payment Learning and Action Network," Centers for Medicare & Medicaid Services, Retrieved from: Health Care Payment Learning and Action Network | CMS Innovation Center.
[56] Ibid.
[57] "Alternative Payment Model, APM Framework," Health Care Payment Learning & Action Network, Refreshed in 2017, Retrieved from: Alternative Payment Model (APM) Framework (hcp-lan.org).

Figure 4. HCP LAN APM Framework



Funding Mechanisms with State Examples for Additional Consideration

State-Directed Payment Pre-Print

States can use the pre-print to require their MCOs or similar entity to implement VBP models for provider reimbursement, such as APMs, P4P arrangements, bundled payments, or other service payment models. In completing the pre-print, the State will be required to provide a brief summary or description of the required payment arrangement selected and state how the payment arrangement will measure outcomes rather than volume of services. Of note, States opting to pursue a directed payment using the VBP/delivery system reform avenue can seek multi-year approval. In terms of the measures the State will use, the State must provide the following information:

- Listing of each measure, and for each measure:
  - Measure Steward, Baseline Year, Baseline Statistic, Performance Measurement Period, Performance Target, and any notes.

- CMS encourages States to use nationally-vetted and outcomes-based measures including measures from the CMS Adult and Child Core Sets if appropriate.

State Example: California District and Municipal Public Hospital (DMPH) Quality Incentive Pool Program

California's current pre-print (approved for January 1, 2021 – December 31, 2023) allows the State to move in the direction of VBPs as they direct their managed care health plans to make quality improvement payments to district and municipal public hospitals (DMPHs) who met performance targets. Measures tied to VBPs are in the categories of: primary care access and preventive care, acute and chronic care, behavioral health, maternal health, patient safety, and overuse/appropriateness of care. DMPHs are required to report on a minimum of two measures to a maximum of 20. Additionally, the pre-print allows for participating DMPHs to earn additional funds in performance years 5 and 6 for over-performance.

Pre-print measures included have identified benchmarks for the Medicaid population and are required to meet one or more of the following criteria:

- Endorsed by the NQF.
- Nationally-accepted Medicaid performance measure.
- Measure has been used in a CMS-approved performance program.[58]

Leveraging Waivers

This section provides an overview of current approved 1115 waivers, including an example of how one state is using of the 1915(i) State Plan home and community-based services benefits to support its Medicaid recipients.

1115 Waivers

The approval of a section 1115 demonstration is opening the door to expand critical treatment options such as continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities that qualify as institutions for mental diseases (IMDs). These demonstrations are also allowing State Medicaid programs to overcome longstanding payment exclusions.[59] The 1115 substance use demonstration waiver allows states to further expand access to SUD treatment and recovery services by offering the full continuum of outpatient, residential, and recovery services to Medicaid beneficiaries. Many states, like West Virginia, are using an 1115 waiver to provide additional services that can support a smooth transition to outpatient treatment and address SDOHs. Below, Myers and Stauffer and Milliman have highlighted some examples where states are using a waiver to meet the complex needs of Medicaid recipients with SUD.

[58] https://www.dhcs.ca.gov/services/Documents/DirectedPymts/CA-PY4-6-QIP-DMPH-Preprint-COVID-Revision-12-17-21.pdf.
[59] https://www.cms.gov/newsroom/press-releases/cms-announces-approval-oklahoma-maines-substance-use-disorder-demonstrations-30th-and-31st-expand.

Oklahoma Section 1115: Institutions for Mental Diseases Waiver for Serious Mental Illness/SUD

The Oklahoma section 1115 demonstration expands treatment for SUD services. In addition to coverage for services provided in an IMD, the following highlights specific portions of the demonstration that have been approved or implemented.[60]

- **Transition from Traditional Waiting List System to an Online Bed Availability List.** The State now requires residential providers to update their bed availability every 24 to 48 hours and list the type of services available and populations served from each provider. This allows outpatient providers to access the list and make appropriate and timely referrals for individuals meeting criteria for residential/American Society of Addiction Medicine (ASAM) Level 3 criteria.
- **Establish Interoperability between Existing State Systems and the Oklahoma Prescription Drug Monitoring Program (PDMP).** Integration and accessibility to real-time PDMP data from RTCs to State agencies will support behavioral health initiatives such as post-discharge patient monitoring or verifying the validity of patient self-reported data.

Maine Section 1115: Substance Use Disorder Care Initiative

Maine has incorporated a few VBP initiatives into an 1115 waiver including the following:

- **Use of Evidence-Based SUD-Specific Patient Placement Criteria.** Establish an incentive within MaineCare's new value-based primary care model for primary care providers to offer medication-assisted treatment (MAT) services in alignment with ASAM guidelines for appropriate level of care, have a cooperative referral process with specialty behavioral health providers including a mechanism for co-management for the provision of MAT, as needed, or be co-located with a MAT provider.[61]
- **Plan for Provider Capacity Improvements.** Establish an incentive within MaineCare's new value-based primary care model for primary care providers to offer MAT services in alignment with ASAM guidelines for appropriate level of care, have a cooperative referral process with specialty behavioral health providers including a mechanism for co-management for the provision of MAT as needed, or be co-located with a MAT provider.[62]
- **Additional Policies to Ensure Coordination of Care for Co-Occurring Physical and Mental Health Conditions.** Incorporate a P4P provision into the Opioid Health Home model that includes a measure on annual primary care or ambulatory visits.[63]

Oregon Section 1115: Health Plan Substance Use Disorder Initiative

Oregon's 1115 demonstration presents several creative payment mechanisms in their milestone criteria:

- **Coverage of Intensive Outpatient Services.** Coordinated care organizations (CCOs) must develop alternative payment methodologies for day treatment services within 12 to 24 months of demonstration approval.[64]

[60] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ok-imd-waiver-smi-sud-ca.pdf.
[61] Ibid.
[62] Ibid, pg. 71.
[63] Ibid, pg. 77.
[64] Ibid, pg. 54.

- **Administrative Approach.** The State will require that CCOs, in collaboration with providers, track and report the services provided to high needs supports enrollees, ensuring accountability for service delivery and payment.[65]

Leveraging Alternative Payment Models

In this section, Myers and Stauffer has included APM examples where a provider can earn incentive payment(s) to provide high-quality care that is also cost-efficient.

Addiction Recovery Medical Home Alternative Payment Model

Patients with SUD often deal with a fragmented medical system to address their needs. A patient-centered SUD continuum is crucial to providing recovery supports necessary to address addiction recovery management.[66] The Alliance for Recovery-Centered Addiction Health Services (ARMH) began gathering clinical and biopsychosocial information in August 2017 to create a comprehensive APM that aligns with an integrated treatment and recovery network care model. The content that follows details the ARMH-APM key elements, as described in their 2019 white paper.[67]

The ARMH-APM key elements comprise the payment model, quality metrics, treatment and recovery, network, and the care recovery team. More specifically, the payment model element focuses on adopting episodes of care and bundled payments. In addition, the Alliance recognizes the different populations served by allowing providers to be flexible in the services they can provide based on available resources. The ARMH-APM model consists of FFS and bundled payment models that are respective to three different patient episodes. The ARMH-APM payment system creates room for performance bonuses and severity adjustments that align to improve the patient's likelihood of long-term recovery.

