PROPOSED REDESIGN OF WEST VIRGINIA'S BEHAVIORAL HEALTH SERVICE SYSTEM

FINAL REPORT

DECEMBER 2006

PRESENTED TO:

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR BEHAVIORAL HEALTH AND
HEALTH FACILITIES

PRESENTED BY:

PUBLIC CONSULTING GROUP, INC.

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I. EXECUTIVE SUMMARY

Introduction

Public Consulting Group, Inc. (PCG) was contracted by the State of West Virginia Department of Health and Human Resources (DHHR) to facilitate a short- and long-term restructuring of the behavioral health service delivery system. We reviewed the program, clinical, financial, legal, and regulatory components of the current system and met with stakeholders to discuss the strengths and weaknesses of the current behavioral health system as well as the changes that should be made to establish a more effective and efficient system of behavioral health in West Virginia. We also reviewed state agency reports and documentation, facilitated regular meetings and interviews with state agency staff, and integrated our behavioral health expertise obtained from working in all 50 states to produce this report.

Vision for the Future & Stakeholder Impacts

We envision a very different behavioral health system present in West Virginia in three years than what is in place today. With all or most of the goals detailed below achieved by BHHF, we believe that West Virginia will be a state with a well-respected, cutting-edge behavioral health system that is supported by accountable and balanced federal and state funding.

Consumers will rely upon the Single Point of Entry service brokerage model to easily obtain needed, high quality services and supports in all regions of the state. Through the Single Point of Entry service brokerage model, consumers will realize improved choice in their decisions regarding service providers. Added clinical expertise and specific behavioral health knowledge will improve the delivery of services and supports by the system's direct care workforce. New opportunities for services will exist for consumers and providers through the addition of Medicaid waiver programs and amendments to existing Medicaid waiver programs. The roles and responsibilities within the DHHR Bureaus will be well-defined in the new system and there will be consistent communication between the Agencies, Offices, and Bureaus of the state's behavioral health system to accommodate the smooth transitioning of consumers through a comprehensive continuum of services. Quality providers, who are well-informed by the State about all aspects of the system and interact on a daily basis with the Bureau, will be a central component of the new system. Technological innovations, such as electronic medical records and telehealth resources, will be incorporated into the system to promote further access to services and supports. Precise monitoring approaches and quality assurance methods will be in place throughout the system and evidence-based practices will be applied.

Consumers will: realize more choice in the supports and services received;

- be able to self-direct their services;
- experience a system where the process of how to access services and supports is clear;
- receive higher quality services;
- have a wider range of services and supports available to them;
- have access to a well-understood grievance process to resolve any problems;
- have more of a voice within the system; and
- experience an improved quality of life.

Family Members / Guardians will:

- experience more choices and less confusion when interacting with the service system;
- have more voice within the system;
- experience more support and better communication with providers and agencies; and

- experience more satisfaction with the services and supports that their family member is receiving.

Providers will:

- develop improved communication amongst each other and with BHHF;
- have the ability to serve the client instead of simply following the money;
- provide higher quality services and supports to consumers as well as increased information and communication to their family member(s);
- incorporate more clinical services and knowledge into their service mixes;
- experience less burdensome paperwork and quality assurance procedures; and
- have a chance to incorporate telehealth innovations into their everyday processes.

State Agencies will:

- have a chance to more effectively communicate and collaborate with each other;
- rethink the way in which services and supports are delivered to consumers;
- restructure the types of services offered within the system;
- reassess the consumers served by the system;
- have a chance to communicate the vision and mission statement of the system more effectively to stakeholders;
- have a chance to change the way in which services are funded;
- have the ability to provide higher quality and a wider range of services;
- bring added accountability into the West Virginia behavioral health system; and
- move the system towards being a national leader in the delivery of high quality behavioral health supports and services.

Goals to Accomplish System Redesign

GOAL #1 Establish a group that will guide, oversee and monitor behavioral health system redesign efforts in West Virginia over the next three years that will prioritize regular communication with the Bureau.

GOAL #2: Revise and enhance the vision of BHHF and its mission statement to more clearly and accurately reflect the values, purpose, and philosophy of the Bureau and ensure that these are well understood by all stakeholders.

GOAL #3: Discuss plans for launching a Single Point of Entry service brokerage model for accessing behavioral health services throughout the state, which includes an independent service / care coordination component. It is essential that the service brokerage entity be separate from the direct provision of services. This will facilitate the delivery of behavioral health services to the target populations in a streamlined and coordinated manner and will result in improved access and accountability.

GOAL #4: Clarify and clearly distinguish the roles and functions of the various Bureaus within the Department of Health and Human Resources, including the Bureau of Health and Health Facilities, the Bureau of Children and Families, the Bureau of Public Health, and the Bureau of Medical Services. Improve coordination, communication, and collaboration, and ensure that there is efficient utilization of all funding streams, resources, and personnel so that the Bureau for Behavioral Health and Health Facilities can effectively

provide leadership and policy direction in the program areas of behavioral health for the State of West Virginia.

GOAL #5: Begin the process of on-going strategic planning for the behavioral health service system to provide BHHF with a blueprint to set goals, strategies, and performance outcomes with which to guide the service system. The strategic plan should specify how BHHF will monitor and evaluate the changing system as it is modified and expanded, should include an oversight component to track the progress of achieving goals on an annual basis, and should include a provision that would allow BHHF to make modifications in the strategic plan as necessary.

GOAL #6: Enhance BHHF's website to enable consumers to easily access a full range of information regarding state and national behavioral health resources. Develop a mechanism to monitor website utilization and seek feedback on the ease of the website's use as well as ideas on additional information or links that would enhance the website's utility.

GOAL #7: Establish clear definitions for the Bureau's target populations, as it is an essential element that assists in the prioritization of individuals most in need and focuses the expenditure of state and federal dollars to meet their needs.

GOAL #8: Discuss and develop a basic behavioral health service package to be provided throughout the state to all consumers meeting the eligibility criteria for the target populations, which will be available in all communities with open access to any eligible provider. Expand the number of eligible providers that consumers can access by including other licensed / certified provider types and Primary Care Centers.

GOAL #9: Facilitate the on-going exchange of information with providers of all supports and services, including all types of licensed or certified clinicians and behavioral health providers, in order to maximize the clinical and organizational knowledge and expertise available across the state.

GOAL #10: Compel providers to move toward the adoption of evidence-based practices and practice-based evidence with a focus on quality and documented outcomes. BHHF will promote this practice through the development and enforcement of performance-based provider contracts, which will result in the purchasing of effective, high quality services for the target populations.

GOAL #11: Improve BHHF utilization and monitoring capabilities through improved data management processes to ensure that outcomes and results are tracked and the information gathered is used to modify and enhance the system as needed.

GOAL #12: Implement revenue enhancement and cost saving initiatives to help fund the new service system.

GOAL #13: Implement a fiscal approach to funding behavioral health services that promotes and rewards accountability, programmatic creativity, efficiency, and competitiveness.

GOAL #14: Compel the Office of Health Facilities and the Office of Behavioral Health Services to function as an integrated unit within the Bureau of Behavioral Health & Health Facilities to assure that the system reflects a continuum of services that functions in a coordinated manner to best meet the needs of the target populations.

GOAL #15: Expand jail diversion strategies such as drug courts, mental health courts, teen courts, and treatment compliance orders to divert individuals from occupying forensic beds in state psychiatric facilities and to promote community-based service options.

GOAL #16: Provide on-going education and information regarding the consumer advocacy, grievance, complaint, and appeals procedures required of every licensed behavioral health provider to ensure that the process is better understood and more properly utilized.

GOAL #17: Expand data collection to include both Medicaid and non-Medicaid eligible populations for the purposes of improving data sources regarding services, improving utilization management, and increasing quality assurance.

GOAL #18: Develop an improved staff recruitment, retention, and development plan, including statewide work force development initiatives to ensure that the state has a well trained, highly qualified workforce and consumers can readily access the high quality provision of services and supports.

GOAL #19: Maximize service and support opportunities available to Medicaid consumers by redesigning existing waivers and writing new waivers to generate new federal revenues that can provide additional service options. Continue to closely follow the development of regulations and guidelines defining the waiver options proposed under the Deficit Reduction Act for applicability to West Virginia.

GOAL #20: Review and modify the Health Care Authority's Certificate of Need process to ensure that it is not inadvertently having a negative impact on consumer choice or the promotion of a competitive market, as choice and competition can improve both the quality of service and consumer outcomes.

GOAL #21: Streamline various monitoring and auditing processes and improve information-gathering in order to facilitate quality outcomes for consumers without creating burdensome reporting requirements for providers.

GOAL #22: Enhance access to services in the rural areas of the state by reimbursing providers for efficiencies such as telemedicine, electronic medical records, and other innovative practices that promote better access to and the provision of high quality services.

GOAL #23: Review the progress to date made on the implementation of the Single Point of Entry service brokerage model and communicate the progress to stakeholders of the behavioral health system.

II. PURPOSE & METHODOLOGY

Purpose

Public Consulting Group, Inc. (PCG) was contracted by the State of West Virginia Department of Health and Human Resources (DHHR) to facilitate a short- and long-term restructuring of the behavioral health service delivery system.

A central component of this project was to collaborate with staff from the Bureau for Behavioral Health & Health Facilities (BHHF) as well as other stakeholders within and outside of DHHR, including consumers, family members, advocacy groups, and providers, to best plan for a service infrastructure that supports consumer-driven and family-centered behavioral health services with a focus on recovery and resiliency. Resiliency is defined as the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses and to go on with life with a sense of mastery, competence and hope. These are important tenets of an innovative, advanced service system that seeks to fully support real choice and control and the right to rich experiences, learning opportunities, employment and freely given relationships.

In our effort to delineate a vision for a behavioral health system in West Virginia that allows for these tenets to be fully met, we have tried to be specific to the system's particular target populations and their individual experiences and issues in navigating the service system. However, we also realize that each individual's contact with the system is unique. Therefore, this report was developed with a significant reliance upon stakeholder input that was gathered by way of focus groups in eight different sites throughout the state as well as through individual and group interviews with stakeholders.

The goals of this project embraced the promotion of interagency collaboration, the enhancement of programs and services that facilitate positive outcomes for consumers, cost effectiveness, and the inclusion of a wide variety of stakeholders to ensure that all points of view were heard.

Methodology

Several key objectives were established for the project, which included: producing a statewide study of West Virginia's current behavioral health system; ensuring the involvement of stakeholders throughout the planning process; providing a linkage with West Virginia's Behavioral Health Commission; promoting collaborative efforts within and outside of DHHR; designing optimal funding strategies to support system redesign including approaches of integrated funding; and, preparing a report on the behavioral health system highlighting key system redesign goals.

PCG staff members formed 3 teams to complete this work, based on background and experience: a Program & Clinical Team, a Legal & Regulatory Team, and a Budget & Reimbursement Team. We began the project by facilitating on-site project kick-off meetings. During the project kick-off meetings, our project team was introduced to the state staff members who would be involved in this project, discussed the goals and anticipated outcomes of the project, determined possible stakeholders to interview, reviewed the project expectations as a group, and conducted interviews and data collection with BHHF and other Bureau staff.

Once the project kick-off meetings were facilitated, we set out to fully understand and analyze West Virginia's behavioral health service system as a whole. This step of the project involved individual interviews, group interviews, and focus groups throughout the state to gain input from state staff

members, consumers, family members, providers, advocates, and legislators; developing a data request to BHHF to obtain relevant documentation pertaining to the system's programs and services, information technology utilization, financial structure, and reporting mechanisms; and meeting with a core group of state staff on a bi-weekly basis to discuss any barriers to receiving information and to confirm the receipt of information. Information and feedback collected during this phase of work included:

- strengths, weaknesses, and capacity of behavioral health service system within and outside of DHHR;
- current use of diversion and the subsequent need for additional community-based services;
- consumer and family needs for behavioral health services and community supports;
- the state's compliance with regulatory and judicial mandates (i.e. Olmstead);
- provider capacity to deliver core services and community supports in appropriate settings;
- the unique role of the Comprehensive Community Mental Health Centers ("Comprehensive Community Mental Health Centers"), hospitals, MRDD centers, and other providers of behavioral health services;
- information resources within DHHR and at provider sites;
- data integrity of current systems;
- current regulatory environment, including Chapter 27 of West Virginia Statute;
- organizational structure of BHHF and its administrative capacity to support system redesign;
- current federal, state and other third-party funding streams;
- efficiency of allocation methodologies for system funding, including mechanisms for disbursement of funds to sub-recipients; and,
- the use of alternative funding / accountability methods.

This report represents the culmination of our findings and puts forward goals for the redesign of West Virginia's behavioral health system. Stakeholder feedback has been included in this report, as individuals and groups provided feedback to BHHF on the draft report, released to the public in October of 2006. Groups submitting feedback to the Bureau on the draft report included state staff, private and state-operated providers, consumers, family members, advocates, and legislators.

III. VISION FOR REDESIGN AND STAKEHOLDER IMPACT

We envision a very different behavioral health system in West Virginia in three years than what is in place today. By 2010, with all or most of the goals detailed below achieved by BHHF, we believe that West Virginia will be a state with a well-respected, cutting-edge behavioral health system that is supported by accountable and balanced federal and state funding. Consumers will rely upon the Single Point of Entry service brokerage model to easily obtain needed, high quality services and supports in all regions of the state. The Single Point of Entry service brokerage model will also provide consumers with improved choice in their decisions regarding service providers. Added clinical expertise and specific behavioral health knowledge will improve the delivery of services and supports by the system's direct care workforce. New opportunities for services will exist for consumers and providers through the addition of Medicaid waiver programs and amendments to existing Medicaid waiver programs. The roles and responsibilities within the DHHR Bureaus will be well-defined in the new system and there will be consistent communication between the Agencies, Offices, and Bureaus of the state's behavioral health system in order to accommodate the smooth transitioning of consumers through a comprehensive continuum of services. Quality providers, who are well-informed by the State about all aspects of the system and interact on a daily basis with the Bureau, will be a central component of the new system. Technological innovations, such as electronic medical records and telehealth resources, will be incorporated into the system to promote further access to services and supports. Precise monitoring approaches and quality assurance methods will be in place throughout the system and evidence-based practices will be applied.

Redesigning the behavioral health system to accommodate a new vision of behavioral health service delivery in West Virginia will have a significant impact on the stakeholder groups that were consulted during the development of these goals:

Consumers will:

- realize more choice in the supports and services received;
- be able to self-direct their services;
- experience a system where the process of how to access services and supports is clear;
- receive higher quality services;
- have a wider range of services and supports available to them;
- have access to a well-understood grievance process to resolve any problems;
- have more of a voice within the system; and
- experience an improved quality of life.

Family Members / Guardians will:

- experience more choices and less confusion when interacting with the service system;
- have more voice within the system;
- experience more support and better communication with providers and agencies; and
- experience more satisfaction with the services and supports that their family member is receiving.

Providers will:

- develop improved communication amongst each other and with BHHF;
- have the ability to serve the client instead of simply following the money;
- provide higher quality services and supports to consumers as well as increased information and communication to their family member(s);
- incorporate more clinical services and knowledge into their service mixes;

- experience less burdensome paperwork and quality assurance procedures; and
- have a chance to incorporate telehealth innovations into their everyday processes.

State Agencies will:

- have a chance to more effectively communicate and collaborate with each other;
- rethink the way in which services and supports are delivered to consumers;
- restructure the types of services offered within the system;
- reassess the consumers served by the system;
- have a chance to communicate the vision and mission statement of the system more effectively to stakeholders;
- have a chance to change the way in which services are funded;
- have the ability to provide higher quality and a wider range of services;
- bring added accountability into the West Virginia behavioral health system; and
- move the system towards being a national leader in the delivery of high quality behavioral health supports and services.

NEW SYSTEM OF BEHAVIORAL HEALTHCARE IN WEST VIRGINIA		
FROM:		**TO:**
System dominated by Comprehensive Community Mental Health Centers	→	Network of providers selected by consumer through system navigator
Multiple points of entry	→	Single point of entry
Grant funding	→	Fee for Service
Workforce crisis	→	Workforce Development initiatives
Duplicative, burdensome auditing processes	→	Streamlined auditing processes
Sparse data collection	→	Comprehensive data collection
Lack of stakeholder access to information	→	Information available to all stakeholders
Vision and mission statement do not actually convey values, purpose, philosophy of Bureau	→	Vision and mission statement accurately reflect values, purpose, philosophy of Bureau
Providers follow $ instead of supplying needed services to individuals	→	Consumer choice compels providers to provide quality services in order to receive $
Lacking access and accountability	→	Improved access and accountability
Unclear roles and responsibilities within DHHR, communication gaps amongst Bureaus	→	Clearly distinguished roles and responsibilities within DHHR, collaboration amongst Bureaus
No long-term strategic plan in place	→	Cycle to ensure ongoing planning and evaluation
Website with information gaps	→	Enhanced website
Undefined / unclear target populations	→	Clearly defined targeted populations
Service menu poorly defined	→	Well-defined publicly-funded behavioral health package
Little interaction between primary and behavioral healthcare	→	Improved collaboration between primary and behavioral healthcare
Communication gaps between BHHF & providers	→	Regular communication between BHHF & providers
Little utilization of evidence-based practices	→	Focus on evidence-based practices where applicable
Narrow jail diversion strategies	→	Expanded jail diversion strategies
MR/DD and A&D Waivers need revision and updating	→	New and redesigned waivers
Limited access to services in rural areas	→	More access in rural areas through telehealth

IV. TRANSITION PLAN TO ACCOMPLISH REDESIGN

The goals for system redesign that are provided in this report are based on our current understanding of the State of West Virginia's behavioral health system and reflect our thoughts regarding the direction in which the system should move to more efficiently provide improved services to its consumers. The Transition Plan presented in this section is a tool that BHHF should utilize for the implementation of these goals. For purposes of this document, the term "Transition Plan" means the process by which West Virginia's system of behavioral health incorporates the goals proposed in this report.

The Transition Plan includes goals that should be started within the next three (3) years, with detailed tasks for the completion of each stated goal, potential responsible agencies to carry out the goal, and an indication of whether or not legislative changes are required to accomplish the goal. The goals have been listed in order of priority so as to provide BHHF with the sequential approach and framework that we believe will be most beneficial in completing the process of systems change; however, it is not an expectation that BHHF will be able to address every goal simultaneously and within a short amount of time. Therefore, it is important to note that goals listed later are no less important than goals listed earlier in the list. Also, it is likely that steps towards implementation of goals indicated later in the Transition Plan will begin sooner than indicated, given the complexity of some of the goals and the resources required for successful implementation.