Certified Community Behavioral Health Clinics

Certified community behavioral health clinics (CCBHCs) can serve as a key program in furthering behavioral health care innovation in West Virginia. The CCBHC model of care, authorized by Section 223 of the Protecting Access to Medicare Act (PAMA) statute in 2015, has continued to grow expediently since its inception. CCBHCs provide a continuum of coordinated services and supports, including rapid response 24/7 crisis services in supportive settings, peer and family support, specific support for active and veteran military, targeted case management, clinical outpatient psychotherapeutic interventions, and timely screening and assessment of behavioral health and physical needs.[68] Care coordination is critical to ensuring CCBHC services represent an improvement over existing services.[69] This integrated care approach can be especially impactful for individuals who have co-occurring diagnoses of a mental health disorder and a SUD or individuals with both a mental health disorder and a physical health disorder. Entities participating in the PAMA demonstration must meet the certification criteria to become a CCBHC as established under PAMA.

Under the demonstration, CCBHC providers are paid based on a prospective payment system (PPS) which can be either a daily or monthly predetermined, set amount. States also have the opportunity to

[65] Ibid, pg. 96.
[66] Addiction Recovery Medical Home Alternative Payment Model Consensus Learning Model White Paper, 2019.
[67] Ibid.
[68] https://www.samhsa.gov/sites/default/files/ccbh_clinicdemonstrationprogram_081018.pdf.
[69] https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf.

allow CCBHCs the opportunity to earn a quality bonus payment (QBP) in addition to the PPS rate. The QBP can be earned by meeting pre-defined benchmarks for quality measures collected and reported annually as required by the demonstration.

For states not pursing and/or selected in the demonstration, they can use a state plan amendment (SPA) to add CCBHCs as approved Medicaid providers. Using a SPA will allow West Virginia flexibility in program design as the services provided do not have to align one-for-one with the services or approaches covered under the demonstration. Additionally, there is potentially more flexibility in payment of services that can be compared to demonstration providers.

Myers and Stauffer understands that West Virginia will pursue participation in the Medicaid CCBHC demonstration program. Most recently, under the Bipartisan Safer Communities Act (BSCA), enacted June 25, 2022, the existing CCBHC Medicaid Demonstration program was extended and expanded.

In addition to the extension for existing programs, the BSCA also expands the demonstration to additional states. Beginning July 1, 2024, and every two years thereafter, 10 additional states will be eligible to participate in the demonstration. Each selected state's demonstration period will be four years. Furthermore, additional planning grants will be available to all states that have not already been selected for the demonstration. BSCA has allocated $40 million in funding for fiscal year 2023 for planning grants and technical assistance to states. Each state wishing to participate in the CCBHC Demonstration Program must first apply for and receive a one-year planning grant.

Appendix E: 2022 RTC Survey Methodology

Additional details regarding RTC survey methodology is found below.

The West Virginia BMS, in coordination with Myers and Stauffer, developed and conducted two surveys of RTCs in June and July 2022. The purpose of the June 2022 RTC survey was to understand the technological capabilities, current HIE efforts, and perceptions of SB419. The survey is the first-of-its-kind and serves as baseline data on RTC capabilities. While survey results aim to inform the SB419 final report, these surveys also serve as valuable data for future BMS initiatives.

Survey Recruitment

The target audience for the RTC survey were 26 BMS-approved residential treatment facility providers. Additional outreach regarding survey participation was conducted by Myers and Stauffer and BMS through existing provider communication channels and listservs.

Survey Structure

The survey questions designed for the RTC survey were developed by Myers and Stauffer as a result of preliminary feedback from the SB419 Advisory Committee and BMS. Additionally, the West Virginia Association of Health Plans provided supplemental questions for the June 2022 survey.

The survey used a mixed-methods approach to obtaining RTC feedback as both quantitative and qualitative data can help gain a more complete understanding of the RTC landscape. Qualitative data was added to the survey to help offer insights into the RTC experience and context behind the quantitative question responses.

The survey contained a combination of multiple choice, single-selection, matrix, and free response questions. Some questions were required by the respondent, while some were optional. To increase the likelihood of survey completion, questions were designed with branching logic so only questions relevant to an individual respondent were asked. Branching logic led the respondent to different sets of survey questions related to EHR adoption, SDOH assessment and referral, and discussion of SB419 measures, among others. For example, if a respondent stated they did not have an EHR, they were not asked questions regarding electronic reporting.

Survey Distribution and Analysis

The June 2022 survey was administered from June 9 to June 24. The July 2022 survey was administered from July 27 through August 5. Email marketing campaigns were delivered using a Myers and Stauffer constant contact platform to distribute the survey link via email. BMS Behavioral Health and Long-Term Care Services staff were invaluable in ensuring distribution of the survey, as well as assisting to increase the survey response rate.

Survey responses received were reviewed for errors and inconsistencies. When necessary, respondents received follow-up requests for clarification. After removing duplicate and invalid responses, surveys were reviewed for validity. Response data from both surveys was aggregated, tabulated, and analyzed to identify patterns and common themes. The results of the surveys were compared with the results of the SB419 Advisory Committee discussions and other qualitative data received through MCO discussions to generate common themes, guide findings, and logically flow into potential recommendations relating to SB419.

RTC Survey Limitations

The surveys had several limitations, acknowledged by both Myers and Stauffer and BMS. Survey respondents' interpretations of survey questions may have varied and influenced survey results. Additionally, findings do not represent all Medicaid RTCs in West Virginia, as three RTCs did not participate in the survey despite multiple attempts to request completion. This report relies heavily on self-reported data. Myers and Stauffer did not verify the accuracy of the RTC, Advisory Committee, or MCO-provided responses.

Acronyms

Acronyms

Acronym	Definition
APM	Alternative Payment Model
ARMH	Alliance for Recovery-Centered Addiction Health Services
ARMH-APM	Alliance for Recovery-Centered Addiction Health Services Alternative Payment Model
ASAM	American Society of Addiction Medicine
BBH	Bureau for Behavioral Health
BMS	Bureau for Medical Services
BSCA	Bipartisan Safer Communities Act
WVCHIP	West Virginia's Children's Health Insurance Program
CARF	Commission on Accreditation of Rehabilitation Facilities
CCBHC	Certified Community Behavioral Health Center
CCO	Coordinated Care Organization
CFR	Code of Federal Regulations
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CY	Calendar Year
DHHR	Department of Health and Human Resources
DMPH	California District and Municipal Public Hospital
EHR	Electronic Health Record
HIE	Health Information Exchange
IMD	Institutions for Mental Diseases
FFS	Fee-for-Service
FMAP	Federal Medicaid Assistance Percentage
HCP LAN	Health Care Payment Learning and Action Network
LOCHHRA	Legislative Oversight Commission on Health and Human Resources Accountability
MAT	Medication-Assisted Treatment
MCO	Managed Care Organization
NQF	National Quality Forum
NCQA	National Committee for Quality Assurance
ODCP	Office of Drug Control Policy
P4P	Pay-for-Performance
PAHP	Prepaid Ambulatory Health Plan
PBP	Performance-Based Payment
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PRSS	Peer Recovery Support Services
PY	Program Year
ODCP	Office of Drug Control Policy
OUD	Opioid Use Disorder
PDMP	Prescription Drug Monitoring Program
PMPM	Per Member Per Month
QBP	Quality Bonus Payment
RAS	Residential Adult Services
RTC	Residential Treatment Center
SB419	Senate Bill 419
SDOH	Social Determinants of Health
SDP	State-Directed Payment

Acronym	Definition
SFY	State Fiscal Year
SPA	State Plan Amendment
SUD	Substance Use Disorder
SUPPORT Act	Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act
VBP	Value-Based Payment
WVU	West Virginia University

MILLIMAN REPORT

Senate Bill 419 Actuarial Analysis

State of West Virginia, Department of Health and Human Resources, Bureau for Medical Services

January 13, 2023

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Introduction

West Virginia Senate Bill (SB) 419[1] instructs the West Virginia Department of Health and Human Resources (DHHR) to enter into contracts with Medicaid managed care organizations (MCOs) that include performance-based payments for substance use disorder (SUD) residential treatment services. SB 419 was passed on March 7, 2022 and went into effect 90 days from the bill being passed.

DHHR, through the Bureau for Medical Services (BMS), was also tasked in SB 419 to conduct an actuarial analysis of the pilot program on an annual basis and submit this report along with a separate detailed report of the overall performance of the pilot program.[2] This report is intended to address the actuarial analysis requirement of SB 419 and is to be used in conjunction with the separate detailed report of the overall performance of the pilot program. Milliman has been retained by Myers and Stauffer LC (MSLC), under its engagement with BMS to provide actuarial and managed care consulting services, to draft the actuarial analysis required under SB 419.

Senate Bill 419 Overview

SB 419 sets forth several mandates for the DHHR,[3] including but not limited to:

1. Enter into contracts with managed care organizations that require payments to facilities providing SUD treatment services based on performance metrics;
2. Evaluate the impact that post-discharge planning and the provision of wraparound services have on the outcomes of SUD in three years post-substance use disorder residential treatment;
3. Seek an amendment of existing waivers from the Centers for Medicare and Medicaid Services (CMS);
4. Create an advisory committee;
5. Set terms of the performance-based contract; and
6. Require reporting on the SUD pilot program.

SB 419 further directs BMS to seek an amendment to the existing waiver with CMS to support this pilot program.[4] More specifically, the legislation directs BMS to enter into contracts with the MCOs wherein, at a minimum, 15 percent of SUD residential treatment contracts for facilities providing SUD treatment services are paid based upon performance-based measures. The bill does not require SUD residential treatment facilities to participate in the pilot program.

SUD residential treatment facilities that opt for performance-based contracting shall comply with the following:[5]

1. Programs must be evidence-based and research-based. There also must be promising practices in providing services to the patient population that include fidelity and quality assurance provisions.
2. The SUD residential treatment facility shall develop a robust post-treatment planning program, which includes:
    a. Connecting the patient population to community-based supports, also known as wraparound services, to include designation of a patient navigator to assist each discharged patient with linkage to medical, substance use, and psychological treatment services;
    b. Assistance with job placement;
    c. Weekly communication regarding status for up to three years; and

[1] "Senate Bill 419," West Virginia Legislature, 2022 Regular Session, Passed March 7, 2022, Retrieved from: SB419 SUB1 ENR.pdf (wvlegislature.gov).

[2] Ibid.

[3] Ibid.

[4] Ibid.

[5] Ibid.

d. Assistance with housing and transportation.

The advisory committee shall create performance-based metrics on which payment is based that includes, but are not limited to the following:[6]

1. Whether patient is drug free, 30 days post-discharge, six months post-discharge, one year post-discharge, two years post-discharge, and three years post-discharge.
2. Whether patient is employed, 30 days post-discharge, six months post-discharge, one year post-discharge, two years post-discharge, and three years post-discharge.
3. Whether patient has housing, 30 days post-discharge, six months post-discharge, and one year post-discharge.
4. Whether SUD residential treatment facility has arranged medical, substance use, psychological services, or other community-based supports for the patient and whether the patient attended, 30 days post-discharge, six months post-discharge, one year post-discharge, two years post-discharge, and three years post-discharge.
5. Whether the patient has transportation 30 days post-discharge; and
6. Whether a patient has relapsed and needed any additional SUD treatment, 30 days post-discharge, six months post-discharge, one year post-discharge, two years post-discharge, and three years post-discharge.

The MCO may transfer risk for the provision of services to the SUD residential treatment facility during this pilot program, only to the limited extent of implementing a performance-based payment methodology.[7] The MCO may also develop a shared saving methodology, under which the SUD residential treatment facility shall receive a defined share of any savings that result from improved performance.

The advisory committee will evaluate this pilot program annually for effectiveness, adjust metrics as indicated to improve quality outcomes, and assess the pilot for continuation.[8]

The pilot program shall terminate in three years unless it is recommended for further evaluation.[9]

Actuarial Analysis of SUD Treatment Utilization in West Virginia Medicaid

As of this report date, the pilot program has not been officially launched. To meet the reporting requirements in SB 419, we have performed an actuarial analysis of SUD treatment utilization in West Virginia's Medicaid managed care programs. To better understand the total cost of care and the potential for benefit to the individual and to the state of a focused investment in individuals with SUD treatment needs, we are sharing both SUD and non-SUD per member per month (PMPM) service costs for members enrolled in Medicaid managed care in West Virginia as well as other related statistics.[10]

MANAGED CARE BACKGROUND

West Virginia operates its Medicaid programs for most non-elderly adults and children through two managed care programs. Since 1996, Mountain Health Trust (MHT) provides managed care services to approximately 87% of the state's Medicaid membership, including most non-elderly adults and children.[11] Mountain Health Promise (MHP) began in March 2020 as a specialized managed care program designed to assist children in foster care, kinship care, and adoptive care.

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] Ibid.

[10] SUD services are defined based on Milliman's *Health Cost Guidelines* using revenue codes, CPTs, and Diagnosis Related Groups for institutional and professional claims. All point-of-sale pharmacy claims are excluded from this analysis.

[11] https://dhhr.wv.gov/bms/Members/Managed%20Care/Pages/default.aspx

MHT provides most services, excluding opioid treatment prevention (OTP) services and point-of-sale pharmacy, through three MCOs (Aetna Better Health of West Virginia, Health Plan of the Upper Ohio Valley, and UniCare). MHP provides most medical services (excluding OTP and point-of-sale pharmacy) and home- and community-based services for children with serious emotional disorder through one MCO (Aetna Better Health of West Virginia). The State continues to pay carved out services (such as OTP and point-of-sale pharmacy) through the fee-for-service (FFS) program for MHT and MHP members and all services for non-managed care members.

Given the focus of SB 419 on value-based purchasing for substance use disorder treatment services for managed care organizations, this analysis is limited to managed care members in the MHT and MHP programs. Encounter data is limited to those services paid by the MCOs and OTP services paid by the FFS program.