Transition Plan: Goals with Key Tasks for BHHF System Redesign			
GOALS	**KEY STEPS**	**Responsible Party**	**May Require Legislative Changes**
Goal #1: Establish an Advisory Group to guide, oversee and monitor the Bureau's system redesign efforts ↓	a. Select members to join the Advisory Group b. Convene and set a schedule of regular, monthly meetings to occur over the next 3 years c. Discuss the Single Point of Entry service brokerage model that will be infused into the State's behavioral health care system over the course of the next 3 years and the steps of work that will need to be completed to bring this model to fruition d. Collectively review the goals and subtasks for system redesign; add or edit the goals and subtasks as necessary e. Determine the process that will be used to set contracts with service brokerage agencies and direct service providers--this will include making decisions such as determining the members of an RFP writing subcommittee, establishing the timeline and steps of the procurement process, developing the scoring criteria and evaluation methodology, determining the terms and conditions of the RFP, and setting a proposal review subcommittee f. Schedule a meeting with BHHF and other agencies for the purpose of determining the list of target populations that the behavioral health system will serve g. Work with the Office of Finance & Administration to discuss different financing strategies that could support the revised model of behavioral health service delivery	Advisory Group, BHHF	No
Goal #2: Revise and enhance BHHF's mission and vision statements ↓	a. Select a subgroup from the Advisory Group to assist BHHF in the completion of this goal b. Reach a consensus on the proposed changes to the current mission and vision statements c. Draft proposed revisions of these items and modify them through a public feedback process with stakeholders	Advisory Group, BHHF, All Stakeholders	No
Goal #3: Discuss plans for launching a Single Point of Entry service brokerage model ↓	a. Determine the geographic dispersion of the proposed service brokerage entities or other model of service delivery b. Establish the role of the service brokerage entities as the area's single point of entry into the behavioral health care system by drafting and finalizing a description of the service brokerages' responsibilities c. Discuss strategies that can be implemented during this redesign process that will increase the interaction between primary care and behavioral health care providers d. Revise the West Virginia Code, rules and regulations as necessary to support the revised system e. Adopt a continuum of care and expand funding for community-based services for children & families, including juvenile justice • Review the service systems in place for children and families in other states that are working well • Engage in a process to consider improvements to the system of care for children that can be infused into the system redesign / service brokerage model • Create linkages between the state's juvenile justice agency and other state and local agencies; ensure that these linkages will remain with the implementation of redesign efforts f. Draft, finalize and release to the public a Request for Proposals (RFP) to procure the service brokerage entities g. Draft, finalize and release to the public a Request for Proposals (RFP) to procure the direct service providers	Advisory Group, BHHF, BMS, Providers, DJS	Yes
Goal #4: Clarify and distinguish the roles and functions of the various Bureaus within DHHR ↓	a. Select members of the Advisory Group to assist with the achievement of this goal b. Delineate a list of services and supports that each Bureau is currently charged with providing and/or funding, and revise the list to include services and supports that these Bureaus should provide and/or fund in the future c. Distribute list amongst Bureaus for feedback and consensus-building purposes d. Publicize list by posting on the DHHR website so as to better inform consumers and other stakeholders of the responsibilities of the various Bureaus within DHHR e. Strategize to establish a more collaborative approach between BHHF and BMS in the provision of behavioral health care services and the utilization of Medicaid dollars f. Set objectives for each Bureau within DHHR to meet each year in order to solidify collaboration across the Department	Advisory Group, BHHF, BMS, BPH, BCF	No
Goal #5: Conduct ongoing strategic planning for the behavioral health care service system ↓	a. Schedule and facilitate meetings to discuss the goals, services, and outcomes expected of West Virginia's behavioral health care service system in the next 3 years and in the next 5 years (meetings should include a complete array of BHHF stakeholders) b. Develop a draft planning document that details a strategic plan for the entire behavioral health system, including goals, objectives, and anticipated outcomes over a three year and five year timeframes c. Ensure that the meetings and draft planning document address geographic issues and consider cultural/target population issues d. Publish the planning document on BHHF's website in order to make it accessible to stakeholders statewide e. Establish an annual statewide behavioral health conference that will assist in revising and adding to the planning document	BHHF, Stakeholders, BMS	No
Goal #6: Update the BHHF website ↓	a. Enhance the BHHF website by incorporating ample amounts of information for consumers, providers, advocates, and state employees and improving consumer ease in navigating the site; include mechanisms to monitor its utilization and seek feedback from users b. Post regular updates on the website regarding the system's redesign efforts, goals met, and outcomes achieved	BHHF	No
Goal #7: Establish clear definitions for BHHF's target populations and determine their needed and desired services ↓	a. Collaborate with the Advisory Group to develop and finalize a comprehensive list of the target populations that BHHF will serve b. Identify a comprehensive catalog of supports and services needed and desired by each of the target populations c. Assess where clinical expertise is needed within the continuum of services and supports for the target populations (on a regional level and/or provider level) d. Facilitate a review process to obtain feedback from all applicable Bureaus within DHHR regarding the list of target populations and associated catalog of services e. Develop a draft menu of services that will be provided to the target populations by the service brokerage agencies and a draft menu of services that will be provided to the target populations by the direct service providers f. Obtain feedback on the proposed menus of services from all Bureaus within DHHR and revise draft service menus as necessary g. Schedule and facilitate collaborative training sessions for providers, DHHR staff, and other stakeholders across the state on the services and supports needed by target populations	Advisory Group, BHHF, Other DHHR Agencies, Providers	No

Goal #8: Discuss and develop a basic behavioral health service package to be provided throughout the state to all consumers meeting the eligibility criteria for the target populations ↓	a. Finalize the menu of services to be provided by the service brokerage agencies and the menu of services to be utilized by direct service providers b. Work with OHFLAC to review provider licensing requirements to ensure that no updates / revisions are needed to fulfill the objectives of the revised behavioral health c. Develop a comprehensive approach to funding direct services in the redesigned service system • Review options for payment systems by service category (case rate, per diem, etc) • Identify gaps in the funding of current services • Establish a preliminary funding methodology for service provision and facilitate a meeting to review and finalize	Advisory Group, BHHF, BMS, OHFLAC	No
Goal #9: Facilitate ongoing dialogue with providers of behavioral health supports and services ↓	a. Reach out to providers in the state to discuss the redesign efforts that are being planned and those that are underway; provide a feedback mechanism so as to obtain provider input statewide on system redesign plans b. Employ marketing efforts to encourage private providers to participate in existing provider associations c. Set up quarterly meetings for those providers who are unable to participate in the associations	Advisory Group, BHHF, Provider Associations, Private Providers	No
Goal #10: Compel providers to move toward the adoption of evidence-based practices, focusing on quality and outcomes ↓	a. Engage in a process to assess the Bureau's Quality Management and Improvement efforts b. Complete a gap analysis to determine the areas that are not covered c. Develop and include more specifications and requirements for accountability in BHHF's contracts with providers d. Establish mechanisms for contract enforcement	BHHF, BMS, Providers	No
Goal #11: Improve BHHF utilization and monitoring capabilities through improved data management processes ↓	a. Develop a regular report showing the number of clients served and costs of the services b. Develop a "behavioral health dashboard" to measure the progress and impact of quality management and utilization criteria	BHHF	No
Goal #12: Implement revenue enhancement and cost saving initiatives which help fund the new system of care ↓	a. Consider implementing the following community services revenue enhancement strategies: • Align existing Medicaid rates with Comprehensive Community Mental Health Center costs • Transition Targeted Case Management (TCM) to a monthly billing rate • Eliminate the requirement to prove "demonstrated capability" for authorizing Rehabilitative Services • Enhance Medicaid rates for mental health services provided in schools b. Consider implementing the following State facility revenue enhancement and cost saving strategies: • Maximize Medicaid fee for service (FFS) or disproportionate share (DSH) reimbursement • Implement Medicare initiatives which maximize funding for the state acute care hospital and psychiatric facilities • Implement cost savings initiatives which promote the effective and efficient management of facility service	BHHF	No
Goal #13: Implement a fiscal approach to funding services that promotes accountability, creativity, efficiency, and competitiveness ↓	a. Develop IOP rates for services under the new service system b. Select Respite Care Medicaid coverage option for mental health and develop BHHF rate c. Identify all available funding for Supported Employment services d. Develop a bundled Crisis Service rate for BMS and BHHF e. Enhance the BMS ACT rate and develop a BHHF ACT rate f. Enhance the BMS Day Treatment rate and develop a BHHF Day Treatment rate g. Eliminate or significantly modify the current method of using grants to fund behavioral health service delivery • Convert residential programs to a per diem reimbursement based on audited cost reports • Convert outpatient grants to procedure code payments • Convert case management to a fee-for-service payment with an inflation index • Transition behavioral health codes to fee-for-service • Consider options for developing a procedure code-based payment technology • Outline options for claims payment technologies	Advisory Group, BHHF, BMS, BCF, DOE	Yes
Goal #14: Compel the Office of Health Facilities and the Office of Behavioral Health Services to function as an integrated unit ↓	a. Engage in a process to align the facilities and the community-based system under the same leadership and direction to propel the redesign efforts b. Create several new roles and staff positions that will allow the two offices to interact more collaboratively c. Revise West Virginia Code, rules and regulations as necessary to complete these changes	BHHF (specifically OBHS, OHF)	Yes

Goal #15: Expand jail diversion strategies ↓	a. Conduct a review of jail diversion strategies used across the country and in comparable states b. Determine program and financial feasibility of implementing jail diversion programs in West Virginia c. Develop a statewide implementation strategy	BHHF, BMS, Department of Corrections	No
Goal #16: Provide education and information regarding consumer grievance, complaint, and appeals procedure ↓	a. Engage in public education and outreach processes to educate West Virginians on the current complaint processes b. Educate consumers on the role and functions of the Office of the Ombudsman c. Disseminate information regarding advocacy groups and agencies	BHHF, Office of the Ombudsman	No
Goal #17: Expand data collection to cover both Medicaid and non-Medicaid populations ↓	a. Discuss the most efficient ways of collecting data b. Determine the data elements that need collection with regard to each target population and service	BHHF, BMS	No
Goal #18: Develop an improved staff recruitment, retention, and development plan ↓	a. Discuss the state's current issues of staff training, retainment, and recruitment with stakeholders b. Develop strategies to address the recruiting and retaining of qualified staff, particularly in light of redesign efforts c. Recruit more clinicians and clinical consultants for the Bureau to utilize • Add a consulting psychiatrist to BHHF's current workforce • Create the position of Assistant Commissioner for Clinical Services • Engage in a process to discuss other possible strategies to incorporate additional clinical leadership into BHHF	Advisory Group, BHHF, Stakeholders	Yes
Goal #19: Maximize opportunities available to Medicaid consumers by redesigning existing waivers / writing new waivers ↓	a. Increase the availability of state general funds to add flexibility to the menu of supports and services offered through the waivers b. Develop a supports waiver for eligible individuals who may not require 24-hour supports c. Consider the use of innovative person-centered planning and self-directed service options d. Amend existing waivers and / or develop new waivers as necessary	Advisory Group, BHHF, BMS, CMS	No
Goal #20: Review and modify the Health Care Authority's Certificate of Need (CON) process ↓	a. Engage in public discussions about the impact of the current CON process and the utilization of Chapter 27 regulations on the proposed new service brokerage model b. Use the public discussions to explore the implementation of a more viable CON process and changes to Chapter 27 c. Assist legislators in the revision of CON rules and regulations and Chapter 27 regulations as needed	Advisory Group, BHHF, OHFLAC	Yes
Goal #21: Streamline various monitoring and auditing processes and improve information-gathering ↓	a. Encourage providers to adopt a regular methodology of documenting their activities b. Establish / revise Bureau standards conducting an annual evaluation of providers and their data	BHHF	No
Goal #22: Enhance access to services in the rural areas of the state by reimbursing providers for efficiencies such as telemedicine, electronic medical records, and other innovative practices ↓	a. Consider the implementation of reimbursement methodologies to advance the concept of telemedicine across the state b. Conider the benefits and financial implications of implementing electronic medical records (EMR) c. Develop a statewide strategy for implementation of incentives	Advisory Group, BHHF	No
Goal #23: Review implementation of Single Point of Entry service brokerage system to date ↓	a. Review the progress to date b. Determine areas where implementation is succeeding and areas where implementation of the new system is encountering significant barriers or delays c. Develop and implement solutions to any issues or barriers d. Continue to communicate the progress of the implementation of the new service model to stakeholders across the state	Advisory Group, BHHF	No

V. GOALS TO ACCOMPLISH REDESIGN

The following goals for the Bureau to begin working towards over the course of the next three (3) years have been developed based on an extensive data review, a review of the current service system's structure, and the feedback obtained from consumers, family members, advocates, state agency staff, providers, and legislators on their perception of the current behavioral health system. These goals move BHHF towards the common goal of all stakeholders of having a more recovery-based, person-centered system that incorporates more consumer choice and permits providers to supply high quality services.

We realize that in some cases the information received was not completely accurate, given that it represented a perception of the state's behavioral health system. These perceptions can represent divergent points of view on what should be changed in the system, how it should be changed, and when it should be changed. With these viewpoints in mind, we have created goals for the Bureau that try to address these sometimes divergent perceptions, while acknowledging that all of these tensions cannot be attended to at once. Readers of the report need to keep in mind that while changes are occurring to the state's behavioral health system, the current system will continue to exist and provide services to the residents of the state. This will, at least initially, add to the complexity of the change.

The proposed goals for system redesign, detailed on the following pages, may lead to drastic changes in the provision of behavioral health services across the State of West Virginia. Therefore, in order for West Virginia to achieve clear and tangible results, the implementation of the proposed goals must be approached gradually and through a carefully planned process.

Not all changes can or should be taken on immediately; it has been necessary for us to prioritize the actions that should be taken first, and in doing so we considered the current financial, political and cultural environment in West Virginia. The prioritized actions represent the changes essential to the development of a stronger foundation for the state's behavioral health system, to better meet the needs of the target populations, to maximize the use of federal revenues, and to effectively and efficiently spend state general funds.

GOAL #1 Establish a group that will guide, oversee and monitor system redesign efforts over the next three years for West Virginia's system of behavioral health system that will prioritize regular communication with the Bureau.

We recommend that the Bureau's first goal in working towards a redesigned behavioral health service system be the organization of a group that guides and monitors the systems change activities throughout the subsequent three years, as delineated in the Transition Plan found within this report. This Advisory Group will be able lend added focus to the Bureau's redesign efforts, provide the Bureau with regular status updates as implementation progresses, and will be able to organize subgroups for redesign goals that require additional effort and attention.

The Advisory Group will be comprised of the West Virginia Behavioral Health Commission and any additional stakeholders that can provide helpful input to the group, including stakeholders. The Bureau should also assist in convening the first meeting of the Advisory Group and working with them to set a schedule of regular, monthly meetings that will occur over the next three (3) years of the redesign effort.

The Advisory Group should collectively review the goals and subtasks that have been outlined for system redesign in West Virginia and add or edit the goals and subtasks as necessary. In particular, the Advisory Group should focus on determining the merits of the Single Point of Entry service brokerage model and

the steps of work that will need to be completed to bring this model (or other model recommended by the Group) to fruition.

This Advisory Group will be central in providing recommendations to the Bureau as redesign goals and activities are discussed and ideas are formulated. The Bureau will then be the final decision-maker, utilizing the Advisory Group's recommendations to finalize decisions on redesign activities.

GOAL #2 ***Revise and enhance the vision of BHHF and its mission statement to more clearly and accurately reflect the values, purpose, and philosophy of the Bureau and ensure that these are well understood by all stakeholders.***

The Bureau's role is to provide continued leadership for the behavioral health system in the State of West Virginia. An important part of this leadership role is to set clear policy for the direction of the service system. The policy-setting function of the Bureau includes establishing the vision, mission, values, and philosophy by which the system is developed, guided and evaluated. An essential action for the Bureau is to communicate a stronger vision and a more resounding mission statement to its stakeholders, who have indicated that they are presently without a full understanding of the values, philosophy, roles and responsibilities of the behavioral health system in West Virginia that are assumed by BHHF.

It is recommended that a subgroup from the Advisory Group be selected to assist BHHF to revise its current vision for the system, enhance and solidify its mission statement, and re-establish the values and principles of the Bureau. A vision is a statement of the reason and purpose of the organization and a statement of what it hopes to achieve. A mission statement specifies the major goals and performance objectives for the organization and is specific as to who is served and any unique competencies required. Values and principles encompass the philosophical underpinnings of the organization, and in the case of the Bureau, would include such things as recovery focus, wellness, self-direction, person-centered, integration, independence, interdependence, and a community-based focus.

Once a consensus is reached between the subgroup and BHHF on the proposed changes to the current mission and vision statements, a draft of the proposed revisions should be vetted through a public process with stakeholders. After input and feedback has been received, the Bureau should make any agreed-upon revisions and publish the new versions. These revised documents will serve as the basis for all additional changes throughout the reorganization process.

GOAL #3 ***Discuss plans for launching a Single Point of Entry service brokerage model for accessing behavioral health services throughout the state, which includes an independent service / care coordination component. It is essential that the service brokerage entity be separate from the direct provision of services. This will facilitate the delivery of behavioral health services to the target populations in a streamlined and coordinated manner and will result in improved access and accountability.***

Under the West Virginia State Code 27-2A-1, the director of health and human services is "…authorized to establish, maintain and operate comprehensive mental health centers and comprehensive mental retardation facilities…" Among the specified requirements is that each Comprehensive Community Mental Health Center has "… a written plan for the provision of diagnostic, treatment, supportive and aftercare services and written policies and procedures for operation of these services." The Code continues to delineate the roles and responsibilities of the state as well as the non-profits that operate the Comprehensive Community Mental Health Centers, which are supposed to form the foundation of a comprehensive system of behavioral health services.

Our analysis of the system found that the current Comprehensive Community Mental Health Centers are each unique unto themselves; as a result, the current system does not fulfill the statutory vision of providing a comprehensive system of behavioral health services for consumers. Regardless of how the Comprehensive Community Mental Health Centers have evolved, the focus now needs to shift towards how the Bureau can establish a system of comprehensive behavioral health services that meets the needs of its consumers and supports the concepts of access and equity.

PCG's Proposed Model for Providing Comprehensive Behavioral Health Services

In order to reform the current service delivery system into one that is more consumer-friendly and comprehensive, we recommend that BHHF engage in a process to procure administrative service brokerage entities across the state that would manage the service system locally. These brokerage entities would provide a single point of entry into the behavioral health system and would provide a variety of administrative functions to help consumers navigate the service system and obtain the level of care that best meets their needs. The entities would be charged with the following functions:

- intake;
- eligibility determination;
- initial assessment and planning;
- service authorization;
- service capacity and provider development (i.e. qualified provider panel);
- information and referral;
- quality management;
- some prevention services, including education and counseling for individuals at risk activities designed to reduce risk;
- coordination of physical and behavioral health services for eligible individuals; and,
- initial clinical assessment(s) review of existing reports and evaluations.