DATA OVERVIEW

To complete the analysis, we relied on eligibility, managed care encounters, and FFS claims data received December 8, 2022, with enrollment and paid claims through October 2022. The following adjustments were made to the data:

- The data was limited to members enrolled in the MHT and MHP managed care programs from July 2020 through June 2022 as this is the most recently available data for both the MHT and MHP programs.
- Enrollment missing key demographic fields used in assigning rate cells, such as a region, age, or gender, were excluded.
- Managed care encounters and FFS claims that do not have an associated managed care enrollment record for the member and month of service were removed.
- Costs for value-added benefits (managed care services that are not covered by the Medicaid State Plan and that are not approved as in-lieu of services) were excluded. In this reporting period, the only such service included in the encounter data is HCPCS code E0603 for electric breast pumps.
- For managed care encounters incurred from February 2021 through June 2022, we received a detailed claims-level reconciliation file that has the final adjudicated paid amounts as determined by MSLC's review of each plan's claims and financials. We used this file to adjust the final paid amount and utilization metrics as necessary.[12]
- We summarized total managed care encounter spending and OTP claims paid FFS. We did not include any point-of-sale pharmacy or other FFS claims in our final summaries.
- The MCO encounters include most services paid through subcapitated arrangements. However, there are limited instances when the MCOs do not provide reliable encounters for costs incurred through subcapitated arrangements. Therefore, we may be missing a small amount of subcapitated costs from our analysis.
- We have not adjusted for incurred but not paid amounts (IBNP). We have included claims paid through October 2022 which includes at least four months of run-out for the incurred period. While additional IBNP is expected, based on historical claim run-out patterns we do not believe the IBNP materially impacts the results of this analysis. Additionally, there are known issues with the run-out for managed care encounters incurred from July 2020 through January 2021 due to changes in data warehouses. As such, state fiscal year (SFY) 2021 incurred managed care encounter data and summaries are assumed to be incomplete. The materiality of missing encounters (including IBNP) varies widely by MCO and member category of aid (e.g., pregnant women, children in foster care, etc.). We estimate that we are missing between two and nine percent of managed care encounters costs in SFY 2021 depending on the MCO and category of aid. While incomplete, we believe the general findings of the analysis are still valid.

METHODOLOGY

We summarized FFS OTP claim costs and managed care encounter costs for members enrolled in managed care for state fiscal year (SFY) 2021 (July 2020 through June 2021) and SFY 2022 (July 2021 through June 2022). We identified SUD treatment services in the managed care encounter data based on Milliman's *Health Cost Guidelines* and actuarial judgment using revenue codes, CPT codes, and Diagnosis Related Groups for institutional and professional claims. We also quantified the percent of members using SUD treatment services and stratified

[12] For claims incurred from July 2020 through January 2021, no such reconciliation is available.

members using SUD treatment services into high-utilizers (more than $1,500 paid for SUD treatment services in the fiscal year) versus low-utilizers ($1 to $1,500 paid for SUD treatment services in the fiscal year). We then classified members by regions and type and into one of three populations: expansion adults (formerly known as West Virginia Health Bridge), other adults, and children. For simplicity, we stratified adults and children based loosely on the rate cells used for managed care rate development. The following groups are considered children for this analysis (while all other groups are considered adults):

- Children with Special Health Care Needs (CSHCN);
- MHP members who are age 17 and younger and not enrolled in the Children with Serious Emotional Disorder (CSED) waiver;
- Temporary Aid for Needy Families (TANF) members age 19 and younger; and
- Social Security Income (SSI) members age 20 and younger.

KEY METRICS

Key spending metrics for SUD treatment services statewide are shown in Tables 1 and 2 below for SFY 2021 and SFY 2022, respectively. Each table includes the percentage of members receiving at least one SUD treatment service in the year, along with the total costs for SUD treatment services in millions of dollars (paid FFS or by the MCOs) and PMPM costs for members utilizing SUD treatment services. We also included a comparison of PMPM non-SUD costs for both SUD treatment utilizers and non-SUD treatment utilizers (referred to as SUD utilizers and non-SUD utilizers, respectively).

Table 1: SUD Treatment Spending, Statewide – SFY 2021

					MCO Costs				
Population	% of Members Considered High SUD Utilizers	% of Members Considered Low SUD Utilizers	FFS SUD OTP Costs ($mil)	MCO SUD Costs ($mil)	SUD PMPM for High Utilizers	SUD PMPM for Low Utilizers	Non-SUD PMPM for High Utilizers	Non-SUD PMPM for Low Utilizers	Non-SUD PMPM for Non-SUD Utilizers
Expansion	4.8%	5.2%	$ 8.6	$ 65.6	$591	$34	$580	$614	$235
Other Adults	3.6%	4.9%	$ 4.4	$ 15.8	$383	$33	$590	$724	$355
All Children	0.0%	0.1%	$ 0.0	$ 1.0	$1,107	$26	$1,381	$603	$139
Total	**2.6%**	**3.0%**	**$ 13.0**	**$ 82.4**	**$540**	**$34**	**$588**	**$647**	**$213**

Table 2: SUD Treatment Spending, Statewide – SFY 2022

					MCO Costs				
Population	% of Members Considered High SUD Utilizers	% of Members Considered Low SUD Utilizers	FFS SUD OTP Costs ($mil)	MCO SUD Costs ($mil)	SUD PMPM for High Utilizers	SUD PMPM for Low Utilizers	Non-SUD PMPM for High Utilizers	Non-SUD PMPM for Low Utilizers	Non-SUD PMPM for Non-SUD Utilizers
Expansion	5.4%	4.6%	$ 10.3	$ 84.6	$611	$36	$555	$573	$227
Other Adults	4.0%	4.3%	$ 4.8	$ 20.2	$431	$34	$625	$716	$348
All Children	0.0%	0.1%	$ 0.0	$ 0.7	$821	$23	$1,193	$1,216	$158
Total	**2.9%**	**2.7%**	**$ 15.2**	**$ 105.5**	**$568**	**$35**	**$575**	**$622**	**$218**

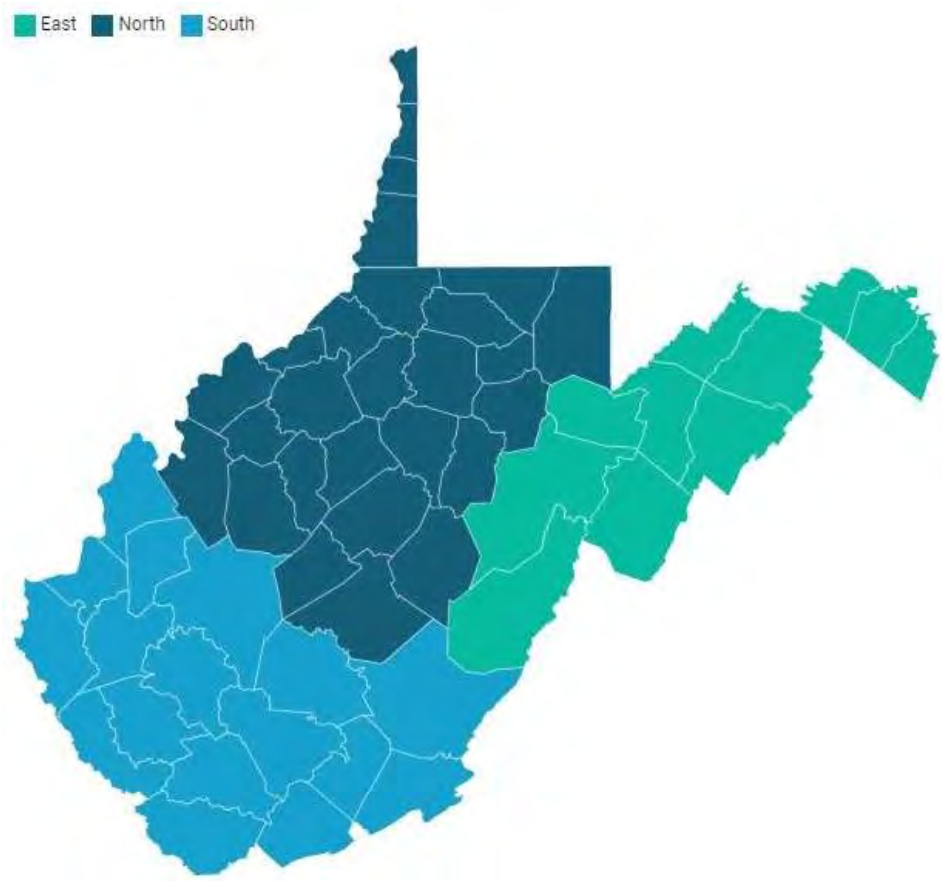
In SFY 2021 and SFY 2022, nearly 10% of managed care adults received at least one SUD treatment service in each year. As Tables 1 and 2 show, the percentage of members by population category using SUD treatment services remained relatively stable. However, SFY 2022 did see an increase in the percentage of members identified as high-SUD utilizers compared to non-SUD utilizers. Additionally, the total MCO SUD treatment costs increased from $82.4 million in SFY 2021 to $105.5 million in SFY 2022. This is a 28% increase in MCO spend compared to SFY 2021, driven by a higher percentage of high-SUD utilizers, more Medicaid members overall, and increased SUD treatment cost per member.[13] FFS OTP costs similarly increased from $13.0 million to $15.2 million.