While the service brokerage entities will conduct eligibility determinations, this will be limited to BHHF service eligibility determination. By this, we mean a determination of whether or not the individual meets the defined eligibility criteria for one of the target populations (listed later in this report). This determination would be completed using consistent tools and criteria to establish eligibility, without regard to funding streams for which the individual may be eligible. Medicaid eligibility determination would not be completed by these entities, but rather through the existing Medicaid eligibility process administered by BMS. However, the brokerage entities could refer or assist individuals with the Medicaid application process.

It is important to note that the service authorization function performed by the brokerage entities will be distinct from the Medicaid prior authorization process currently conducted by the ASO, since their role only pertains to the Medicaid-eligible populations. Using this new model of service delivery, the brokerage entities will complete service authorization for all BHHF consumers, regardless of payer source, as long as the funding flows through BHHF (which includes any public funds).

The service brokerage entities recommended in this new model will be procured through a competitive bidding process, such as a Request for Proposals (RFP). The RFP will be developed by the Bureau to procure these services statewide and would provide specific detail regarding the functions, performance requirements, and interactions of the brokerage entities with BHHF and with direct service providers.

Setting this up as a competitive process ensures that the service brokerage entities are able to provide all required services and meet consumer needs.

This goal does not suggest the elimination of the Comprehensive Community Mental Health Centers from the behavioral health service system—the procurement of the brokerage entities will merely result in the administrative functions being separate from the provision of direct services. Therefore, each of the current Comprehensive Community Mental Health Centers will have the opportunity through the competitive bidding process to decide if it wants to function as either a service brokerage entity or as a direct service provider. **No entity will be able to act as both a service broker and a direct service provider under this new system of service delivery—entities must select one of these two operations.**

Distribution of the Service Brokerage Entities

A key decision in the development of this new system will be to determine how many service brokerage entities will be established across the state. The Comprehensive Community Mental Health Centers current employ a system that divides the state into 13 service areas, but we recommend that BHHF engage in a process to consider what would be the most appropriate configuration for the distribution of the service brokerage entities. As it engages in such process, we recommend that BHHF take into account:

- the size of the geographic area covered by the entity / the number of miles / length of time a person would have to travel to reach an office;
- the number of potential eligible individuals who would need to access the entity for service brokerage functions;
- the availability of service providers in the defined geographic area; and,
- other geographic delineations used in the state that citizens are familiar with as service areas or typical locations for accessing social and medical services.

Regardless of the number of service areas identified, the procurement process will give BHHF the opportunity to determine the number of and the way in which service brokerage entities are established. BHHF may decide to have one vendor operate all of the service brokerage entities throughout the state, may decide to have different vendors operate separate entities, or may prefer a combination of these choices.

Single Point of Entry Process

The entities selected as service brokers in each one of the service areas will act as the area's single point of entry for accessing services and supports paid for with public funds through the behavioral health system. By definition, a single point of entry process provides:

- one place for information, referral, and advocacy;
- one place to find out about and apply for services; and,
- one place to provide recommendations about services[1].

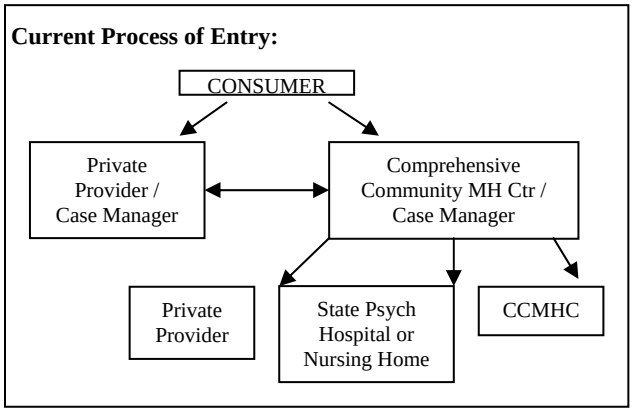
A single point of entry process will assist consumers and their family members considerably. Single Point of Entry processes are already successfully running in 32 states and the District of Columbia[2]. In

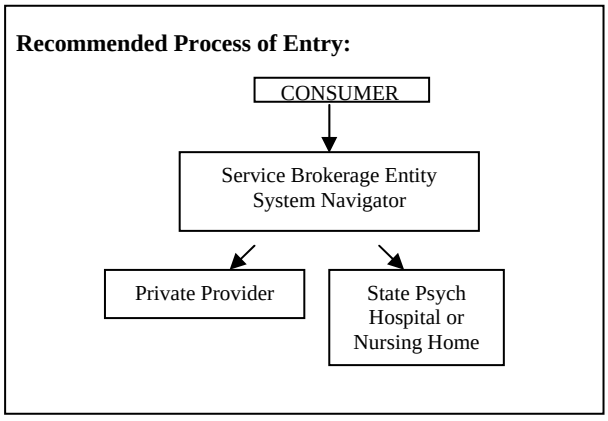
[1] http://olrs.ohio.gov/ASP/olrs_spoe.asp

West Virginia, the single point of entry process would allow consumers and family members to have their BHHF eligibility determined in one step and then be assigned to a system navigator who will assist in the identification and authorization of appropriate services and supports. Services can then be obtained from any of the qualified providers who are part of the provider network, including private providers, school health providers, and primary care centers, a list of which will be maintained and utilized by the service brokerage entity. Individuals who receive behavioral health services through an Emergency Room visit or through school-based mental health services will be routed to a system navigator / service brokerage entity following their ER visit or interaction with the school-based clinician.

BHHF will then establish units and rates for the approved services and supports. In most cases, units of service will be specified either by the hour, by the day, or in some instances, by the month. In order to assure and build capacity and availability of services such as crisis respite or ACT / PACT teams, BHHF may want to contract for ongoing capacity and availability based on a projected level of utilization, thus assuring that the service exists and is available when needed.

The single point of entry is a process, not a physical location, so consumers even in the most rural areas of the state will be assisted by the new process. Separating system navigators from direct service provision allows for the navigators to advocate for, independently monitor, and coordinate services on behalf of eligible individuals. The appropriate size of caseloads will to be determined based on a case-mix approach to ensure that system navigators have adequate time to work with the individuals, who will have varying degrees of need and complexity within the array of services and supports that have been authorized. Specifics, such as publicizing the entry points in all areas of the state and how many service brokerage entities will exist in the state, will be determined during the implementation phase of redesign efforts.





Service Provider Agencies under PCG's Proposed Model

Under the new model, each service brokerage entity would be responsible for obtaining and maintaining a cadre of qualified providers that effectively meet the needs of the BHHF target populations. By qualified providers, we mean that providers of services and supports would be required to meet licensing, certification or other appropriate standards that are already in place in West Virginia. Providers must accept and fit into the BHHF menu of services and supports for target populations, corresponding

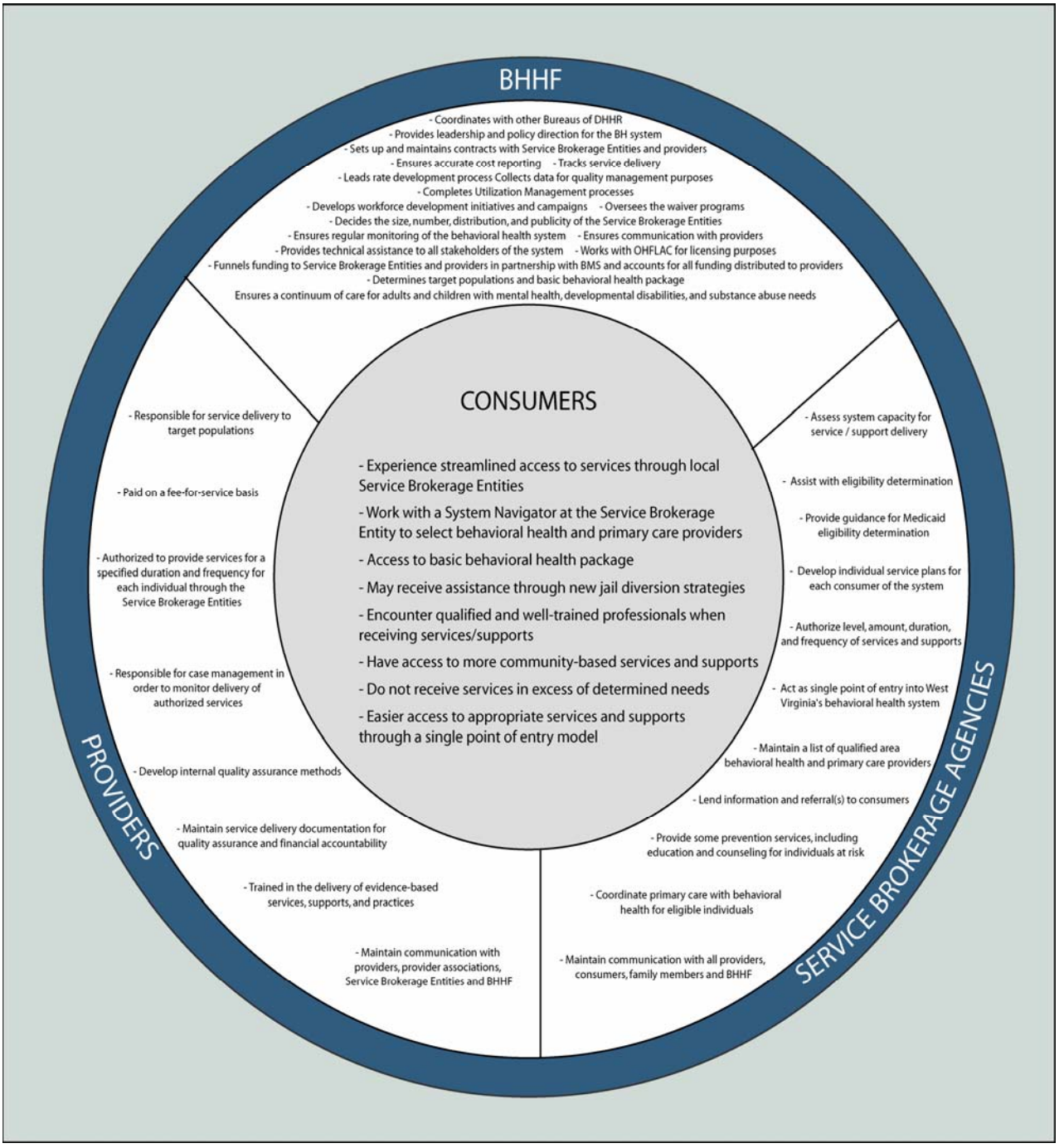
[2] Mollica, Robert and Gillespie, Jennifer. "Single Entry Point Systems: State Survey Results." National Academy for State Health Policy. August 2003: p.1.

published rates, and unit type. This will include services that are paid for with Medicaid as well as non-Medicaid dollars.

In most cases, service providers will be paid on a fee-for-service basis and will receive an authorization from the service brokerage entity that specifies the frequency and duration of the service / support to be provided for the eligible individual. Rates for the approved services and supports will delineate a unit for payment, such as hourly, daily, monthly, and depending upon the individual needs and choices, as well as the provider service offerings, the authorization could be for one or more service. This will improve accountability within the behavioral health system as opposed to the current method of funding services at the Comprehensive Community Mental Health Centers and private providers through grants.

Service providers would be responsible for case management in order to monitor the delivery of the authorized services within their agency. This would include the development of and/or participation in plans of service or Treatment Plans for individuals authorized to receive services from their agency. The service providers would also be responsible for having internal quality assurance methods to ensure the delivery of high quality services based on the approved service plans, to evaluate the progress of the individual. Additionally, service providers would be required to maintain service delivery documentation to substantiate financial claims for supports and / or services provided.

This recommended service model, which proposes a separation of the administrative service brokerage functions from the provision of direct services, will provide a consumer-friendly approach to providing comprehensive behavioral health services for all West Virginians. This model will assist in reflecting the values of self-direction, community integration, choice, recovery focus, and self-determination. However, it is important to point out that although PCG strongly endorses this new model for providing comprehensive behavioral health services in West Virginia, it is not intended to exclude other possible solutions or ideas that the Advisory Group may have.



Improving the Interaction of Primary Care & Behavioral Health Service Providers

The Single Point of Entry / Service Brokerage model we propose also seeks to improve the collaboration between primary care and behavioral health service providers. Interviews with stakeholders revealed that communication between primary health care providers and behavioral health providers in West Virginia is discontinuous and often a primary health care provider is not even in place for consumers. This leads

to an over-reliance on behavioral healthcare providers in the state, as they sometimes fulfill the role of a primary care provider, increasing their hours and the complexity of their work.

In order to increase interaction between primary care and behavioral health providers, one of the functions of the new service brokerage entities will be the coordination of primary care with behavioral health service providers. The brokerage entities will maintain list of primary care providers who currently collaborate well with behavioral health service providers and will also conduct outreach, with assistance from BHHF, to identify new primary care providers who can be added to the qualified provider list.

Increased alliances between primary and behavioral health care providers would improve the overall healthcare of West Virginians, assist in the reduction of healthcare costs, and aid in more effective time management of clinicians. In order to improve these relationships and facilitate better service coordination between the primary care provider and behavioral health provider, BHHF will need to provide the primary clinical leadership to identify the most effective methods to intervene. Creative strategies need to be developed to better link the primary health care provider on a routine basis with the behavioral health services team. This may include expanding case management responsibilities to include the assurance that each consumer has an identified primary care provider and recommending that primary care clinicians in the state promote holistic behavioral healthcare prior to an individual's receipt of behavioral health services.

It should be noted that West Virginia is not exceptional with regard to this issue. In fact, it has generated national concern. A January 2005 report from the National Association of State Mental Health Program Directors (NASMHPD) reinforces a recommendation from The American Association of Community Psychiatrists, which urges that behavioral health providers incorporate a systematic program for coordinating and integrating with primary care provider organizations in their communities. According to the report, an integrated program would include, at a minimum:

- effective means of bi-directional communications between behavioral health providers and primary care providers;
- determination of what information is most essential to share between the two types of providers; and,
- adoption of appropriate confidentiality and consent protocols[3].

The current national trend is to develop a Disease Management approach when redesigning mental health service delivery models. This effort is focused on incorporating interventions that are focused on the reduction and management of symptoms for adults with mental illness and children with severe emotional problems, with the goal to promote recovery. Disease Management works to match consumer needs with available resources to enable a positive outcome. For West Virginia, this approach will be useful particularly in underserved and understaffed areas. The steps West Virginia would need to take in initiating a Disease Management program would include: (1) sequentially incorporating Evidenced Based Practices (EBPs) throughout the service delivery system, including but not limited to Assertive Community Treatment, Family Psychoeducation, Supported Employment, Co-Occurring Disorders Treatment, Crisis Services, Psychosocial Rehabilitation Services and Medication Management, which have been identified as priorities by the state; and, (2) instituting a monitoring program that ensures the

[3] Parks, Joe, M.D. and David Pollack, M.D., editors. *Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities.* National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, January 2005.

development of EBPs in West Virginia adhere to the fidelity of the model—partnering with University research staff may help to accomplish this.

Implementing EBPs can be difficult and complex and there can be significant barriers that impede progress. For West Virginia, there will need to be an effort to address: any resistance to change that may emerge within entrenched organizations; the reimbursement structure, which currently does not support these practices; the lack of provider training specifically tuned to evidence-based practices; and, the gaps in resources that exist in various parts of the state.

Services for Children and Families

While redesigning the behavioral health service system over the next three years, BHHF also needs to adopt a continuum of services and expand funding for community-based services for children and families, including individuals involved in the juvenile justice system. The creation of such a system of services will promote better outcomes and may reduce the need for more intensive and / or continuing service needs in the future. Behavioral health services for children in the State of West Virginia reach only about 27% of the children believed to need them, as estimated by the Division of Children's Mental Health. A lack of concentration on these specialized services and financial support have led to a behavioral health system for children that does not cover the population's needed and requested services, leaves children without appropriate community supports, advances the idea of stigma surrounding behavioral health, hinders the opportunities of children and their family members, and counters the critical ideas of resilience and recovery. While certain focused initiatives and school-based mental health services have filled some of these gaps, these services are not universally available and don't reach all needy children in the state, especially juveniles within the justice system. Particular problems that were noted by stakeholders in the area of children's mental health include the following:

- a dearth of residential centers for children with developmental disabilities in the state;
- the system lacks a step-down / aftercare component, which may contribute to children cycling through the system;
- children's behavioral health resources operate in silos resulting in no continuum of services;
- a problem of "bouncing treatments" for children—kids are sent from one provider to another and average 13 placements throughout their utilization of children's services;
- no connection or communication between children's behavioral health and the state's system of juvenile justice; and,
- children are being sent out-of-state to receive services because there is a shortage of community services for children in West Virginia.

However, increased focus is beginning to emerge for children's behavioral health services in West Virginia, with parents and advocacy groups being more vocal in striving to create change. As an example, The Mountain State Family Alliance, as part of a system of care project, created a program of wraparound behavioral health services for children in the Charleston area that has been very successful. The Bureau, Department of Education, and Local Education Authorities have acknowledged that there is a need for services such as this in all areas of the state and, accordingly, have allocated $1M to the Division of Children's Mental Health to expand this program to other areas of the state over the course of next year.

Where it is present, school-based mental health in the state appears to be comprehensive and successful. As such, the state should strengthen its continually growing presence in school-based mental health programs through efforts by the Division for Children's Mental Health, so as to provide an all-

encompassing spectrum of services for the children of West Virginia. This modification would allow for the estimated 6% of public schools in the state that currently provide mental health services to significantly increase and would also improve equalization in the amount of services accessible to children in schools across the state. Planning for this increased presence could include heightened collaboration between the Division of Children's Mental Health and school-based mental health services to assure that there is a behavioral health services package available and accessible to children within a set amount of miles or within every school district.

GOAL #4 ***Clarify and clearly distinguish the roles and functions of the various Bureaus within the Department of Health and Human Resources, including the Bureau of Health and Health Facilities, the Bureau of Children and Families, the Bureau of Public Health, and the Bureau of Medical Services. Improve coordination, communication, collaboration, and ensure that there is efficient utilization of all funding streams, resources, and personnel so that the Bureau of Behavioral Health and Health Facilities can effectively provide leadership and policy direction in the area of behavioral health for the State of West Virginia.***

BHHF is the designated leadership entity and provides policy direction in the program areas of mental health, substance use, and developmental disabilities. In effectively performing this role, it is important that BHHF ensures that the other Bureaus of DHHR—Bureau of Public Health (BPH), Bureau of Children and Family (BCF), and Bureau of Medical Services (BMS)—understand how and where they should effectively interface.

It is recommended that a subgroup from the Advisory Group be selected to assist with the achievement of this goal. As a first step, the subgroup should work to delineate a list of services that each Bureau is currently charged with providing and funding. Once this list has been completed, any necessary revisions to include additional services and supports that each Bureau should provide in the future should be discussed. The revised list should then be distributed amongst the Bureaus for feedback purposes and publicized on the DHHR website to keep consumers informed of the responsibilities of various Bureaus.

Particular attention should be paid to the relationship between BHHF and BMS. Currently, providers in the BHHF system receive a significant amount of funding through BMS in the form of Title XIX dollars. Our assessment showed this is the basis for setting policy direction, and therefore, BMS takes the lead instead of BHHF. The result is a system focused on only those services that BMS will pay for and the delivery of services in a manner directed by BMS. We recommend that a more collaborative approach be taken in this area: BHHF needs to determine what services and supports need to be provided to the consumers it is charged with serving and then collaborate with BMS on the utilization of Medicaid dollars. Since both BMS and BHHF are located within the same umbrella department, the Secretary of DHHR can direct both Commissioners to engage in a planning process that delineates roles and responsibilities and ensures that policy issues are led by BHHF and funding issues are collaboratively worked out with BMS when federal Medicaid dollars are utilized. It is recommended that an outside facilitator be utilized to facilitate this objective process, which must include documentation of all decisions made and monitoring of any new agreements to ensure adherence by both divisions.

<u>Juvenile Justice</u>

With regard to the juvenile justice population, behavioral health services could be improved by creating linkages between the state's juvenile justice agency and other state and local agencies that attempt to address the behavioral health needs of children and youth, including the Bureau. The West Virginia

Division of Juvenile Services (DJS) is isolated organizationally, programmatically, and fiscally—which is reinforced by the placement of DJS within the Department of Military Affairs and Public Safety (DMAPS). DMAPS is a sister agency to DHHR and, because DJS is outside the scope of health and human services, it has limited access to federal entitlement programs and funding. This enforces a dependence on state funding and serves to discourage program collaboration with other agencies serving children and youth.

Behavioral health services provided on behalf of juveniles served by DJS qualify for reimbursement under the Medicaid Rehabilitation Option; however, although DHHR agencies and their provider networks receive this reimbursement for behavioral health services, it is not accessed by DJS. DJS receives no federal matching participation in the cost of their services, which total $5.6M annually. In addition to this reimbursement, DJS could receive Medicaid reimbursement for after care case management – currently funded at an annual cost of $865,000 per year. If DJS accessed this Medicaid resource, it could substantially increase the scope and quality of the services for juveniles it provides.

GOAL #5 ***Begin the process of ongoing strategic planning for the behavioral health service system to provide BHHF with a blueprint to set goals, strategies, and performance outcomes with which to guide the service system. The strategic plan should specify how BHHF will monitor and evaluate the changing system as it is modified and expanded, should include an oversight component to track the progress of achieving goals on an annual basis, and should include a provision that would allow BHHF to make modifications in the strategic plan as necessary.***

This report provides West Virginia with recommended changes to begin the restructuring of behavioral health service funding and provision. However, given that the foundation for this study is a review of the current system, this document will not function as an ongoing statewide strategic plan for behavioral health services. A redesign provides the goals and objectives for the next few years, while a strategic plan lays out specific strategies for attaining those goals and objectives. Therefore, to ensure that West Virginia's behavioral health service system continues to be responsive to its consumers, providers, and all other stakeholders, we recommend that a statewide strategic planning process for BHHF-administered services, covering 3 to 5 years, be developed by the state. A statewide strategic planning process will require state staff to collaborate with the complete array of stakeholders who receive and provide behavioral health services across the state and will provide BHHF with a blueprint to set goals, strategies, and performance outcomes that can be used to guide the service system as it continues to grow and expand. Developing a plan for 3 to 5 years in length will allow BHHF to respond and recalibrate its direction as consumer needs and funding changes.

It is recommended that a schedule of meetings be established to discuss the goals, services, and outcomes expected of West Virginia's behavioral health service system in the next 3 years and in the next 5 years. These meetings should include a complete array of BHHF stakeholders, including consumers, family members, providers, advocacy groups, agency staff, and legislators. The meetings should result in the development of a draft planning document that details a strategic plan for the entire behavioral health system, including goals, objectives, and anticipated outcomes over a 3 year to 5 year interval. Once the planning document is completed, it should be published on BHHF's website in order to make it accessible to stakeholders statewide.

The draft planning document should be comprehensive in scope, but BHHF must ensure that it incorporates a consideration of geographic issues and of cultural/target population issues. Both of these elements have an impact on the array of available services, the continuum of services in each region of

the state, and the way in which services meet or overlook the specific needs of the target populations. To ensure that thorough attention is paid to geographic needs, the plan should at a minimum: address urban, rural, and remote areas; describe services available and missing in each region of the state; and, address the transportation challenges facing each region and suggest solutions for these challenges. To ensure that thorough attention is paid to cultural/target population needs, the plan should at a minimum recognize and discuss strategies for serving the different, specific populations receiving behavioral health services in the state.

In addition to the regularly scheduled meetings, BHHF could also establish an annual statewide behavioral health service conference or utilize an existing annual conference to assist in revisiting and adding to the planning document. This annual event would provide the state with an opportunity to bring together all of the key stakeholders across the state along with national experts in the behavioral health field. The agenda of the conference could be broken down into separate tracks for each of the target populations, as well as joint sessions to foster a collaborative approach to assessment and service provision. Most importantly, this type of event will help to cultivate a culture of communication and collaboration across the DHHR agencies. BHHF likely would be able to solicit the participation of the CMS regional office and national experts in the field to share their expertise on issues pertinent to West Virginia's consumers, providers, and service delivery system as a whole. This process would also benefit the state's current infrastructure of task forces, commissions, and boards, as BHHF would be able to evaluate the current relationships of these entities with each other and with the state.

GOAL #6 ***Enhance BHHF's website to enable consumers to easily access a full range of information regarding state and national behavioral health resources. Develop a mechanism to monitor website utilization and seek feedback on the ease of the website's use as well as ideas on additional information or links that would enhance the website's utility.***

The Bureau's website currently relies upon disconnected pull-down lists for each office within DHHR that contain minimal information for stakeholders. Information on an upgraded website should be more straightforward and employ the use of graphics and interactive maps that can be easily manipulated by consumers, families, state employees, providers, advocates, and other stakeholders. Accessing information from an updated website should be a quick, uncomplicated process that provides the user with an ample amount of valuable information on all aspects of the state's behavioral health system.

West Virginians must have available to them on a 24-hour per day, 7-day per week basis a reliable resource that allows them to:

- review the state's menu of available behavioral health programs, services and supports;
- acquire continuously updated information regarding the waiver and waitlist;
- conduct research on providers (both state-operated and private) to discover their service offerings, area served, and whether or not they specialize in a target population;
- access contact information for providers and state offices;
- look up the process for registering a complaint;
- view DHHR and BHHF announcements, new activities, publications, and upcoming events;
- become familiar with the state's consumer advocate groups; and,
- stay updated on the system's redesign efforts, goals met, and outcomes achieved.

GOAL #7 ***Establish clear definitions for the Bureau's target populations, as it is an essential element that assists in the prioritization of individuals most in need and focuses the expenditure of state and federal dollars to meet their needs.***

Service inconsistencies are more prevalent when a list of target populations is not in place, which can lead to a fragmented system of services that lends to stakeholder misunderstandings and results in some individuals 'falling through the cracks.' Therefore, it is recommended that BHHF collaborate with the Advisory Group to develop and finalize a comprehensive list of the target populations that the behavioral health system will serve. The development of this list will allow BHHF to direct and lead a comprehensive, integrated system of behavioral health. This activity will also assist the system's providers by allowing them to focus on specific behavioral health needs so that they can customize their services. Accordingly, once this list is in place, providers will begin to more successfully serve the populations in need of services, instead of simply 'following the money' and developing services for populations with higher reimbursement rates. In addition, this list of targeted populations will promote ease in determining service eligibility, and will aid in dispelling any confusion regarding eligibility that consumers and their families may encounter. A proposed, possible list of target populations—prioritized to address those individuals with the highest need—that should be served by the West Virginia behavioral health service system is as follows:

- Individuals with serious mental illness. (This can be further defined through the eligibility determination process by creating a list of approved diagnoses, which includes all of those relevant to serious mental illness. The goal here is not to screen out individuals but rather to identify those most in need.)
- Individuals with developmental disabilities.
- Individuals with substance use disorders.

The above populations cover all ages of consumers, from children to adults to the elderly. In addition to the above list, special consideration should be given to providing service options for the following subpopulations:

- Forensic individuals.
- Individuals with co-occurring mental illness / substance use.
- Individuals with co-occurring mental illness / mental retardation.
- Homeless individuals.
- Individuals with autism. (This population is currently served to a limited extent in the MR/DD system but would benefit from autism specific services not services designed to meet the needs of individuals with mental retardation or developmental disabilities.)
- Individuals with Acquired Brain Injury (ABI).

It should be noted that the prevalence of co-occurring diagnoses is high in West Virginia. For individuals with mental health or developmental disability diagnosis, it is important that a built-in mechanism for the consistent screening and evaluation of a diagnosis of substance use be present. Studies clearly demonstrate that in order for services to be successful, both diagnoses need to be addressed simultaneously; therefore, the Bureau needs to ensure that there is access to this process.

Qualified and well-trained professionals are a key element of this goal, particularly for the specialized sub-populations, and as West Virginia does not appear to have an adequate supply of these individuals to address demand, staffing will be a hurdle in accomplishing this goal. To improve access to these services, it is recommended that West Virginia expect clinical staff to become cross-trained in providing substance

use evaluation and services within their respective clinical area of expertise. Additionally, collaborative training efforts across agencies that bring together the clinical experts within the state is a recommended strategy in developing clinical expertise among the service providers treating these subpopulations. A couple of years ago, the Division on Alcoholism and Drug Abuse (DADA) facilitated statewide training sessions for co-occurring disorders that encouraged training in specialized areas of behavioral health. Additionally, all children's behavioral health providers must have co-occurring training programs in order to be licensed (The Alliance for Children is now offering this training). These are excellent examples of the training that West Virginia should continue to focus on for ensuring quality services for individuals with dual diagnosis and specialized service needs.

GOAL #8 ***Discuss and develop a basic behavioral health service package to be provided throughout the state to all consumers meeting the eligibility criteria for the target populations, which will be available in all communities with open access to any eligible provider. Expand the number of eligible providers that consumers can access by including other licensed / certified provider types and Primary Care Centers.***

Currently, the Bureau maintains a list of five "core services" that is supposed to be available at each behavioral health provider site within the state:

- crisis services;
- linkages with inpatient and residential facilities;
- diagnostic and assessment services;
- treatment services; and,
- support services.

However, in our system review and stakeholder interviews across the state, we found that this was, in fact, not true. Inconsistent availability of the core services lends to an overall fragmentation of the system, so that some individuals are able to receive a full cadre of core services while some are not. Consumers most affected by this disparity are those in the more rural locations in the state.

In order to ensure that a uniform set of basic services are consistently provided across the state, the Advisory Group, BHHF, BMS, and OHFLAC need to work together to revisit and revise what is currently considered to be core services. It is also recommended that BHHF works with OHFLAC to review provider licensing requirements to ensure that no updates or revisions are needed to fulfill the objectives of the revised behavioral health system. Below is a proposed menu of services that could be provided under the new service delivery model proposed by PCG, splitting service delivery into service brokerage entities and the direct service providers. Uniform and universal access to this list of services will result in better services for West Virginia's consumers. This menu was developed based on flexible models of service provision that are directed at meeting individual needs and utilize a person-centered approach instead of a provider-centric approach.

Service Brokerage Entity Menu of Services	Direct Provider Agency Menu of Services	
Initial Evaluation	Individual Therapy	Supervised Residential
Eligibility Determination	School-Based Services	Intensive Residential
Service Coordination	Group Therapy	Inpatient Hospitalization
Service Brokerage	Family Therapy	Involuntary Commitment
Prevention Services	Medication Management	Transportation
	Intensive Outpatient Programs	Companion Services
	Case Management	Nursing Services
	Respite	Psychological Evaluation
	Psychosocial Rehabilitation	Medical Evaluation
	Supported Employment	Environmental Adaptations
	Transitional Employment	General Support Services
	Day Treatment	Socialization Support
	Supported Housing	Drop-In Center
	Crisis Evaluation Services	Peer Support
	Crisis Stabilization Services	P.I. Education Classes
	Crisis Wraparound Services	Primary Care Services
	Crisis Mobile Outreach	
	Home Care Services	
	Jail Diversion	
	Assertive Community Treatment (ACT)	
	Intensive Case Management	
	Partial Hospitalization	

As indicated in this list, both the service brokerage entities and the direct service providers will have their own respective menu of services. The first menu of services includes services that will be provided exclusively by the service brokerage entities. These services are administrative in nature and assist consumers with obtaining the appropriate direct services provided by state and private agencies.

The second menu of services includes services that will be provided exclusively by the state-funded behavioral health facilities (ex: the state psychiatric hospitals and nursing homes) and private direct service providers. It includes waiver and non-waiver services that should be considered essential to the behavioral health system for West Virginians. While direct service providers across the state will likely provide services that are unique unto themselves and are beyond what is included here, the service package indicated is one that all consumers will have access to, regardless of service area or where he/she enters the behavioral health system. Consumers will be referred to these essential services by the service brokerage entities upon intake and assessment, and will have full access to these services as deemed appropriate to meet their identified needs.

More detail regarding this recommended package of services and its impact on the current behavioral health system can be found in the funding section of this report.

An essential component in the establishment of a basic behavioral health package will also be the development of a comprehensive approach to funding direct services in the redesigned service system that is fair and equitable statewide. In a changing system of services and where resources are constrained, it is imperative that West Virginia maximize available funding and establish the appropriate controls for allocating funds. Even if no program or service changes are implemented as a result of this effort, the Bureau must still consider a new approach to funding existing community services. Today's approach to funding community services is driven by an antiquated method that does not promote good policy or service outcomes. BHHF's historical approach to funding community services uses grants to create

specific programs, but results in inconsistent service delivery across the state dependent on where grants are given. These historical services are weak in linking funding with actual services and utilization. A thorough community service funding reform would establish financial accountability, equity of payments, and conformance with a consistent behavioral health service package.

Perhaps most importantly, the current fiscal approach employed by BHHF does not promote accountability and is administratively burdensome for state staff. An effective fiscal approach promotes the efficient and effective delivery of service to consumers and holds providers accountable for providing these services in the most cost-effective manner possible: this is a goal that West Virginia should work towards. Providers should be promised competitive reimbursement for services delivered as well as supplying important utilization and service data, so that the Bureau may effectively manage a better system of services over time. Other states have been successful in reforming their methods for paying community-based providers, including methods such as procedure code based systems, case rates, per member / per month initiatives, and other approaches.

As BHHF considers new approaches to funding community services, significant attention must also be paid to developing information systems to support the administration of the new method. This may include enhancing the current CSDR system, procuring for a new data system, developing new systems to manage claims processing and the accumulation of service/utilization data, and introducing new tools such as cost reports or other data gathering instruments to further support the new method of funding community services.

GOAL #9 ***Facilitate the ongoing exchange of information with providers of all supports and services, including all types of licensed or certified clinicians and behavioral health providers, in order to maximize the clinical and organizational knowledge and expertise available across the state.***

The West Virginia Behavioral Health Care Providers Association is a standing group that meets regularly in Charleston to discuss the on-going development of the behavioral health service system in West Virginia and to address what is needed in the system. The Association provides BHHF with a regular source of feedback regarding providers' needs across the state. However, while the Association's website states that membership is comprised of "…behavioral health provider organizations serving recipients in each of the State's fifty-five counties"[4], it appears that the Association's members come only from the state's current Comprehensive Community Mental Health Centers. Private providers interviewed during the data collection phase of this engagement indicated that private providers do not attend the Association meetings. Regardless of the reason for this apparent schism, anecdotal data indicates that the feedback being conveyed to BHHF via the Provider Association is limited to the voices of the current Comprehensive Community Mental Health Centers.

The Association provides BHHF with a good dialogue channel with some West Virginia providers; however, there needs to be better mechanisms in place to facilitate dialogue between the Bureau and all providers. Without a channel in place to obtain provider feedback on a regular basis, an important component of the service delivery system has limited voice. Instead, BHHF should encourage all providers to participate in similar forums as the Association. If logistical or financial issues prevent some providers from participating in these meetings, BHHF should take steps to arrange quarterly meetings with these providers as a way to solicit feedback and provide updates of initiatives being pursued by the Bureau. BHHF should also encourage and enable better communication with any association with private

[4] West Virginia Behavioral Health Care Providers Association, http://www.wvbehavioralhealth.org/.

providers as members. Regardless of the type of feedback mechanism utilized, the focus should be on fostering a more consistent dialogue between the Bureau and providers, which will result in enhanced collaboration and also ensure that BHHF is informed of all the issues facing its providers.

In addition, special effort should be made to regularly communicate with providers regarding the plans for behavioral health system redesign plans, the anticipated outcomes of those plans, and the progress of the plans' implementation. A feedback mechanism should be established so that providers can continually add their voices and thoughts to the state's redesign plans.

GOAL #10 ***Compel providers to move toward the adoption of evidence-based practices and practice-based evidence with a focus on quality and documented outcomes. BHHF will promote this practice through the development and enforcement of performance-based provider contracts, which will result in the purchasing of effective, high quality services for the target populations.***

Current quality management efforts exist within various aspects of the Bureau, but there is not one place where all information and data comes together for a comprehensive review and evaluation. Quality management methods employed by the Bureau are neither consistent nor driven by the same set of values, and most measures of effectiveness are process-oriented rather than consumer outcome-focused.

To bring together an organized approach to Quality Management and Improvement, the Bureau should assess all of their current efforts and determine the comprehensiveness and effectiveness of each activity. A gap analysis should be completed to determine the areas that are not covered and should make note of any duplication or activities that are not yielding information critical to effective system management. BHHF needs to consider a new structure of outcome-focused quality management, administered by select agencies, which supplies providers with regular monitoring and suggestions for improvement tactics. Another option that BHHF may also want to consider is facilitating training sessions for providers on the processes behind the adoption and implementation of evidence-based practices. The outcome-driven methodology used by the Mental Health Block Grant staff with Marshall University should assist in this effort, as will training on data collection methods. Stakeholder input and collaboration should be relied upon by the Bureau to develop a new scheme of quality management. An effective model of quality assurance is a combination of activities that results in a coherent system for evaluating and improving the systems it is charged with assessing. The system must be data-driven and reflect the system values while taking into account compliance with regulatory requirements as well as person-centered outcomes, with all efforts directed toward assuring health, safety and well-being.

Data available to the Bureau is currently too focused on processes instead of on outcomes, which is problematic. A good example of this fact is the data reported to Medicaid, which provides information through the MMIS that is essential to financial management but not to program management. This restricts access to consumer outcomes and information on the impact services have had on a person's life. To correct these issues, BHHF needs to include more specifications / requirements for accountability in their contracts with providers. Once these measures are established, the Bureau also needs to put into place mechanisms for contract enforcement. If the contract is not enforced, it serves no purpose in assuring quality, and functions merely as a mechanism to pay a provider. The contract needs to include both financial performance requirements as well as service delivery performance requirements.