Tables 1 and 2 also illustrate that the non-SUD PMPM for SUD utilizers is significantly higher than for non-SUD utilizers. Appendix A contains cost models based on SFY 2021 and SFY 2022 managed care encounter and membership data, shown separately for high-SUD utilizers, low-SUD utilizers, and SUD non-utilizers. The cost models in Appendix A further illustrate how high-, low-, and non-SUD utilizers compare across all managed care costs and FFS OTP costs. Both high- and low-SUD utilizers have higher inpatient medical (non-behavioral health) costs, psychiatric costs, emergency room costs, and ambulance costs than non-SUD utilizers.

REGIONAL RESULTS

In addition to providing statewide SUD treatment cost metrics, we also included regional summaries consistent with the MHT rating regions. Figure 1 provides a map of the MHT rating regions by county.

Figure 1: Regions



[13] Note that BMS' state Medicaid fee schedules for behavioral health and other services changed during SFY 2021 and SFY 2022. There were significant changes to the behavioral health fee schedule from April 2021 through June 2022 due to incentives for enhanced spending on home- and community-based services, including behavioral health, in the American Rescue Plan Act of March 2021. This may be one driver of the increase in SUD cost per member and it may contribute to the increase in high-utilizers compared to low-utilizers. Additionally, SFY 2021 generally has higher missing encounter rates which may contribute to a small share of the increase in paid managed care SUD costs.

Tables 3 through 5 detail key spending metrics for SUD treatment services for the North, East, and South regions, respectively, in SFY 2022. As illustrated in the tables, the Southern Region experiences the highest SUD treatment utilization, where over 11% of adults are receiving SUD treatment services, and non-SUD spend on these individuals is the highest in the state.

Table 3: SUD Treatment Spending, North Region – SFY 2022

				MCO Costs		
Population	% of Members Receiving SUD Services	FFS SUD Costs ($mil)	MCO SUD Costs ($mil)	SUD PMPM for SUD utilizers	Non-SUD PMPM for SUD utilizers	Non-SUD PMPM for Non-SUD Utilizers
Expansion	8.2%	$ 2.5	$ 27.0	$376	$572	$237
All Other Adults	6.8%	$ 1.0	$ 6.4	$249	$659	$352
All Children	0.1%	$ 0.0	$ 0.3	$307	$1,195	$162
Total	**4.7%**	**$ 3.6**	**$ 33.7**	**$342**	**$600**	**$225**

Table 4: SUD Treatment Spending, East Region – SFY 2022

				MCO Costs		
Population	% of Members Receiving SUD Services	FFS SUD Costs ($mil)	MCO SUD Costs ($mil)	SUD PMPM for SUD utilizers	Non-SUD PMPM for SUD utilizers	Non-SUD PMPM for Non-SUD Utilizers
Expansion	7.7%	$ 1.2	$ 7.6	$281	$532	$226
All Other Adults	7.3%	$ 0.7	$ 2.1	$194	$613	$314
All Children	0.1%	$ 0.0	$ 0.2	$348	$868	$143
Total	**4.4%**	**$ 1.9**	**$ 9.8**	**$258**	**$559**	**$201**

Table 5: SUD Treatment Spending, South Region – SFY 2022

				MCO Costs		
Population	% of Members Receiving SUD Services	FFS SUD Costs ($mil)	MCO SUD Costs ($mil)	SUD PMPM for SUD utilizers	Non-SUD PMPM for SUD utilizers	Non-SUD PMPM for Non-SUD Utilizers
Expansion	11.8%	$ 6.6	$ 50.0	$338	$565	$219
All Other Adults	9.7%	$ 3.1	$ 11.8	$216	$691	$354
All Children	0.1%	$ 0.0	$ 0.2	$184	$1,341	$160
Total	**6.8%**	**$ 9.7**	**$ 62.0**	**$304**	**$604**	**$218**

CONCLUSION

Nearly 10% of Medicaid managed care adults statewide are receiving SUD treatment services (5.7% of all managed care members including children). Total spending by the MCOs on SUD treatment services in State Fiscal Year

(SFY) 2022 was $105.5 million. Additionally, $15.2 million in Opioid Treatment Services was paid by the State under FFS for managed care members in SFY 2022.

The per member per month (PMPM) SUD treatment costs for those members receiving SUD treatment services are over $300 PMPM. The non-SUD costs for these members are nearly three times those of members not receiving SUD treatment services, at almost $600 PMPM. The impact of a successful SUD treatment program may affect the entire scope of services for individuals. Therefore, it is important to understand the current SUD treatment and non-SUD spend for those with SUD treatment needs to better assess the full potential fiscal impact of a value-based approach to SUD treatment payments. Assuming SUD treatment will positively affect comorbidities, there is substantial opportunity for statewide benefits related to non-SUD services for those with SUD treatment needs.[14]

Data Reliance and Caveats

The terms of the contract with BMS effective on February 15, 2022 and the MSLC subcontract signed February 10, 2022 apply to this email and attachments and its use.

We relied on certain models in the preparation of these exhibits. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs).

This report is intended for the use of the State of West Virginia, Bureau for Medical Services (BMS) in support of the Medicaid managed care programs. We understand that this information may be shared with third parties. To the extent that the information contained in this report is provided to third parties, the document should be distributed in its entirety.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Similarly, third parties are instructed that they are to place no reliance upon this report prepared for BMS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

This analysis has relied extensively on data provided by BMS and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. Identified data deficiencies (such as limited run-out) are noted throughout the report. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Annie Hallum, Justin Birrell, Daniel Gerber, and Lu Miao are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis presented herein.

[14] https://www.ncbi.nlm.nih.gov/books/NBK424848/#:~:text=Because%20substance%20use%20complicates%20many,and%20reduce%20health%20care%20costs.