Another important aspect of quality management is the inclusion of a process that reflects consumer evaluation input. West Virginia already conducts activities to include consumer input, such as

satisfaction surveys, but should review the national models that are employed in other states that could be added to the system to boost the amount of consumer input utilized for quality management purposes.

GOAL #11 Improve BHHF utilization and monitoring capabilities through improved data management processes to ensure that outcomes and results are tracked and the information gathered is used to modify and enhance the system as needed.

One reason for originally implementing the Bureau's current encounter system, the CSDR, was to provide a tool that fully documented the services supplied by grant programs. However, the CSDR does not allow for specific information to be presented, leaving a disconnect between the Bureau's payment of grants and services actually provided. Because the data system does not quite align with grant funding, roughly 150 grants have no common data on how many services are provided, what kinds of services are provided, and who services are provided to.

Consequently, we recommend that BHHF consider implementing an improved data collection system that includes cost reporting and rate development, provides technical and financial assistance to providers, tracks services for individuals who need repeated and/or costly services, creates shared databases, and facilitates bill paying. Particular consideration should be given to:

- Developing a web-based, electronic, centralized and uniform reporting standard across all providers of community behavioral health services.
- Shifting to transparent cost and utilization reporting. BHHF, DHHR, providers, and consumers would be better served with full access to cost and statistical information related to behavioral health service delivery.
- Ensuring that any report modifications are consistent with federal or state law/regulations. This includes documented compliance with certain licensure and staffing levels. Specific data must be collected and maintained by the state to fulfill these requirements.
- Reviewing program definitions to ensure that providers and agency staff are interpreting data elements in a consistent manner.
- Developing technical assistance capabilities for providers regarding equipment purchasing, staff hiring, and linking computer systems so information on clients can be stored and shared.
- Creating a system which will allow BHHF to move to an outcomes-based payment system.
- Adopting a system that can output a regular report that shows the number of clients served and the cost of the service on a regular basis.
- Developing a "behavioral health dashboard" to measure the progress and impact of quality management and utilization criteria, including a regular report of measures that define a healthy community and information on both processes and outcomes, such as the number of people living in recovery, the number of people served, and the number of people on waiting lists for various services.

Some of these goals require additional funding to be realized. However, these are seen as essential expenses needed to fully support a new system of behavioral health services in West Virginia. An investment into the behavioral health system's technology resources could considerably improve the quality of BHHF's services.

GOAL #12 Implement revenue enhancement and cost saving initiatives to help fund the new behavioral health system.

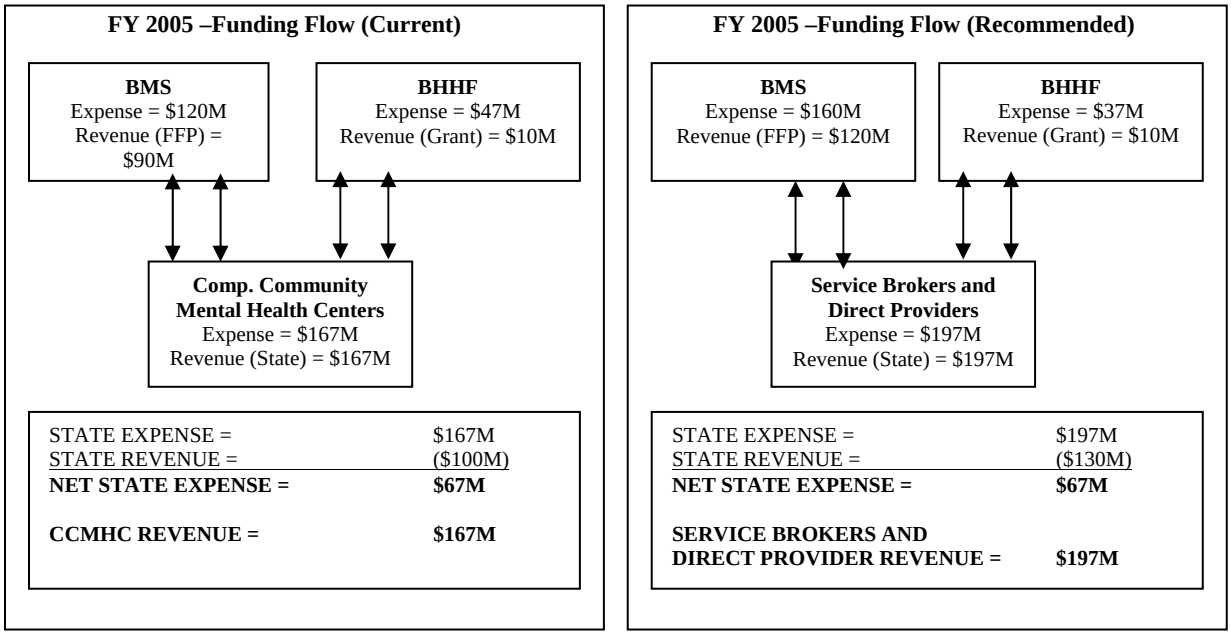
West Virginia currently has opportunities to leverage existing funds and maximize the recovery of federal dollars. Revenue maximization of all available sources could support future program changes and the redesign suggested in this report. It is important to note that not all of the behavioral health redesign can be funded with Medicaid dollars. Additional state funds must be made available to support the redesign as well.

PCG has identified several revenue enhancement initiatives for consideration by BHHF. Many of these recommendations require collaboration with other stakeholders; therefore, West Virginia would need to implement multi-agency workgroups and groups to direct the process in a coordinated fashion.

Currently, BMS and BHHF spend $167M to provide behavioral health services through the Comprehensive Community Mental Health Centers and MR/DD Agencies. BMS recovers approximately $90M of this funding through federal Medicaid payments and BHHF recovers approximately $10M of this funding through federal block grants. The result is a Net State Expense of $67M. In a redesigned funding system, Medicaid could increase rates with funding made available from BHHF. This would allow the state to leverage state funding with federal Medicaid payments, resulting in a stronger behavioral health system.

For example, BHHF could shift $10M in state general funding to BMS to support Medicaid rate increases, which will lead to approximately $30M in Federal Financial Participation (FFP). In PCG's model for a redesigned behavioral health system in West Virginia, service brokers and service providers will be pleased to find that more funding is available for services (approximately $30M). The state could also remain level-funded if an alternative approach to PCG's model is used assuming the net state expense of $67M.

Current and Recommended State Funding System for Community Services



Based on our review of the service and funding system, interviews with state staff, and regulatory research, PCG has developed a list of revenue maximization and cost saving initiatives for consideration. The following strategies should be fully vetted by the state to determine their feasibility of implementation and ability to fund the new behavioral health system:

Community Services Revenue Enhancement Strategies

- *Align existing Medicaid rates with Comprehensive Community Mental Health Center costs.* PCG recommends that BHHF consider reallocating a portion of their state funding allocations to support increased Medicaid rates. Providers routinely complain that Medicaid reimbursement rates are not adequate to support the cost of services; a detailed rate study should determine fair and equitable rates.
- *Transition Targeted Case Management (TCM) to a monthly billing rate.* In order to alleviate some administrative burden, PCG recommends changing the billing period from a 15 minute increment to a monthly rate, which only requires a single validating service within the month to bill. By implementing the change to a monthly TCM rate, Comprehensive Community Mental Health Centers will still need to assure that billed recipients meet all the other prior authorization requirements. This should ensure that case management services are being provided appropriately to clients within the target group and with linkages to holistic service planning. Monthly billing is still considered fee for service as rates would be established and a fee schedule adopted for the services.
- *Eliminate the requirement to prove "demonstrated capability" for authorizing Rehabilitative Services.* Neither federal nor state legislation requires the documentation of prior demonstrated abilities in the areas of deprived functioning; therefore, this appears to be an unnecessary requirement. PCG recommends reviewing BMS guidelines and removing unintended barriers to providing needed services wherever possible.
- *Enhance Medicaid rates for mental health services provided in schools.* West Virginia currently reimburses several other school based services on a cost basis, but mental health services are not cost based. We recommend that BMS update the reimbursement method for school based mental health services. Utilizing county school board expenditures as the matching funds will enable West Virginia to leverage federal Medicaid dollars without increasing state general revenue.

State Facility Revenue Enhancement and Cost Saving Strategies

Maximize Medicaid fee for service (FFS) or disproportionate share (DSH) reimbursement. In order to maximize Medicaid FFS or DSH reimbursement, PCG recommends the following initiatives:

- Convert Welch Community Hospital's acute unit to a cost-based reimbursement through a State Plan Amendment (SPA).
- Include allowable physician costs in established Medicaid per diem rates
- Appeal Lesser of Costs or Charges (LCC) determinations made to state nursing facility cost reports from FY 1998 – FY 2004[5].
- Revisit existing assumptions concerning the current DSH distribution for publicly owned and operated facilities through a workgroup comprising DHHR, BMS, and BHHF staff.
- Pursue third-party liability (TPL) on the clients being "diverted" from the two state psychiatric hospitals to private facilities.

[5] See the Code of Federal Regulations at 42 CFR 413.13 for a description of the LCC principle.

- Examine the DHHR cost allocation plan (CAP) to ensure that central services costs are being allocated appropriately to the Bureau.

Implement Medicare initiatives which maximize funding for the state acute care hospital and psychiatric facilities. In order to maximize funding for state acute care hospital and psychiatric facilities, PCG recommends the following initiatives:

- Seek to establish formal teaching agreements with accredited council for graduate medical education (ACGME) institutions, qualifying teaching facilities and electing reimbursement on a cost basis (Worksheet D-9) for physician reimbursement for Medicare, in order to increase federal funds for West Virginia hospitals.
- Pursue Medicare Part D reimbursement for individuals in state facilities.
- Explore Medicare bad debt recovery opportunities at state hospitals where services provided to Medicare beneficiaries result in uncollectible deductible and coinsurance amounts.
- Conduct Medicare TEFRA reviews and make appeals in order to provide relief from federal cost limitations on reimbursement at psychiatric hospitals.
- Re-evaluate and analyze the benefits of converting Welch Community Hospital to a critical access hospital (CAH).

Implement cost savings initiatives which promote the effective and efficient management of facility service. In order to realize cost savings, PCG recommends the following initiatives:

- Conduct an inpatient bed demand and community needs study in order to "right size" the present complement of inpatient beds to better serve the needs of West Virginians and to improve the determination of resources and funds required to operate an efficient system.
- Continue to address alternatives to expensive "diversions" for state hospital services.
- Analyze and implement diversions replacement unit options.
- Explore the option of wrapping a general acute care hospital license with one of the state psychiatric facilities (IMD)

GOAL #13 Implement a fiscal approach to funding behavioral health services that promotes and rewards accountability, programmatic creativity, efficiency, and competitiveness.

Historically, BMS has participated in reimbursing behavioral health providers for certain services covered in the Medicaid state plan or in waivers. However, recent cuts to Medicaid payments and the implementation of utilization controls have placed strains on BHHF's budget. Providers are overly dependent on BHHF funding because of low Medicaid rates.

Every state strives to fund a balance between utilizing Medicaid dollars for medically necessary services and implementing strict utilization management protocols to ensure that services provided meet Medicaid standards. West Virginia is no different. BMS is concerned with Medicaid dollars being expended in an economical and efficient manner consistent with recent reforms while BHHF is concerned that providers are reimbursed in a manner and amount that is sufficient to ensure the provision of quality services. Both agencies recognize the need to work closely in designing a Medicaid benefit package for behavioral health services that can accommodate both existing and proposed new or expanded services.

BHHF and Medicaid must make every effort to use the flexibility of Federal Medicaid regulations to develop new reimbursement methods that support a comprehensive benefit package which includes Medicaid and Social Supports. As discussed above, we recommend that the Advisory Group, BHHF, and

BMS meet to discuss Medicaid issues, including payment methodologies for certain services and reimbursement amounts calculated pursuant to available funds.

PCG obtained data from BHHF's CSDR system and BMS's MMIS to create a list of procedure codes used by Medicaid and the Bureau to reimburse providers for supplying direct services, shown on the following page. The table includes services that are part of the current service package and those that are under the proposed service package under the redesigned system along with actual BMS spending for each service / support, which was developed through data analysis by PCG.

The following table has been organized to identify service brokerage functions (identified at the top) and also procedure codes related to direct services provided by licensed practitioners. Services highlighted in yellow represent opportunities for further discussion between BMS and BHHF to utilize Medicaid and other funding sources to support the redesigned system that would go beyond the current ways these services are funded (or presently not funded) by Medicaid.

West Virginia - Bureau of Behavioral Health and Hospitals
Required Services - Crosswalk to Current BHHF and BMS Procedure Codes

BHHF SERVICE	BHHF CODES	BMS (MEDICAID) CODES	BMS (MEDICAID/ WAIVER) CODES	BMS (UNITS)	BMS ($)
Initial Evaluation Eligibility Determination Service Coordination Service Brokerage	90801 - Psychiatric Testing with Interpretation and Report; 96100 - Comprehensive Evaluation Psychiatrists; 96101 - Psychological Testing with Interpretation and Report; 96110 - Developmental Testing; 96115 - Neurobehavioral Status Exam; 99080 - Medical Reports; H0031 – MH Assessment; H0032 – MH Plan Development; H2019 - Behavior Management Development/Implementation; T1016 - Service Coordination T1023 - Screening by Licensed Psychologist	90801 - Psychiatric Testing with Interpretation and Report; 96100 - Comprehensive Evaluation Psychiatrists; 96101 - Psychological Testing with Interpretation and Report; 96110 - Developmental Testing; 96115 - Neurobehavioral Status Exam; 99080 - Medical Reports; H0031 – MH Assessment; H0032 – MH Plan Development; H2019 - Behavior Management Development/Implementation; T1016- Service Coordination T1023-HE - Screening by Licensed Psychologist	H0031 - Initial Social History T1016 - Service Coordination	867,209	$ 13,716,064
Prevention Services	TBD	TBD - EPSDT < 21		-	$ -

BHHF SERVICE	BHHF CODES	BMS (MEDICAID) CODES	BMS (MEDICAID/ WAIVER) CODES	BMS (UNITS)	BMS ($)
Individual Therapy School Based Services Group Therapy Family Therapy	90804 - Individual Psychotherapy 20-30 minutes; 90806 - Individual Psychotherapy 45-50 minutes; 90807 - Individual Psychotherapy w/ Medical Eval. and Management; 90846 - Individual Psychotherapy w/ Med Eval & Mgmt Serv; 90847 - Family Psychotherapy (with Patient Present) 90853 - Group Psychotherapy - 75-80 minutes; 90899 - Special Evaluation Services; 99205 - Office or Other Outpatient Visit - New Patient- 60 min; H0004 - BH Counseling, Supportive, and Individual; H5020 - Supportive Group Therapy	90804 - Individual Psychotherapy 20-30 minutes; 90806 - Individual Psychotherapy 45-50 minutes; 90807 - Individual Psychotherapy w/ Medical Eval. and Management; 90846 - Individual Psychotherapy w/ Med Eval & Mgmt Serv; 90847 - Family Psychotherapy (with Patient Present) 90853 - Group Psychotherapy - 75-80 minutes; 90899 - Special Evaluation Services; 99205 - Office or Other Outpatient Visit - New Patient- 60 min; H0004 - BH Counseling, Supportive, and Individual; H5020 - Supportive Group Therapy	Not Applicable	424,668	$ 3,895,355
Medication Management	90782 - Injection; 90862 - Pharmacological Management; H2010 - Clozapine Management; J2680, J1630, J1631, J2794 - Injections	90782 - Injection; 90862 - Pharmacological Management; H2010 - Comprehensive Medication Services; J1630, J1631, J2680, J3230, J3310, J2794 - Injections	Not Applicable	45,290	$ 1,584,894
Intensive Outpatient Programs	H0004 w/Modifiers	H0004 w/Modifiers	Not Applicable	-	$ -
Case Management Intensive Case Management	90887 - Case Consultation; T1017 - Targeted Case Management; G9008 - Physician Coordinated Care Oversight Services	90887 - Case Consultation; G9008 - Physician Coordinated Care Oversight Services	T1017 - Targeted Case Management	348,470	$ 4,056,016
Respite	T1005- Respite	TBD	T1005 - Respite	493,282	$ 9,326,319
Psychosocial Rehabilitation Clubhouse	H2014 - Skills Training and Development; H2015 - Comprehensive Community Support; H0036 - Community Psychiatric Supportive Treatment; BH521 - Training/Education; BH641 - Socialization 1:1; BH642 - Socialization 1:2-3	H2014 - Skills Training and Development; H2015 - Comprehensive Community Support; H0036 - Community Psychiatric Supportive Treatment	Not Applicable	1,249,740	$ 8,285,295
Supported Employment	BH656 - Supportive Employment 1:1; BH657 - Supportive Employment Group; T2019 - Supported Employment	TBD - Pursue Food Stamps, TANF, and Vocational Rehabilitation	T2019 - Supported Employment	83,556	$ 438,251
Transitional Employment	BH550 - Work Adjustment; BH551 - Sheltered Work; T2015 - Prevocational Training	TBD - Pursue Food Stamps, TANF, and Vocational Rehabilitation	T2015 - Prevocational Training	89,379	$ 800,686
Day Treatment	H2012 - Day Treatment	H2012 - Day Treatment	Not Applicable	44,475	$ 450,475
Supported Housing	TBD	Not Applicable	Not Applicable	-	$ -
Crisis Evaluation Services Crisis Stabilization Beds Crisis Wraparound Services Crisis Mobile Outreach	H2011 - Crisis Intervention; BH496 - Crisis Phone Call	H2011 - Crisis Intervention		8,638	$ 127,011
Home Care Services	TBD	TBD	TBD	-	$ -
Jail Diversion	TBD	TBD	TBD	-	$ -
Assertive Community Treatment (ACT)	H0040 - ACT	H0040 - ACT	Not Applicable	22,981	$ 525,329
Partial Hospitalization	TBD	TBD - Medicare Available	Not Applicable	-	$ -
Supervised Residential Intensive Residential Services	H0019 - Residential Services; BH590 - 24 Hour Residential Services; BH634 - Supportive Residential Services 1:1; BH635 - Supported Residential Services 1:2; T2017 - Community Residential Habilitation	H0019 - Residential Services	T2017 - Community Residential Habilitation	2,715,959	$ 29,166,487
Inpatient Hospitalization	Various	Various	Not Applicable	-	$ -
Involuntary Commitment	BH497 - Involuntary Commitment Linkage Service; BH498 - Involuntary Commitment Certification Service	TBD (Level of Care Issues)	Not Applicable	-	$ -
Transportation	A0120 - Non-Emergency Transportation; A0160 - Mileage; BH660 - Transportation Services: Agency; BH661 - Transportation Services: Mileage	A0120 - Non-Emergency Transportation; A0160 - Mileage	A0120 - Non-Emergency Transportation; A0160 - Mileage	1,768,180	$ 6,539,058
Day Habilitation (MR/DD)	T2021 - Day Habilitation	Not Applicable	T2021 - Day Habilitation	1,847,645	$ 14,486,534
Companion Services (MR/DD)	S5135 - Adult Companion; T1019 - Personal Care Services	Not Applicable	S5135 - Adult Companion; T1019 - Personal Care Services	325,571	$ 5,943,859
Nursing Services (MR/DD)	BH652 - Nursing Services; T1000 - Involved Nursing; T1001 - RN Assessment/Cert/Recert; T1002 - RN Services; T1003 - LPN	Not Applicable	T1000 - Involved Nursing; T1001 - RN Assessment/Cert/Recert; T1002 - RN Services; T1003 - LPN	147,944	$ 3,492,339
Psychological Evaluation (MR/DD)	96111 - Psychological Evaluation (Triennial Eval); T2021 - Psychological Evaluation (Annual Update)	Not Applicable	96111 - Psychological Evaluation (Triennial Eval); T2021 - Psychological Evaluation (Annual Update)	1,215	$ 60,961
Medical Evaluation (MR/DD)	99XXX - Annual Medical Evaluation	Not Applicable	99XXX - Annual Medical Evaluation	121	$ 10,539
Environmental Adaptations	S5165 - Environmental Adaptations (Home); T2039 - Environmental Adaptations (Vehicle)	Not Applicable	S5165 - Environmental Adaptations (Home); T2039 - Environmental Adaptations (Vehicle)	4,886	$ 111,022
Support Services	AD522 - DUI Classes AD530 - Drug/ urine Screening BH630 - General Support Services; BH631 - Socialization Support; BH632 - Drop-In Center; BH633 - Peer Support; BH520 - P.I. Education Classes; BH999 - Other Unspecified	TBD - Supports Waiver or Rehab Option	TBD - Supports Waiver	-	$ -
Other	Not Applicable	Not Applicable	Not Applicable	77,674	$ 5,083,344
TBD - Pending further discussion with BHHF and BMS staff			**TOTAL**	**10,566,883**	**$ 108,099,839**

As highlighted above, there are several opportunities for Medicaid and other federal sources to fund the redesigned system of services and the comprehensive menu of behavioral health services. Some of these financial sources include:

- Utilizing a 1915(b), 1915(c) or combined 1915 (b) and (c) waiver and/or expanded State Plan services to finance a broader menu of behavioral health services than currently exists in West Virginia. 1915(b) waivers in California, Colorado, Iowa, Minnesota, Nebraska, New Mexico, and Washington have successfully accomplished this goal and 1915(b) (c) waivers in Michigan and North Carolina have also been able to provide an expanded menu of behavioral health options for consumers.
- Including Intensive Outpatient Programs (IOPs) as part of its menu of behavioral health services. The Bureau also covers the program costs that are not funded from other sources including services provided to non-Medicaid clients. Under a redesigned approach, it would be possible for Medicaid and BHHF to reimburse for a more comprehensive package of IOP services than the small itemized list currently provided, while eliminating its current approach in which BHHF, in theory, only pays for services not covered by Medicaid, but in practice, BHHF funding is used to cover situations where Medicaid payments do not cover the costs to providers.
- Utilizing a 1915(c) Home and Community-Based Medicaid Waiver to financially support the provision of respite services.
- Amending the State Plan to include the provision of personal care services to cover respite services.
- Applying for grant money to implement a children's mental health services demonstration project. [6]
- Offering a subsidized supported employment program through Temporary Assistance for Needy Families (TANF), Food Stamps Employment and Training (E&T), or Federal Vocational Rehabilitation funding.
- Bundling crisis services into one 24-hour per diem rate for Bureau and BMS consumers.
- Promoting the growth of the Assertive Community Treatment (ACT) program by increasing Medicaid rates and providing additional Bureau funding for ACT services provided to non-Medicaid consumers.
- Encouraging the growth of Partial Hospitalization and Day Treatment services with enhanced Medicaid rates and more definitive program structures.

In addition to utilizing new sources of federal funding to reimburse for services and supports provided within the redesigned system of behavioral health services, West Virginia should also eliminate or significantly modify its current grant funding method by transitioning selected grants to a fee-for-service reimbursement methodology. This would ensure enhanced accountability and that funds are used to purchase supports and services that achieve good outcomes for the consumers. The current relationship between Bureau funding and the consumers who eventually receive services from the funding is not clear because of the grant funding methodology utilized by the Bureau. To improve the accountability of Bureau funding dispersed through grant funding, we recommend that the Bureau move to a procedure code-based payment system for non-Medicaid services. Best practices such as inflation adjustors, the impact of occupancy on rate setting, and the reimbursement for property should also be considered. BHHF fiscal staff have access to some, but not all, of the information for this effort to be accomplished so that funding can be determined on a service-by-service basis and the optimal rate setting method or procedure codes that best represent the services can be identified. Therefore, some selected grants can be

[6] http://www.archrespite.org/archfs52.htm#Medicaid

transitioned immediately to a fee-for-service reimbursement methodology; others can be transitioned gradually, so that providers are given ample time to accommodate these changes and so that the Bureau's fiscal staff has sufficient time to work on this effort, which may also require additional resources to implement.

Specifically, the residential programs could be converted to a per diem reimbursement based on audited cost reports. The Bureau funds twenty-nine residential grants, totaling about $9M and comprising approximately 15% of the Bureau's state and federal funding. Medical services offered through these grants could be reimbursed on a fee-for-service basis and a per-diem rate could be established for the room and board and administrative components of the service delivery. It should be noted that establishing these rates will require a conversion process and rate-setting methodology; we envision a two-year process to develop cost reporting forms and train providers on their use. Concurrently, in the residential programs, service billing is first pre-tested and then phased in: per diem rates are used to reimburse nursing homes, children's residential programs, and the ICF/MRs. Instead, the practice of using audited cost reports and annual inflation adjustments could be applied to the Bureau's residential grants, thus eliminating the current approach, which does not provide auditable cost information.

Similarly, outpatient grants could also be converted to procedure code payments. The Bureau spent about $4.6 million on 30 outpatient programs last year, amounting to about 7% of the Bureau's $64M total budget for state and federal spending. Descriptions of these programs indicate a substantial uniformity of services, including: screening and assessment, psychiatric evaluations, services planning, individual and group therapy, case management, medication management, and lab. These activities span both rehabilitation clinic and behavioral health services. In order to convert the outpatient programs to a procedure-based reimbursement methodology, the Bureau should first meet with program directors to be sure their concerns about this transition are understood and covered. The Bureau will then need to collect and review costs for outpatient services and then pre-test a payment process for the services. The process for outpatient programs could be similar to the current Charity Care process, which does not pay on a per-claim basis, or it could entail a claims submission and payment approach. Regardless of the process selected, cost reporting will be necessary to ensure that provider costs are fairly reimbursed. Successfully converting outpatient services to procedure code reimbursement will add a level of accountability in the system and will allow the Bureau to better manage the services it is paying for.

This transitioning will have an effect on case management as well: with case management reimbursed through a fee-for-service procedure code basis, it will be easier to determine how much case management is provided on a regular basis and the Bureau will be able to know the amount of funding that providers are receiving for supplying this service. Therefore, we recommend that case management be reimbursed through a fee-for-service procedure code basis. An inflation index should also be built into the case management rate setting methodology and a cost analysis should be completed to set the rate for this service, annually indexed for inflation. The number of individuals who receive case management services and the costs of providing this service will be clearer with these changes implemented.

Other behavioral health codes should also be transitioned to fee-for-service. The Bureau's support and alternatives services policy contains eighteen procedure codes that are unique to the Bureau and span the following services: "general support," residential, socialization, respite, pre-vocational, supported employment, transportation, and service coordination. The Bureau should build upon its earlier work and continue efforts in this area. As with the other procedure code work, this work will need consultation with providers to identify other codes, will require cost analyses of codes with higher utilization, and will necessitate the review of rates and reporting units. The Bureau will need to train staff on claim forms and

create a claims payment system with associated management reporting. It is anticipated that the definitions of current codes will change with these revisions.

Data is another important aspect of this change to employing a fee-for-service reimbursement methodology. Presently, comparing the costs of operation between nursing homes and ICF/MRs is a task that cannot be completed as this is data that is not collected even though nursing homes and ICF/MRs are both required to submit cost reports. As such, the Bureau should consider requiring providers to submit an annual cost report for each individual facility currently receiving Bureau funding. Cost reports provide important operating information such as occupied bed days and financial information by cost center—this is data that could benefit the delivery of quality services by providers. In conjunction with this new data being collected, we suggest that the Bureau hire an employee that can perform rate setting and cost report reviewing activities.

The Appendix of this report identifies funding and utilization as it relates to MR/DD and mental health services covered by BHHF and BMS. This Appendix provides a baseline report of funding spent by agency which can be used for future strategy development and financial modeling exercises.

GOAL #14 Compel the Office of Health Facilities and the Office of Behavioral Health Services to function as an integrated unit within the Bureau of Behavioral Health & Health Facilities to assure that the system reflects a continuum of services and supports that functions in a coordinated manner to best meet the needs of the target populations.

Because of changing needs, individuals often have to access facility-based services for acute episodes and then return to the community once they have been stabilized. Therefore, when two service systems operate under separate leadership and policy direction, an unnecessarily complex system for consumers to traverse as their needs change is created. In contrast, when these resources work together under the same leadership and policy direction, more effective planning can occur, more appropriate services can be delivered, the system can be simplified, and access to expertise that may not be readily available in the community may be possible.

Currently, the Office of Health Facilities (OHF) operates separately from the Office of Behavioral Health Services (OBHS) under the BHHF umbrella. However, the facilities under OHF are an integral part of OBHS's system of services for individuals with mental health and substance use issues. While we recognize that there may be administrative purposes within BHHF for separating these two offices at the current time, better alignment of these two offices would allow for greater collaboration and enhanced service delivery for West Virginia consumers. Alignment of the facilities so as to reflect the same leadership and direction will result in a system that operates more seamlessly for consumers. Where organizational alignment of these two offices cannot occur, BHHF leadership should ensure continuous collaboration of these two offices and the on-going functioning of these two offices as an integrated unit.

Improving the operation of the two offices as an integrated unit will provide West Virginia stakeholders with access to a more comprehensive continuum of behavioral health services. In addition, the improved communication and better coordination of services along the continuum communication between the state hospitals, the long-term care facilities, and the community supports and services will provide consumers with more effective and efficient behavioral health services across the state. Individuals will be able to more easily transition to and from state hospitals, long-term care facilities, and community services and supports.

The current positions and roles within the Bureau's organizational chart would remain relatively the same with this effort. Several new roles should be added to the infrastructure in order to strengthen a recovery-based, person-centered model of behavioral health, including:

- A Director of Provider Payment & Rate Setting within the Office of Finance and Administration and Rate Setting Staff under his / her direction.
- A Director of Quality Management either under the BHHF Commissioner or within the Bureau for Behavioral Health and Health Facilities.
- An Assistant Commissioner for Clinical Services under the BHHF Commissioner.

Improving the collaboration of OBHS and OHF to function as an integrated unit, in conjunction with the additions of the aforementioned staff positions, will provide BHHF with an enhanced structure necessary for successful behavioral health redesign, continuous system monitoring and improvement, and on-going strategic planning.

GOAL #15 Expand jail diversion strategies such as drug courts, mental health courts, teen courts, and service compliance orders to divert individuals from occupying forensic beds in state psychiatric facilities and to promote community-based service options.

A positive aspect of the West Virginia behavioral health system is that it does not criminalize consumers with mental illness. The state has ensured access to services without legal encumbrances. Despite this philosophy, the state hospitals have experienced an increase in the number of admissions that have a forensic status. This has become an increasing issue for many state systems across the country.

West Virginia has demonstrated a forward-thinking approach to help solve this situation: a transitional housing program that will provide housing and services in a less restrictive setting for individuals who are ready to be discharged from the state hospital and can live more successfully in a less restrictive setting. The addition of this program will assist in reducing the state hospital forensic census, which may free up beds for those individuals now hospitalized in "diversion" beds. In order to successfully maintain these individuals in the community, services will need to be provided in conjunction with a program that focuses on addressing forensic issues, with the goal to prevent recidivism.

The state has implemented a program within its judicial structures to provide for drug courts to reduce the incarceration of individuals who have substance use disorders requiring services. The implementation of these drug courts, although valuable, is not well-coordinated with the community. Decisions regarding location are made without the input of the case manager, which causes fragmentation in services. It is recommended that mechanisms be established through discussions with BHHF and the judiciary to promote better collaboration.

Through the Northern Panhandle Mental Health Court Diversion Program, which was implemented in Hancock, Brooke, Ohio, and Marshall Counties of the state, West Virginia has also taken important steps towards reducing the number of individuals with mental illness who are incarcerated for minor offenses. Because of the success of this program, we recommend that West Virginia consider the implementation of additional jail diversion strategies, which could help the state to transition some of the forensic individuals away from state hospitals and into the community:

Over the past few years, as the need for states to have effective jail diversion strategies has become increasingly clear, several funding sources have become available. The Northern Panhandle Mental Health Court Diversion Program has been funded by a grant from the Bureau of Justice Assistance.

Funding is also available from the Substance Abuse and Mental Health Services Administration (SAMHSA)[7] and through the Center for Mental Health Services Community Action Grants[8].

GOAL #16 ***Provide ongoing education and information regarding the consumer advocacy, grievance, complaint, and appeals procedures required of every licensed behavioral health provider to ensure that the process is better understood and more properly utilized.***

Currently, BHHF and the Ombudsman have in place a very effective process that allows complaints and grievances regarding the behavioral health system to be submitted and addressed. The process aims to produce a resolution to complaints and grievances in an efficient manner that involves mediation as well as involvement from the state's Administrative Services Organization (ASO), BMS, and OBHS. Additionally, the Office of the Ombudsman for Behavioral Health provides a resource to address "…concerns and grievances that they have regarding the behavioral health service delivery system and to provide for a process in which resolution of those issues can be accomplished."[9] The Ombudsman for Behavioral Health accepts anonymous complaints and grievances and considers all material and records of grievance proceedings to be confidential, and is a resource to be used when grievances cannot be resolved by BHHF's process of resolution. The Ombudsman has the "…independence to administratively resolve all complaints or disputes filed with the office" and, furthermore, "…shall have access to all facilities and records, as well as access to patients, staff, contractees, or any other person affected by the behavioral health delivery system for the purpose of gathering information relevant to service need and measuring compliance with the law and court orders resulting from Hartley."[10]

While BHHF and the Ombudsman have a detailed complaint process in place, it became apparent during statewide interviews and focus groups that many stakeholders across the state are not familiar with these resources. Further, the role of the Office of the Ombudsman, and in many cases its existence, was not universally known or understood by consumers. The Office of the Ombudsman should increase its publicity and presence in the state. Particular attention should be focused on the dissemination of information regarding advocacy groups and agencies, because these groups and agencies allow consumers and other stakeholders a forum in which to voice their complaints as well as approval about the behavioral health system. The Office of the Ombudsman has made a strong commitment to increasing its visibility to consumers and we recommend that additional steps are taken through the state's providers, regional/area offices, website, and advocacy groups to better communicate the role, function, and availability of these complaint processes. Through better public education and outreach, BHHF can ensure that all of West Virginia's citizens know the process for filing a complaint, including how and when to utilize the process.

GOAL #17 ***Expand data collection to include both Medicaid and non-Medicaid eligible populations, for the purposes of improving data sources regarding services, improving utilization management, and increasing quality assurance.***

Currently, data is only collected on Medicaid eligible populations and the services these individuals receive through the behavioral health system. This makes quality assurance, data knowledge, and utilization management regarding all aspects of West Virginia's behavioral healthcare system extremely

[7] http://www.samhsa.gov/Grants/2007/fy2007opps.aspx
[8] http://www.apa.org/releases/S1194_law.html
[9] Office of the Ombudsman for Behavioral Health, Department of Health and Human Resources, www.wvdhhr.org/bhhf/ombudsman.asp.
[10] *Ibid*.

difficult, as only half of the entire picture of service delivery is being collected through data measures. Therefore, we feel that BHHF should expand the amount of data collected by providers to include both non-Medicaid eligible populations and non-Medicaid BHHF services in addition to all of the Medicaid-eligible information currently collected. This expansion of data collection would provide more and better data to BHHF on the populations and services utilized when state-only or grant funds are used to pay for services. In turn, this would provide data that is essential for BHHF to better manage, evaluate, and plan for its system of behavioral health services. One aspect of reaching this goal is to provide appropriate training on data collection methods to staff within the behavioral health system.

GOAL #18 Develop an improved staff recruitment, retention, and development plan, including statewide work force development initiatives to ensure that the state has a well trained, highly qualified workforce.

West Virginia's behavioral health system is overwhelmed at present—it does not have enough qualified, trained staff to accommodate the needs of consumers requesting them. Comments about difficulty hiring and retaining staff were raised in almost all interviews with stakeholders. The shortage of staff is far-reaching and includes nursing and physicians, for example child psychiatrists, direct service workers, case managers, and data processing staff. Characteristics of this situation are the continued high turnover of staff, continued level funding from grants, and continued low salaries.

Other states have dealt with this problem for example, Arizona, worried that providers will leave its mental health system, as is happening in numerous other states, chose to combat the problem by making its reimbursement system more competitive. In 2001, the state adjusted provider reimbursement rates upwards for the first time in 10 years. However, this is not always a money issue. We recommend that the Advisory Group convene a separate subcommittee to address this issue. Studies of wages and benefits, professional and non-professional staff availability, and strategies for recruiting and retaining qualified staff must be addressed.

The Bureau needs to recruit more clinicians and clinical consultants for the Bureau to utilize. Additionally, BHHF should organize peer reviews, clinical team meetings, and clinical monitoring teams to monitor the quality of care, outcomes, and to enhance knowledge of current best practices. While there are clinical staff members working within the Bureau, there is not a clear locus of responsibility to facilitate or focus clinical discussions of service provision, service delivery, evidence-based practices (EBPs), and other clinically-driven topics. A number of the staff members have clinical credentials but their role in the Bureau is to focus on administrative duties; therefore, our recommendation is made to ensure that these discussions take place as an important part of the Bureau's functioning. We are not suggesting that a medical model approach be used—rather, that clinical aspects need to be in the mix with service provision.

Our review of the current behavioral health system revealed that the responsibilities of a typical medical director are delegated out to the Bureau staff, who oversee and manage the clinical issues across the three BHHF offices and various divisions. To remedy this situation, BHHF should incorporate additional clinical leadership into its infrastructure. This can be accomplished by utilizing new staff recruiting techniques that seek a higher level of clinical knowledge. Recruiting for clinical expertise should consider individuals already working within the Bureau as well as applicants from outside the system and even outside of the state in order to attract the most qualified pool of clinicians. When recruiting for these new staff members, the importance of a multidisciplinary team should be stressed to ensure that the Bureau has a more comprehensive approach to service system development. Emphasis should be placed on building a recovery-oriented system, focused on promoting consumer choice and self-direction.