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Appendix A-1
West Virginia Bureau for Medical Services
SB419 Actuarial Report
Cost Model for SUD High Utilizers

SFY 2021 MMs: 142,440 **SFY 2022 MMs:** 175,674

	SFY 2021 Data					SFY 2022 Data				
Service Category	Admits Per 1,000	Avg Length of Stay	Utilization Per 1,000	Cost Per Service	PMPM	Admits Per 1,000	Avg Length of Stay	Utilization Per 1,000	Cost Per Service	PMPM
Hospital Inpatient										
IP Medical	106.1	4.8	505.6	$ 1,299.89	$ 54.77	93.7	6.3	588.7	$ 1,139.66	$ 55.91
IP Surgical	31.3	8.5	266.7	1,930.31	42.90	27.4	12.7	346.5	1,603.03	46.29
IP Psych Hospital	79.2	7.7	611.1	785.74	40.02	61.4	8.7	535.2	756.80	33.75
IP Psych Residential	199.3	1.4	274.8	206.95	4.74	153.8	1.0	160.0	118.92	1.59
IP SUD Hospital	152.6	5.8	888.1	1,003.23	74.25	102.3	6.6	675.1	880.18	49.52
IP SUD Residential	11,892.4	1.1	12,816.7	236.94	253.06	13,447.5	1.0	13,733.9	236.05	270.16
IP Normal Delivery	13.6	2.0	27.4	1,435.69	3.28	12.1	2.5	30.6	1,135.66	2.90
IP C-Section Delivery	9.5	3.0	28.8	1,378.77	3.31	6.4	3.9	24.7	1,170.77	2.41
IP Well Newborn	-	-	-	-	-	-	-	-	-	-
IP Other Newborn	-	-	-	-	-	-	-	-	-	-
IP SNF	2.6	0.9	2.3	7,964.44	1.51	0.3	19.5	5.3	460.72	0.20
Subtotal	**12,486.5**	**1.2**	**15,421.6**	**$ 371.82**	**$ 477.84**	**13,904.8**	**1.2**	**16,100.1**	**$ 344.89**	**$ 462.73**
Hospital Outpatient										
OP Observation			127.4	$ 1,246.41	$ 13.23			105.9	$ 1,194.79	$ 10.54
OP Emergency Department			1,836.3	352.76	53.98			1,777.6	343.89	50.94
OP Surgery			132.4	884.49	9.76			135.9	930.45	10.54
OP Radiology			374.5	93.61	2.92			377.2	89.39	2.81
OP Lab/Pathology			2,141.4	66.01	11.78			3,020.8	54.53	13.73
OP Pharmacy			223.7	504.19	9.40			214.7	317.27	5.68
OP Chemotherapy			7.4	3,671.26	2.27			8.9	2,010.37	1.50
OP Cardiovascular			219.4	31.41	0.57			218.0	28.10	0.51
OP PT/OT/ST			63.7	75.87	0.40			66.5	68.56	0.38
OP Psych PHP & IOP			31.4	45.45	0.12			47.1	37.70	0.15
OP SUD PHP & IOP			105.7	92.31	0.81			66.5	89.67	0.50
OP Preventive			551.6	58.35	2.68			850.4	45.64	3.23
OP Other			3,121.4	44.68	11.62			3,053.9	44.51	11.33
OP Clinic			5,775.3	93.45	44.97			6,396.4	92.78	49.46
OP Dialysis			9.7	542.72	0.44			18.6	188.33	0.29
Subtotal			**14,721.2**	**$ 134.47**	**$ 164.97**			**16,358.5**	**$ 118.53**	**$ 161.58**
Physician										
PROF IP Surgery			226.5	$ 207.62	$ 3.92			205.3	$ 209.37	$ 3.58
PROF OP Surgery			489.0	127.14	5.18			458.8	125.74	4.81
PROF Maternity - Normal Deliveries			14.6	849.46	1.03			11.3	765.79	0.72
PROF Maternity - Cesarean Deliveries			9.1	949.61	0.72			7.4	786.70	0.48
PROF Maternity - Other			36.6	75.20	0.23			28.1	75.74	0.18
PROF Maternity - Anesthesia			26.2	203.66	0.44			20.4	211.43	0.36
PROF IP Medical			1,616.6	75.30	10.14			1,498.2	69.74	8.71
PROF IP Psych/SUD			1,282.9	59.91	6.40			1,355.2	51.53	5.82
PROF PCP			1,970.8	60.18	9.88			2,025.3	70.64	11.92
PROF Specialist			6,412.3	60.67	32.42			6,263.1	70.67	36.88
PROF Pharmacy			264.4	45.66	1.01			228.0	129.35	2.46
PROF Chemotherapy			1.5	122.17	0.02			2.7	74.85	0.02
PROF Dialysis			3.7	86.30	0.03			4.9	97.73	0.04
PROF Immunizations			59.3	32.04	0.16			49.0	48.90	0.20
PROF Well Baby Exams			0.1	77.56	0.00			0.2	77.76	0.00
PROF Preventive Exams			913.8	35.69	2.72			619.3	32.86	1.70
PROF Vision Exams			25.6	85.72	0.18			19.1	86.13	0.14
PROF Other			6,711.6	55.33	30.94			5,900.3	70.09	34.46
PROF PT			334.5	30.55	0.85			412.0	26.50	0.91
PROF Radiology			2,696.8	27.37	6.15			2,487.0	24.41	5.06
PROF Pathology/Lab			15,022.2	44.14	55.26			12,400.2	43.87	45.33
PROF OP Psych			4,296.7	171.14	61.28			3,166.6	237.00	62.54
PROF OP SUD			26,483.2	94.43	208.40			24,051.1	121.82	244.16
PROF Case Management			198.7	34.41	0.57			121.6	40.05	0.41
Subtotal			**69,096.9**	**$ 76.06**	**$ 437.94**			**61,335.1**	**$ 92.12**	**$ 470.87**
Ancillary										
OTH Home Health			25.2	$ 136.12	$ 0.29			39.5	$ 137.08	$ 0.45
OTH Hospice			13.6	146.39	0.17			14.5	185.84	0.23
OTH Ambulance			1,323.7	208.28	22.97			1,112.3	204.65	18.97
OTH DME/Prosthetics			526.5	114.00	5.00			552.0	130.15	5.99
OTH Glasses/Contacts			10.6	43.42	0.04			3.7	44.44	0.01
OTH Other Services			130.5	112.86	1.23			71.7	116.49	0.70
OTH Dental			1,435.6	90.19	10.79			1,704.4	103.00	14.63
COVID Testing			1,302.4	63.62	6.90			1,304.1	61.50	6.68
COVID Vaccines			24.3	31.60	0.06			31.7	37.66	0.10
Subtotal			**4,792.4**	**$ 118.82**	**$ 47.45**			**4,834.0**	**$ 118.55**	**$ 47.76**
MCO Medical Encounter Subtotal			**104,032.1**	**$ 130.14**	**$ 1,128.20**			**98,627.7**	**$ 139.06**	**$ 1,142.94**
FFS OTP Subtotal			**10,296.2**	**$ 102.96**	**$ 88.34**			**9,707.1**	**$ 103.71**	**$ 83.89**

Notes:

1) Base costs are derived from Blue Box data incurred through January 2021 and EDI data beginning February 1, 2021 with data submitted through October 2022.

2) Limited to members with high SUD utilization, defined as greater than $1,500 in paid SUD services in the fiscal year.

3) FFS OTP claims identified using HCPCS code H0020. No other FFS claims are included.