Adding clinical staff members, including a consulting psychiatrist, to the Bureau's current workforce will move BHHF in the direction of having more internal clinical expertise and will also improve BHHF's compliance with West Virginia State Code. As currently written, Chapter 27, Article 1A provides requirements for having a qualified physician or psychiatrist on staff in the capacity of either commissioner, assistant commissioner, or as the supervisor of the division of professional services. While §27-1A-3 does not require the commissioner of the department of mental health (BHHF) to be a qualified physician or psychiatrist, it does delineate that:

> *Provided, That if the commissioner is other than a psychiatrist or physician there shall be appointed by the commissioner a deputy commissioner for clinical services who shall be a psychiatrist.*[11]

Furthermore, §27-1A-6 of the code describes the power and duties of the supervisor of the division of professional services. The section states:

> *There shall be a division of professional services in the department of mental health. The supervisor shall assist the director in the operation of the programs or services of the department and shall be a qualified psychiatrist.*[12]

We believe that the most beneficial way to integrate clinical leadership into the current behavioral health system is to create a position for an Assistant Commissioner for Clinical Services within BHHF. This Assistant Commissioner position would be filled by a qualified psychiatrist and would report directly to the Commissioner of BHHF. The individual filling this position would need to provide on-going clinical guidance regarding service provision for both institutional and community-based levels of care, among other clinical tasks, and would also need to regularly review emerging and existing evidence-based practices and assess how these practices could be incorporated into the system.

Other strategies that could be supported by BHHF include licensing Ph.D. psychologists with pharmacy training so that they may provide medication management (this will require specialty licensing by the Board of Examiners of Psychology and OHFLAC) and hiring more practitioners with backgrounds in psychology and specialized areas of behavioral health such as traumatic brain injury to expand the system's work force. Working with the universities to promote a program wherein medical / psychology students remain in West Virginia after completing their training to receive a tuition exemption will also boost workforce development for the state.

Additionally, it is important that the state develop a forum for clinical discussion that makes recommendations to the Commissioner on a regular basis about how to structure the delivery of services throughout the state. The new Assistant Commissioner could facilitate this forum. This is a critical step to improving the state's forum for clinical discussion; however, it should be noted that the incorporation of additional clinical leadership into the system does not suggest and by no means condones the use of the medical model for West Virginia's behavioral health system. In fact, BHHF leadership should ensure that whatever steps are taken to bolster the agency's clinical infrastructure are ones that emphasize community-based, recovery-oriented strategies. The aim of this goal is to increase consumers' access to services, not to promote a clinical approach to behavioral health services.

[11] West Virginia State Code, §27-1A-3.
[12] West Virginia State Code, §27-1A-6.

GOAL #19 ***Maximize service and support opportunities available to Medicaid consumers by redesigning existing waivers and writing new waivers to generate new federal revenues that can provide additional service options. Continue to closely follow the development of regulations and guidelines defining the waiver options proposed under the Deficit Reduction Act for applicability to West Virginia.***

While Medicaid Title XIX dollars have historically been used to finance health-related services based on a medical model, there have been several changes over the last several decades that have resulted in the ability to utilize these dollars for previously unfunded services and supports. Specifically, the Home and Community-Based (HCBS) Waivers for people with mental retardation and developmental disabilities, the elderly, individuals with traumatic or acquired brain injury, physical disabilities, or mental health issues utilize Title XIX dollars. Individual eligibility for these HCBS Waivers is based on Medicaid eligibility as well as the individual's need to meet a specified level of care. However, not all services or supports funded through the waiver are of a medical nature. It is recommended that BHHF engage in a conversation with BMS about how Medicaid dollars can be used more flexibly to provide services to people who are not in 24-hour residential situations. Since BMS and BHHF are located within an umbrella human services agency, CMS allows for the delegation of many administrative and operations responsibilities for the waiver including development and implementation to be completed by the program Bureau. This simply requires that the state indicate to CMS that the waiver is administered by a separate division within the overarching agency.

Waiver Enhancements

Currently, West Virginia is utilizing an Aged and Disabled Waiver to provide home and community based services (case management, homemaker services, adult day health, and transportation services) to the aged, blind, and disabled who are 18 years or older and who would require the level of care provided in a Nursing Facility, the costs of which would be reimbursed under the approved Medicaid State Plan. The state also has a MR/DD Home and Community-Based Waiver program in place, which provides residential and day habilitation, respite, transportation, prevocational training, supported employment, and service coordination.

In the current system, there are numerous examples of how BMS has not utilized the waiver authority to promote community-based service delivery and to exercise the flexibility CMS allows for under HCBS Waivers. A few examples include: describing the waiver as a health care coverage program; stating that waiver participants must require continuous active services (which is not the HCBS Waiver standard per Medicaid Letter #97-10); and the creation of complicated definitions of services and restrictions on service delivery based on the environment in which the services are delivered instead of based on individual need. These identified issues are not an exhaustive list, but are meant to illustrate the kinds of issues that need policy leadership from BHHF.

While Medicaid has become a primary funder of community-based service systems, it is important to note that services and supports funded with state-only dollars remain an available option. This is important to realize, as not all people in need of services are Medicaid eligible and not all services and supports that a state may wish to fund can be covered by Medicaid (although we assert there are services that can be covered with Medicaid dollars that are not currently in West Virginia). West Virginia uses a rigid model and interpretation of what services and supports can be covered, which results in a menu of services that may not be flexible enough to meet individual needs. Having some flexible dollars, usually state general funds, is an advisable practice for any comprehensive system such as the one BHHF desires. Flexible dollars can support services and supports that can be preventative in nature, thus avoiding a crisis

approach to service delivery. Although West Virginia has some flexible dollars available, the amount needs to be boosted to accomplish a menu of services that meets the specific needs of individuals.

New Waivers

The current service delivery system in West Virginia is structured in a way so that individuals who qualify for the MR/DD Waiver require 24-hour supports and receive a comprehensive package of services, while individuals who are not eligible for this comprehensive waiver receive significantly less or no services. Non-waiver services for individuals with mental retardation and/or developmental disabilities are limited and fragmented in their availability. This fact leads to the impression that the system is crisis-focused and that only people in dire need receive services, while others struggle until crisis occurs.

BHHF can approach changes to the MR/DD Waiver in one of two ways: 1) leave the current comprehensive waiver as is and also develop a new supports waiver; or 2) develop two new MR/DD Waivers–one which would provide 24-hour residential supports and another which would provide support services to individuals living at home or independently. All individuals currently receiving waiver services would be assessed to determine which waiver would most effectively meet their assessed needs and assure their health and safety.

A supports waiver would allow BHHF to serve additional consumers who do not need the full gamut of services offered under the comprehensive waiver, but still need waiver services to support them in their home or community and assures that their health, safety and well-being needs are fully met. As mentioned above, a supports waiver may be appropriate for some individuals currently enrolled in the comprehensive waiver but who could 'step down' to the supports waiver. Enrollment in any waiver only occurs after an objective assessment of need; after the individual chooses to participate in the HCBS waiver; and after there is an assurance by the state that the person's health and safety needs will be met. As always the individual has appeal rights. Having a fuller compliment of waiver options would make a wider spectrum of supports and services available to West Virginians and would ensure that people do not have to be in crisis to receive services in the state.

BHHF could pursue the addition of support services through an Amendment to the State Plan, given the recent changes made through the Deficit Reduction Act of 2006 (DRA). However, such changes to the State Plan cannot be guaranteed because the federal rules and regulations regarding the DRA have not yet been promulgated by CMS. Therefore, until this opportunity is in place through CMS policy, we recommend that BHHF pursue the addition of support services to the system through the development of a supports waiver for people with mental retardation and developmental disabilities. BHHF and BMS can proactively monitor the development of DRA regulations so that they are poised to utilize the State Plan option; however, counting on this option without the detail of the regulations does not seem the best approach in meeting the identified needs of BHHF and their statutory responsibilities.

Many states across the country utilize MR/DD supports waivers in addition to their comprehensive MR/DD waivers. States such as Virginia, Pennsylvania, and Indiana utilize supports waivers and the Commonwealth of Massachusetts is in the process of developing a supports waiver. For purposes of providing an example for West Virginia, we have included a description of Pennsylvania's Person / Family Directed Support Waiver, included in the table below. While some of the eligibility criteria may differ from that in West Virginia, the example is meant to encourage creativity in BHHF's thinking about how waivers can be utilized.

Financial Eligibility	Functional Eligibility	Services
$2,000 resource limit (does not apply to dependent children under 21) Income limit 300% Federal Benefit Rate	Age 3 and older Mental retardation Does not require Office of Mental Retardation licensed community residential services	Adaptive services and equipment Environmental accessibility adaptation Habilitation services (residential, day, prevocational, supported employment) Homemaker / chore services Personal support Respite care Therapies (physical, occupational, speech, hearing, language, visual / mobility, behavioral) Transportation Visiting nurse

Source: Commonwealth of Pennsylvania, Department of Public Welfare, http://www.dpw.state.pa.us/ Health/AccessHealthCare/SuppServWaivers/003671641.htm, Accessed 5/17/06.

Developing a supports waiver will require BHHF to make several key decisions. First, BHHF will need to determine the target population for whom the supports waiver and objective assessment process will be used. Second, the types of services and supports to be provided under the supports waiver will need to be determined. Perhaps the most critical decision will be for BHHF to estimate how many individuals waiting for waiver services could have their needs appropriately met through a supports waiver and how many individuals on the comprehensive waiver may be able to have their needs met more appropriately through a transition to the supports waiver. A supports waiver may provide the opportunity for consumers to move from larger settings to more individualized, smaller settings.

Once a supports waiver is in place, BHHF will have a resource to better meet the needs of its consumers who have mental retardation and/or developmental disabilities who seek community-based services through the waiver program. In developing this waiver, BHHF will want to look at utilizing the option for self-direction of services, which would allow individuals more flexibility in service and provider options through the utilization of non-traditional providers and a more flexible menu of services. It is also important for the Bureau to note that there is no requirement that a person who needs ICF/MR level of care receive active services when enrolled in a 1915(c) waiver.

Options for Waiver Enhancements and New Waivers

When enhancing its current HCBS waiver and developing the proposed supports waiver, the Bureau should consider incorporating features of the *Independence Plus* initiative, such as person-centered planning and self-directed service options. Further implementation of some of the features of *Independence Plus* into current and new waivers (some implementation of these features is currently completed through the state's A/D waiver) could improve the lives of the individuals served by allowing them to maximize control over the services they receive.

It is important to emphasize that self-directed programs for individuals with mental illness are still in the early stages of development. Nevertheless, several states have utilized waivers authorized under section 1115 of the Social Security Act to provide individual budgets and cash allowances for individuals with developmental disabilities. This self direction model could be easily modified to also serve the mental

health population. An example of a self-determination program aimed at individuals with mental illness is Florida's Self-Directed Care program, which serves individuals living in northeast Florida. The program offers independent brokerage and coaching services to adults with mental illness who are dependent on public funding to receive mental health services. Participants are given the freedom to choose the traditional and non-traditional community-based services and providers of those services they want. Participants have the option of managing the funds allocated to them for services though a fiscal intermediary.[13]

One other option for West Virginia to consider involves submitting a waiver application for a waiver that assists individuals with highly specialized needs—individuals with acquired or traumatic brain injury (ABI / TBI). Many other states have applied for and successfully implemented ABI / TBI waiver programs through a waiver from CMS; this is one other option for West Virginia to consider in meeting the needs of all of its consumers.

GOAL #20 Review and modify the Health Care Authority's Certificate of Need process to ensure that it is not inadvertently having a negative impact on consumer choice or the promotion of a competitive market, as choice and competition can improve both the quality of service and consumer outcomes.

A significant point of concern conveyed during the data collection process and statewide public forums is that the Certificate of Need (CON) regulations currently in place are restrictive and burdensome on providers. Providers across the state indicated that the application process itself is lengthy and requires a great deal of information and documentation. In addition, providers commented that once applications are submitted there is a great deal of scrutiny and subjectivity that drives the evaluation process. Therefore, we strongly recommend that BHHF, while not having primary responsibility for the CON process, actively engage in conversations with the Advisory Group about the adverse or potentially adverse impacts the current process may have on the new service brokerage service delivery model. Through these discussions, a more viable CON process should be explored. It is important to note that many states do not use a CON process for anything other than the development of acute care health facilities or nursing home facilities, because they have found the CON process to be unnecessarily burdensome in developing community-based behavioral health services and additionally, it restricted individual choice of a wider variety of qualified providers.

Based on our review of the CON statutes – both §16-2D of West Virginia Code and Title 65-7-1 – West Virginia's existing CON requirements and application process appear to be overly restrictive and require very detailed applications from providers requesting a CON. The complaint being echoed throughout many within the provider community is that the rigidity of the statutes and process deter providers from submitting CON applications to the state, consequently limiting the number of behavioral health service providers. In a state where the number of healthcare providers and staff is not overly abundant, a restrictive or even simply the perception of a restrictive CON process exacerbates the problem.

Additionally, throughout the information-gathering stage of this project, we heard that Chapter 27 of the West Virginia Code, which is the guiding set of regulations for the state's behavioral health system, is outdated, lacks specificity, and is in general, vastly ignored. In our experience, we have found that

[13] Substance Abuse and Mental Health Administration, National Mental Health Information Center. "Promoting Self-Determination for Individuals with Psychiatric Disabilities through Self-Directed Services: A Look at Federal, State, and Public Systems as Sources of Cash-Outs and Other Fiscal Expansion Opportunities" http://www.mentalhealth.samhsa.gov/publications/allpubs/NMH05-0192/default.asp. July 13, 2006

detailed, regularly updated state regulations are central to the provision of high quality services in a coordinated manner to fully meet the needs and expectations of consumers. State regulations serve as an anchor for the development and operation of behavioral health programs and services and are an important component to keeping a behavioral health system fully functional and law compliant—aspects that consumers and other stakeholders expect from the system.

GOAL #21 Streamline various monitoring and auditing processes and improve information gathering in order to facilitate quality outcomes for consumers without creating burdensome reporting requirements for providers.

Behavioral health providers in West Virginia are struggling to keep up with the multitude of auditing processes and the large amount of documentation that is required of them. At present, the following agencies conduct regular audits of West Virginia behavioral health providers:

- The Office of Health Facility Licensure and Certification (OHFLAC);
- The MR/DD Waiver Office;
- Advocacy groups, such as WV Advocates, WV EMS TSN, and Legal Aide;
- Adult Protective Services;
- Division of the Bureau for Children and Families;
- The ASO;
- WVMI; and,
- Child Protective Services.

To accommodate these audit processes, providers must document their activities in frequent increments. Providers that spoke with Public Consulting Group emphasized that documenting activity in such small increments often creates administrative burden for staff, which reduces the amount of time clinicians can spend with consumers and bolsters the high rate of staff turnover at provider sites.

Standards for an annual evaluation process of the providers need to be established by the Bureau. Current auditing processes and documentation could be blended into a new method of evaluating provider services with new, properly defined standards and a statewide commitment to utilize this new method. Potential results of implementing this change include: more specific recommendations for providers to utilize; a reduction in the amount of paperwork required to complete auditing process; the availability of more time for providers to spend with consumers and their families instead of filling out documentation in frequent intervals; and less staff turnover because of the reduction in paperwork.

GOAL #22 Enhance access to services in the rural areas of the state by reimbursing providers for efficiencies such as telemedicine, electronic medical records, and other innovative practices that promote better access to and the provision of high quality services.

The rural nature of West Virginia, along with its current shortage of behavioral health clinicians, lends to an environment perfect for the use of telemedicine, which is the delivery of medicine at a distance using video-conferencing equipment. Indeed, these factors prompted West Virginia to incorporate a system of telemedicine into its behavioral health system in the late 1990s called Mountaineer Doctor Television (MDTV).

MDTV was an important technological advancement for the state. According to Dr. James Brick, Chairman of the Department of Medicine at the Robert C. Byrd Health Science Center in Morgantown in

a September 1999 testimony to the Subcommittee on Science, Technology, and Space of the Senate Committee on Commerce, Science, and Transportation:

> …Patients get the advantage of seeing a specialist without having to travel for hours to a major medical center. A patient in pain might find such travel too demanding. Patients may not be able to take a day off work, and some patients don't have transportation and depend on family or community transportation. For patients in need of immediate attention, the delay involved in travel might put their lives in jeopardy. Rural doctors benefit from MDTV because it gives them the same level of professional support that doctors in urban or academic centers take for granted… Rural hospitals benefit from MDTV because they can keep patients in the community who might otherwise have to be transferred to larger hospitals. For many of these locations, the ability to use telemedicine becomes a powerful recruitment tool for gaining medical staff…

MDTV has been in place in West Virginia for over five years; however, the system is under-utilized, as expansion of the network has been inhibited by both the cost of maintaining the infrastructure and payment for the services. Additionally, under-utilization of MDTV in West Virginia may be occurring due to the fact that stakeholders do not have knowledge of and/or training in using the technology.

According to the federal Health Resources and Security Administration (HRSA), the absence of consistent, comprehensive reimbursement policies is often cited as one of the most serious obstacles to the complete integration of telemedicine into a state's health care practice. At present, 27 state Medicaid programs acknowledge at least some reimbursement for telehealth services, with the most rapid expansion being in the area of behavioral health. States are beginning to enact legislation that acknowledges telemedicine as a legitimate medical service and additionally, have begun to incorporate telehealth reimbursement laws into their respective state codes—Arizona, California, Colorado, Hawaii, Kentucky, Louisiana, Minnesota, Nebraska, Oklahoma, Texas, and Virginia have all at least begun this process. In addition, four more states have enacted state legislation concerning telemedicine reimbursement: Massachusetts (S 503, SC 1252), New Mexico (NM H 665), New York (A 7155, S 463), and Oregon (HJR 4)[14]. As such, we recommend that West Virginia consider these reimbursement methodologies to advance the concept of telemedicine in the state and provide a solution to the geographic barriers that hamper the provision of quality behavioral services to consumers.

Electronic medical records, or EMRs, should also be considered as part of this goal for the Bureau. EMRs allow for access of patient data by clinical staff at any given location, promote wide accessibility and efficiency, and promise increased patient safety and cost savings.

Pricing for EMR systems is varied and highly dependent upon the needs of the organization. Often the EMR system selected must be custom-tailored to better fit the medical specialty adopting the EMRs, which can be an expensive endeavor. Therefore, we recommend that the Bureau begin to think about the implementation of electronic medical records to enhance the state's behavioral health service system while keeping in mind the financial implications of this technology.

[14] http://telehealth.hrsa.gov/licen/#part1.