Appendix A-2
West Virginia Bureau for Medical Services
SB419 Actuarial Report
Cost Model for SUD Low Utilizers

	SFY 2021 MMs:	165,468				SFY 2022 MMs:	164,793			
	SFY 2021 Data					SFY 2022 Data				
Service Category	Admits Per 1,000	Avg Length of Stay	Utilization Per 1,000	Cost Per Service	PMPM	Admits Per 1,000	Avg Length of Stay	Utilization Per 1,000	Cost Per Service	PMPM
Hospital Inpatient										
IP Medical	141.7	5.2	737.7	$ 1,381.68	$ 84.94	131.1	7.3	954.9	$ 1,102.56	$ 87.74
IP Surgical	51.3	10.2	521.4	2,087.72	90.70	46.5	14.0	653.5	1,601.63	87.23
IP Psych Hospital	39.2	9.7	380.7	676.64	21.47	41.9	9.9	413.3	729.18	25.12
IP Psych Residential	78.5	1.5	114.8	113.22	1.08	108.3	1.3	135.5	325.09	3.67
IP SUD Hospital	1.8	2.0	3.7	436.03	0.13	2.4	3.0	7.3	299.94	0.18
IP SUD Residential	68.8	1.2	80.6	253.50	1.70	91.1	1.1	96.0	280.47	2.24
IP Normal Delivery	17.9	1.8	32.9	1,471.65	4.03	15.0	2.7	39.8	1,142.17	3.78
IP C-Section Delivery	11.4	2.7	30.8	1,571.36	4.04	7.3	3.1	22.4	1,477.87	2.76
IP Well Newborn	-	-	-	-	-	0.1	1.0	0.1	785.41	0.00
IP Other Newborn	-	-	-	-	-	0.1	27.0	2.0	604.93	0.10
IP SNF	1.5	6.6	10.0	1,061.55	0.89	0.3	19.0	5.5	592.49	0.27
Subtotal	**412.1**	**4.6**	**1,912.6**	**$ 1,311.18**	**$ 208.98**	**444.0**	**5.2**	**2,330.3**	**$ 1,097.37**	**$ 213.10**
Hospital Outpatient										
OP Observation			91.8	$ 1,342.31	$ 10.27			83.7	$ 1,288.13	$ 8.99
OP Emergency Department			1,188.2	383.54	37.98			1,246.6	386.63	40.16
OP Surgery			158.5	881.08	11.64			148.9	843.27	10.46
OP Radiology			399.7	101.62	3.39			401.2	104.65	3.50
OP Lab/Pathology			1,879.5	82.80	12.97			1,928.4	81.38	13.08
OP Pharmacy			169.6	223.23	3.16			221.3	230.15	4.24
OP Chemotherapy			9.9	3,501.54	2.90			14.9	2,684.97	3.32
OP Cardiovascular			195.9	37.99	0.62			193.6	40.51	0.65
OP PT/OT/ST			65.8	90.58	0.50			86.9	83.44	0.60
OP Psych PHP & IOP			91.3	26.36	0.20			95.4	17.74	0.14
OP SUD PHP & IOP			142.0	44.10	0.52			74.9	27.52	0.17
OP Preventive			408.2	72.05	2.45			399.9	68.50	2.28
OP Other			2,208.4	54.08	9.95			1,615.9	64.37	8.67
OP Clinic			7,433.1	131.49	81.45			5,921.0	130.39	64.34
OP Dialysis			37.0	379.61	1.17			72.6	219.20	1.33
Subtotal			**14,479.2**	**$ 148.48**	**$ 179.16**			**12,505.3**	**$ 155.40**	**$ 161.95**
Physician										
PROF IP Surgery			430.3	$ 224.48	$ 8.05			360.3	$ 210.43	$ 6.32
PROF OP Surgery			507.6	129.89	5.49			482.0	127.31	5.11
PROF Maternity - Normal Deliveries			18.6	851.05	1.32			14.6	763.23	0.93
PROF Maternity - Cesarean Deliveries			12.4	886.93	0.92			8.6	834.81	0.60
PROF Maternity - Other			46.6	66.38	0.26			34.3	71.86	0.21
PROF Maternity - Anesthesia			31.4	205.99	0.54			24.1	215.96	0.43
PROF IP Medical			2,497.7	74.82	15.57			2,382.3	68.71	13.64
PROF IP Psych/SUD			500.6	60.07	2.51			566.8	53.70	2.54
PROF PCP			3,424.9	58.97	16.83			3,307.8	61.79	17.03
PROF Specialist			7,969.0	60.90	40.44			7,233.6	67.06	40.42
PROF Pharmacy			259.8	33.02	0.71			228.1	41.10	0.78
PROF Chemotherapy			9.4	371.13	0.29			10.0	62.58	0.05
PROF Dialysis			26.8	77.56	0.17			20.2	88.12	0.15
PROF Immunizations			62.2	34.41	0.18			48.7	43.87	0.18
PROF Well Baby Exams			0.4	50.88	0.00			0.8	72.05	0.00
PROF Preventive Exams			1,453.5	34.40	4.17			404.3	39.36	1.33
PROF Vision Exams			21.2	83.09	0.15			18.6	84.65	0.13
PROF Other			5,551.9	51.76	23.95			4,604.8	63.46	24.35
PROF PT			416.9	29.06	1.01			474.1	26.92	1.06
PROF Radiology			2,891.5	27.64	6.66			2,746.1	25.80	5.90
PROF Pathology/Lab			14,928.6	43.22	53.77			11,964.0	41.65	41.53
PROF OP Psych			5,031.7	96.58	40.50			5,274.8	105.16	46.22
PROF OP SUD			8,095.4	44.48	30.00			7,399.0	51.64	31.84
PROF Case Management			205.3	25.93	0.44			118.0	40.59	0.40
Subtotal			**54,393.8**	**$ 56.02**	**$ 253.93**			**47,725.8**	**$ 60.64**	**$ 241.17**
Ancillary										
OTH Home Health			65.4	$ 161.59	$ 0.88			78.9	$ 137.44	$ 0.90
OTH Hospice			30.2	295.27	0.74			83.0	218.90	1.51
OTH Ambulance			834.4	245.13	17.05			794.5	231.85	15.35
OTH DME/Prosthetics			677.7	114.64	6.47			708.8	121.86	7.20
OTH Glasses/Contacts			7.5	44.00	0.03			9.2	43.95	0.03
OTH Other Services			174.1	108.61	1.58			134.0	118.83	1.33
OTH Dental			992.9	89.69	7.42			1,230.7	101.30	10.39
COVID Testing			798.0	66.16	4.40			908.5	59.77	4.52
COVID Vaccines			24.7	32.43	0.07			27.2	37.02	0.08
Subtotal			**3,604.8**	**$ 128.60**	**$ 38.63**			**3,974.7**	**$ 124.76**	**$ 41.32**
MCO Medical Encounter Subtotal			**74,390.4**	**$ 109.81**	**$ 680.71**			**66,536.1**	**$ 118.59**	**$ 657.54**
FFS OTP Subtotal			**314.3**	**$ 91.83**	**$ 2.41**			**329.1**	**$ 93.57**	**$ 2.57**

Notes:

1) Base costs are derived from Blue Box data incurred through January 2021 and EDI data beginning February 1, 2021 with data submitted through October 2022.

2) Limited to members with low SUD utilization, defined as between $1 and $1,500 in paid SUD services in the fiscal year.

3) FFS OTP claims identified using HCPCS code H0020. No other FFS claims are included.

Appendix A-3
West Virginia Bureau for Medical Services
SB419 Actuarial Report
Cost Model for SUD Non-Utilizers

SFY 2021 MMs: 5,205,272 **SFY 2022 MMs:** 5,735,397

	SFY 2021 Data					SFY 2022 Data				
Service Category	Admits Per 1,000	Avg Length of Stay	Utilization Per 1,000	Cost Per Service	PMPM	Admits Per 1,000	Avg Length of Stay	Utilization Per 1,000	Cost Per Service	PMPM
Hospital Inpatient										
IP Medical	29.6	4.2	125.5	$ 1,549.99	$ 16.20	28.4	5.7	162.0	$ 1,356.61	$ 18.31
IP Surgical	13.0	5.7	73.6	3,082.30	18.91	10.9	8.1	88.1	2,401.09	17.63
IP Psych Hospital	8.3	9.6	79.9	848.74	5.65	7.4	11.4	83.7	826.50	5.76
IP Psych Residential	289.5	1.5	429.9	200.63	7.19	291.5	1.3	384.8	200.17	6.42
IP SUD Hospital	-	-	-	-	-	-	-	-	-	-
IP SUD Residential	-	-	-	-	-	-	-	-	-	-
IP Normal Delivery	10.9	1.8	20.2	1,414.31	2.38	9.5	2.3	21.9	1,154.57	2.11
IP C-Section Delivery	5.3	2.3	12.1	1,685.31	1.71	4.5	2.9	13.2	1,417.21	1.56
IP Well Newborn	6.0	1.7	10.3	841.78	0.72	5.4	2.0	10.7	557.72	0.50
IP Other Newborn	5.6	5.6	31.1	1,167.80	3.03	4.9	7.1	34.8	1,091.43	3.16
IP SNF	0.0	23.9	0.8	647.84	0.04	0.1	23.5	1.5	582.72	0.07
Subtotal	**368.3**	**2.1**	**783.4**	**$ 855.26**	**$ 55.84**	**362.5**	**2.2**	**800.6**	**$ 832.20**	**$ 55.52**
Hospital Outpatient										
OP Observation			35.6	$ 1,261.10	$ 3.74			33.3	$ 1,162.28	$ 3.23
OP Emergency Department			566.2	336.43	15.87			651.1	323.24	17.54
OP Surgery			134.6	1,058.90	11.87			129.5	1,001.43	10.80
OP Radiology			369.0	115.78	3.56			367.8	111.68	3.42
OP Lab/Pathology			600.6	73.93	3.70			617.3	73.55	3.78
OP Pharmacy			106.8	683.65	6.08			120.2	621.65	6.23
OP Chemotherapy			17.0	3,069.42	4.34			15.7	2,908.51	3.81
OP Cardiovascular			112.7	54.28	0.51			114.7	52.22	0.50
OP PT/OT/ST			120.5	91.13	0.91			129.7	77.52	0.84
OP Psych PHP & IOP			15.6	115.98	0.15			24.1	102.58	0.21
OP SUD PHP & IOP			-	-	-			-	-	-
OP Preventive			208.8	82.72	1.44			219.4	78.64	1.44
OP Other			413.3	72.57	2.50			333.0	72.72	2.02
OP Clinic			1,822.7	124.46	18.90			2,070.5	128.91	22.24
OP Dialysis			20.0	359.11	0.60			21.7	226.41	0.41
Subtotal			**4,543.3**	**$ 195.96**	**$ 74.19**			**4,848.1**	**$ 189.25**	**$ 76.46**
Physician										
PROF IP Surgery			88.1	$ 241.81	$ 1.78			75.8	$ 223.13	$ 1.41
PROF OP Surgery			466.6	130.22	5.06			432.6	126.64	4.57
PROF Maternity - Normal Deliveries			10.6	852.13	0.75			9.0	759.61	0.57
PROF Maternity - Cesarean Deliveries			5.5	897.95	0.41			4.8	814.84	0.33
PROF Maternity - Other			30.4	82.40	0.21			26.2	85.35	0.19
PROF Maternity - Anesthesia			17.5	216.11	0.32			15.1	207.32	0.26
PROF IP Medical			437.6	83.60	3.05			429.0	80.46	2.88
PROF IP Psych/SUD			46.8	55.98	0.22			61.4	46.85	0.24
PROF PCP			488.7	64.62	2.63			558.9	69.67	3.24
PROF Specialist			1,493.9	66.46	8.27			1,525.8	72.94	9.27
PROF Pharmacy			161.7	105.10	1.42			154.5	136.49	1.76
PROF Chemotherapy			11.0	630.83	0.58			12.1	594.86	0.60
PROF Dialysis			5.8	103.26	0.05			5.2	110.54	0.05
PROF Immunizations			311.6	18.16	0.47			253.8	18.76	0.40
PROF Well Baby Exams			109.9	71.56	0.66			94.7	67.96	0.54
PROF Preventive Exams			208.8	74.82	1.30			209.7	68.53	1.20
PROF Vision Exams			114.8	83.80	0.80			94.5	83.19	0.66
PROF Other			2,405.9	52.56	10.54			2,423.1	56.73	11.45
PROF PT			803.1	34.57	2.31			854.9	31.38	2.24
PROF Radiology			1,314.9	31.31	3.43			1,318.5	27.69	3.04
PROF Pathology/Lab			2,073.0	18.80	3.25			1,706.9	19.68	2.80
PROF OP Psych			972.1	90.32	7.32			950.1	122.16	9.67
PROF OP SUD			-	-	-			-	-	-
PROF Case Management			59.8	51.48	0.26			66.6	62.22	0.35
Subtotal			**11,638.2**	**$ 56.79**	**$ 55.08**			**11,283.3**	**$ 61.36**	**$ 57.70**
Ancillary										
OTH Home Health			47.0	$ 220.61	$ 0.86			46.4	$ 231.24	$ 0.89
OTH Hospice			36.6	199.60	0.61			26.3	202.58	0.44
OTH Ambulance			191.3	242.27	3.86			188.7	230.33	3.62
OTH DME/Prosthetics			616.4	102.08	5.24			604.8	102.43	5.16
OTH Glasses/Contacts			231.6	42.63	0.82			186.0	42.27	0.66
OTH Other Services			82.6	109.79	0.76			64.6	108.37	0.58
OTH Dental			2,338.6	73.66	14.36			2,226.5	75.65	14.04
COVID Testing			592.5	64.97	3.21			729.6	61.52	3.74
COVID Vaccines			22.5	29.46	0.06			23.3	36.65	0.07
Subtotal			**4,159.0**	**$ 85.91**	**$ 29.77**			**4,096.2**	**$ 85.57**	**$ 29.21**
MCO Medical Encounter Subtotal			**21,124.0**	**$ 122.07**	**$ 214.88**			**21,028.2**	**$ 124.91**	**$ 218.88**
FFS OTP Subtotal			**-**	**$ 0.00**	**$ 0.00**			**-**	**$ 0.00**	**$ 0.00**

Notes:

1) Base costs are derived from Blue Box data incurred through January 2021 and EDI data beginning February 1, 2021 with data submitted through October 2022.

2) Limited to members with no SUD utilization in the fiscal year.

3) FFS OTP claims identified using HCPCS code H0020. No other FFS claims are included.