GOAL #23 Review the progress to date made on the planning and implementation of the Single Point of Entry service brokerage model communicate the progress to stakeholders of the behavioral health system.

During the third year of redesign, the Advisory Group and the Bureau should make it a priority to collaborate in order to review the progress that has been made on the implementation plan of the Single Point of Entry service brokerage model. This review is an important step to ensuring that the redesigned system of behavioral health services in West Virginia is launched successfully, with stakeholders fully understanding the changes in services and supports they may experience as this new continuum of services is implemented.

As part of this process, the Advisory Group and the Bureau should determine those areas of the implementation plan that are working well for West Virginia and the behavioral health system's needs as well as those areas that have encountered barriers to implementation and are in need of improvement(s) in order to be accomplished. The collaborative effort should assess the timeframes of the implementation plan that have been met and those that have been delayed. Solutions to any issues or barriers encountered during the implementation process should be developed and revised timeframes should be discussed between the Advisory Group and the Bureau.

During the effort towards this quality assurance goal, BHHF should continually communicate the progress of the new service model implementation to stakeholders across the state. Posting progress updates to the Bureau's website on a regular basis is one way to accomplish this communication.

V. ACKNOWLEDGEMENTS

Stakeholder List

Advocate/Attorney
Alliance for Children, Inc.
Appalachian Community Health Center, Inc.
APS Healthcare, Inc.
Association of Addiction Professionals
Autism Services Center
Bateman Hospital
Bureau for Children & Families
Bureau for Health & Health Facilities
- Division on Alcohol and Drug Abuse
- Office of Behavioral Health Services
- Mental Health & Community Rehabilitation Services
- Children's Mental Health Services
- Data Integration & Security Division
- Developmental Disabilities Services
- Office of Finance & Administration
- Office of Health Facilities
- Forensic Programs

Bureau for Medical Services
Bureau for Public Health
Bureau for Senior Services
Children's Home Society of West Virginia
C. Greg Gibbs Cost Report Preparing Firm
Community Mental Health Programs
Concordia University / Bluefield Regional Student Consumers
Crittenton Services, Inc.
Department of Health and Human Resources
Eastern Panhandle Mental Health Center, Inc.
EastRidge Health
Evergreen Behavioral Health Center
Fair Shake Network
Families of Consumers
Fayette-Monroe-Raleigh-Summers Mental Health Council, Inc.
FMRS Health Systems, Inc.
General Counsel, Department of Health and Human Resources
Home Base, Inc.
Horizons - HCIL
HR Coordinator
Long Term Care Hospital Administrators
Madison Elementary School
Mental Health Association of Greater Kanawha Valley
Mental Health Coalition
Mental Health Consumers Association
Mercy Day Report Center
Mildred Mitchell Bateman Hospital
Mountain State Family Alliance
NAMI of West Virginia
Northwood Health Systems
Office of Accountability and Management Reporting
Office of Behavioral Health Services
Office of Health Facilities Licensure and Certification
Office of the Ombudsman
Olmstead Coordinator
Open Doors, Inc.
PATH
Parents
Pressley Ridge
Prevention/Adolescent Treatment Coordinators
Princeton Community Hospital
Protection & Advocacy
ResCare
Seneca Health Services, Inc.
Sharpe Hospital
Southern Highlands Community Mental Health Center
United Summit Center
West Virginia Advocates
West Virginia Youth Advocate Program
Westbrook Health Services
WV Behavioral Health Commission
WV Developmental Disabilities Council
WV Developmental Disabilities Planning Council
WV Mental Health Consumers Association
West Virginia Mental Health Planning Council
WV Providers Association
West Virginia State Delegate
West Virginia Statewide Independent Living Council
West Virginia University – Center for Excellence in Disabilities
West Virginia University – Behavioral Health Medicine
Youth Services Systems

West Virginia Focus Group Sessions Participation Summary

Focus Group Location	Date	Number of Participants
Princeton	4-19-2006	14
Beckley	4-19-2006	10
Wheeling	4-19-2006	22
Parkersburg	4-19-2006	23
Huntington	4-20-2006	21
Charleston	4-20-2006	14
Martinsburg	4-20-2006	7
Clarksburg	4-20-2006	20

APPENDICES

APPENDIX A: FUNDING FOR STATE FACILITIES

Seven state facilities are funded through state appropriations, tobacco settlements, and hospital service revenues. FY 2006 budgets indicate that 47.8% of funding is made by state general revenue, 20.7% is made by tobacco settlement funds, and 31.5% is made by hospital service revenue. Budgets are developed by fiscal year and spending is made in the "process year;" an important distinction because BHHF operates on a cash-based accounting system. These appropriations are managed through the state's financial information management system (FIMS) which is 14 years old.

Overall facility budgets have risen 31.7% since FY 2000. The majority of this increase is attributed to the state psychiatric facilities: Sharpe Hospital's budget has increased 36.3% since FY 2000 and Bateman Hospital's budget has increased by 52.3% since FY 2000. This dramatic increase in facility budgets can be attributed to many factors such as added diversionary costs of the psychiatric facilities, salary increases, and pay differentials. However, the Bureau has been able to pay for these increased diversion costs by reducing operating costs to a minimum. Also, Tobacco settlement funds became available for West Virginia in FY 2001, reducing the funding reliance on hospital service revenue funds. With these funds remaining relatively static over the past six years, the strain caused by overall hospital service funding has dropped by 2.8 percent since FY 2000.

Table A-1: Funding Sources of Revenues for the Hospitals and Nursing Homes

FACILITY FUNDING SOURCE*	FY00	FY01	FY02	FY03	FY04	FY05	FY06
Hopemont Hospital	$4,935,343	$0	$5,599,454	$5,871,802	$6,211,538	$6,292,388	$6,224,889
Lakin Hospital	$4,935,909	$0	$115,000	$0	$0	$190,164	$6,118,957
Manchin Health Care Center	$2,091,765	$0	$2,372,003	$2,464,782	$0	$0	$2,635,983
Pinecrest Hospital	$6,465,737	$0	$150,000	$0	$7,833,428	$7,460,560	$0
Welch Community Hospital	$0	$0	$0	$0	$12,097,044	$12,356,797	$0
Sharpe Hospital	$13,101,160	$0	$332,890	$5,014,000	$15,777,988	$17,109,962	$16,618,941
Bateman Hospital	$10,065,323	$0	$11,160,936	$14,006,756	$0	$929,689	$14,087,656
Subtotal - 0525 - State General Revenue Funds	**$41,595,237**	**$0**	**$19,730,283**	**$27,357,340**	**$41,919,998**	**$44,339,560**	**$45,686,426**
Hopemont Hospital	$0	$5,241,225	$0	$0	$0	$0	$0
Lakin Hospital	$0	$5,130,493	$5,368,980	$5,700,624	$6,269,912	$5,986,496	$0
Manchin Health Care Center	$0	$2,335,963	$0	$0	$2,639,422	$0	$0
Pinecrest Hospital	$0	$6,805,330	$6,974,631	$0	$0	$0	$7,435,112
Welch Community Hospital	$0	$0	$5,376,272	$11,707,640	$0	$0	$12,143,430
Sharpe Hospital	$0	$14,160,542	$14,269,032	$12,025,191	$635,990	$0	$118,390
Bateman Hospital	$0	$10,769,973	$0	$0	$12,380,095	$13,538,126	$105,224
Subtotal - 5124 - Tobacco Settlement Funds	**$0**	**$44,443,526**	**$31,988,915**	**$29,433,455**	**$21,925,419**	**$19,524,622**	**$19,802,156**
Hopemont Hospital	$1,604,133	$1,654,000	$1,894,748	$1,789,962	$1,729,500	$1,778,700	$1,957,821
Lakin Hospital	$1,346,032	$1,415,000	$1,540,000	$1,480,000	$1,500,500	$1,500,500	$1,679,437
Manchin Health Care Center	$583,644	$613,644	$758,644	$769,000	$687,000	$3,352,146	$771,424
Pinecrest Hospital	$2,248,000	$2,302,500	$2,402,500	$9,703,694	$2,583,500	$2,422,376	$2,696,337
Welch Community Hospital	$16,583,839	$17,983,992	$13,652,593	$8,451,269	$8,529,000	$8,332,000	$8,489,425
Sharpe Hospital	$5,407,000	$5,342,779	$7,039,871	$5,461,769	$7,718,000	$9,238,000	$8,486,589
Bateman Hospital	$3,242,000	$3,409,179	$5,478,914	$5,454,038	$7,283,483	$5,476,000	$6,071,847
Subtotal - 5156 - Hospital Services Revenue Funds	**$31,014,648**	**$32,721,094**	**$32,767,270**	**$33,109,732**	**$30,030,983**	**$32,099,722**	**$30,152,880**
Hopemont Hospital	$6,539,476	$6,895,225	$7,494,202	$7,661,764	$7,941,038	$8,071,088	$8,182,710
Lakin Hospital	$6,281,941	$6,545,493	$7,023,980	$7,180,624	$7,770,412	$7,677,160	$7,798,394
Manchin Health Care Center	$2,675,409	$2,949,607	$3,130,647	$3,233,782	$3,326,422	$3,352,146	$3,407,407
Pinecrest Hospital	$8,713,737	$9,107,830	$9,527,131	$9,703,694	$10,416,928	$9,882,936	$10,131,449
Welch Community Hospital	$16,583,839	$17,983,992	$19,028,865	$20,158,909	$20,626,044	$20,688,797	$20,632,855
Sharpe Hospital	$18,508,160	$19,503,321	$21,641,793	$22,500,960	$24,131,978	$26,347,962	$25,223,920
Bateman Hospital	$13,307,323	$14,179,152	$16,639,850	$19,460,794	$19,663,578	$19,943,815	$20,264,727
Grand Total - All Funding	**$72,609,885**	**$77,164,620**	**$84,486,468**	**$89,900,527**	**$93,876,400**	**$95,963,904**	**$95,641,462**

Source: BHHF Accounting Records

Generally, state general funds are used to operate the long term care facilities. While it appears, based on the table below, that Hopemont, Lakin, and Manchin are funded primarily by state general revenue funds and Pinecrest by tobacco settlement funds (approximately 75% each) with the remaining 25% coming from hospital services revenue funds, it can not consistently be segregated in this manner. It is more commonly accepted that costs associated with personnel at all of the nursing facilities are paid for through state general revenue funds along with tobacco settlement funds while "operating" costs at these facilities are commonly paid for by cash receipts.

Welch Community Hospital is being funded with tobacco settlement funds (59%) and hospital service revenue (41%). Sharpe and Bateman Hospitals are funded with a mix of state general revenue (approximately 65%) and hospital service revenue (approximately 35%).

Table A-2: Funding Sources for Facilities (Dollars and Percentages)

FACILITY FUNDING SOURCE	State General Revenue Funds (0525)	Tobacco Settlement Funds (5124)	Hospital Services Revenue Funds (5156)	Total Hospital Expenditures
Hopemont Hospital	$ 6,224,889	$ -	$ 1,957,821	$ 8,182,710
Lakin Hospital	$ 6,118,957	$ -	$ 1,679,437	$ 7,798,394
Manchin Health Care Center	$ 2,635,983	$ -	$ 771,424	$ 3,407,407
Pinecrest Hospital	$ -	$ 7,435,112	$ 2,696,337	$ 10,131,449
Welch Community Hospital	$ -	$ 12,143,430	$ 8,489,425	$ 20,632,855
Sharpe Hospital	$ 16,618,941	$ 118,390	$ 8,486,589	$ 25,223,920
Bateman Hospital	$ 14,087,656	$ 105,224	$ 6,071,847	$ 20,264,727
TOTAL	**$ 45,686,426**	**$ 19,802,156**	**$ 30,152,880**	**$ 95,641,462**

FUNDING SOURCE AS A PERCENT OF TOTAL (BY FACILITY)	State General Revenue Funds % (0525)	Tobacco Settlement Funds % (5124)	Hospital Services Revenue Funds % (5156)	Total Hospital %
Hopemont Hospital	76.1%	0.0%	23.9%	100.0%
Lakin Hospital	78.5%	0.0%	21.5%	100.0%
Manchin Health Care Center	77.4%	0.0%	22.6%	100.0%
Pinecrest Hospital	0.0%	73.4%	26.6%	100.0%
Welch Community Hospital	0.0%	58.9%	41.1%	100.0%
Sharpe Hospital	65.9%	0.5%	33.6%	100.0%
Bateman Hospital	69.5%	0.5%	30.0%	100.0%
TOTAL	**47.8%**	**20.7%**	**31.5%**	**100.0%**

Source: BHHF Accounting Records

State Facility Revenue

BHHF tracks revenue in 21 specific accounts; these accounts represent both patient-related and non-patient related revenue. OHF collected $65.6M in FY 2005, primarily in Medicaid FFS (40.3%) and Medicaid DSH (37.9%) payments. Medicare represented 11.7% of the FY 2005 OHF revenue. Commercial, Private Pay, Resource/Supplemental, Rent/General Other, and Hospice made up the remaining balance (10.1%).

Table A-3: Percentage of State Facility Revenue by Source, FY 2005

Revenue Source	% of Revenue
Medicaid	40.3%
Medicare	11.4%
Commercial	3.6%
Private Pay	2.5%
Resource/ Supplemental	3.1%
Rent/ General Other	1.1%
Hospice	0.2%
Medicaid DSH	37.9%
Total	100.0%

Source: BHHF Accounting Records

Each BHHF facility has unique reimbursement methodologies, which result in different contributions to the hospital revenue fund by facility. Almost all of the Medicaid FFS revenue is generated by the nursing facilities—the clients in these facilities are virtually 99% Medicaid eligible, resulting in significant Medicaid FFS payments. Medicaid DSH payments are only made to Welch Community Hospital, Sharpe Hospital, and Bateman Hospital. Sharpe and Bateman Hospitals are limited in the amount of DSH funding they can claim because of federal Institutions of Mental Disease (IMD) DSH provisions. The FY 2005 allocation for West Virginia was $63.5M (federal share only), of which $13.9M was designated for IMDs. Under the amendments to section 1923(f) of the Medicaid Modernization Act (MMA), each state's DSH allotment for FFY 2005 and for subsequent fiscal years, is equal to the state's DSH allotment for FFY 2004 and subject to the 12 percent limit. As such, DSH limits in West Virginia will be increased at amounts which approximate the CPI-U on an annual basis. Increasing the DSH limits will not however affect the cash receipts of the facilities as they do not keep any DSH funds.

Most of the Medicare and commercial revenue generated by BHHF facilities is through Welch Community Hospital. The facility operates a Medicare certified acute inpatient and outpatient unit. Sharpe and Bateman also generate some Medicare revenue. Another revenue source is social security income, black lung funding, and Veterans' Affair income. These payments are collected by the nursing facilities on behalf of the residents. Social security payments are significant for these facilities. Hopemont, Lakin, Manchin, Welch, and Pinecrest collected $1.7M in FY 2005. Welch Community Hospital does not deposit SSI funds in the proper object code so the amount found in Table 4A is understated.

Table A-4: FY 2005 Facility Revenue by Source

Revenue Source	Bureau	Hopemont	Lakin	Manchin	Pinecrest	Welch	Weston	Sharpe	Bateman	Annual Revenue
ESCHEATED WARRANT	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13	$ 13
GROUP HOME RENTALS	252,155	-	-	600	-	-	-	-	-	252,755
REAL ESTATE	-	51,032	-	-	-	-	-	-	-	51,032
LEASE/RENTAL-INSTITUTIONS	361,655	-	-	-	6,394	-	-	-	-	368,049
GENERAL COLLECTIONS	2,033	-	-	4,932	-	-	25,000	6,303	-	38,268
COLLECTION OF SALES TAX	-	31	-	60	37	-	-	-	-	128
MEDICAID DSH	-	-	-	-	-	6,444,232	-	11,049,541	7,369,067	24,862,840
OTHER COLLECTIONS - INST.	-	-	-	38	-	-	-	-	-	38
LONG TERM CARE - MEDICAID	-	4,296,473	4,539,925	1,537,633	7,127,281	1,929,351	-	-	-	19,430,662
ACUTE CARE - MEDICAID	-	-	-	-	-	766,085	-	244,455	597,109	1,607,649
MEDICARE A	-	-	-	-	-	4,239,095	-	1,538,885	1,328,271	7,106,251
MEDICARE B	-	-	-	28,397	-	-	-	79,718	261,217	369,332
MEDICAID	-	-	-	33,881	-	2,044,185	-	-	-	2,078,066
THIRD PARTY	-	-	(176)	61,904	-	2,077,904	-	-	202,233	2,341,865
COST SETTLEMENT -MEDICAID	-	697,141	1,024,918	195,996	1,131,460	30	-	273,280	-	3,322,824
SOCIAL SECURITY	-	364,576	403,812	494,709	456,254	534	-	57,915	-	1,777,802
BLACK LUNG	-	11,341	-	-	68,117	111,178	-	-	-	190,637
VETERANS ADMINISTRATION	-	8,862	-	-	9,334	1,944	-	7,914	53,037	81,091
HOSPICE	-	-	-	-	109,980	-	-	-	-	109,980
INDIVIDUAL (PAT/FAMILY)	-	222,415	239,663	23,030	311,326	732,034	-	81,401	63,891	1,673,760
COUNTY DETAINEE RECEIPTS	-	-	-	-	-	-	-	-	661	661
TOTAL	**$ 615,843**	**$ 5,651,872**	**$ 6,208,142**	**$ 2,381,181**	**$ 9,220,183**	**$ 18,346,571**	**$ 25,000**	**$ 13,339,412**	**$ 9,875,499**	**$ 65,663,702**

APPENDIX B: SFY 2005 FUNDING FOR COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS

The tables below provide an overview of how the Bureau spent its funds in SFY 2005. The Bureau's accounting system assigns accounts to five program areas: adult mental health, children's mental health, mental retardation/developmental disabilities, substance use services and plus disaster and crisis programs. Charity care funding, which pays for Medicaid-like services to eligible non-Medicaid recipients, and Support and Alternative dollars which are allocated, are shown separately.

Table B-1 shows SFY 2005 funding for these program areas for the thirteen Comprehensive Community Mental Health Centers and four MR/DD providers, and other licensed providers. The dollars include both state and federal funds expended through the accounts of the Bureau. This does not include Medicaid funding received by providers, but does include federal block grants and other miscellaneous dollars. In SFY 2005, the Bureau received approximately $2.6M in federal mental health block grant funding to pay for mental health services and $8.6M in federal substance use block grant funding.

Table B-1: SFY 2005 Funding To Comprehensive Community Mental Health Centers and other Providers by Program Areas and Funding Method

Behavioral Health Programs	Comps and MR/DD Providers	All Behavioral Health Providers
Adult Mental Health	$ 7,626,971	$ 9,363,224
Children's Mental Health	$ 3,678,928	$ 4,898,508
MR/DD	$ 5,448,267	$ 11,240,556
Substance Abuse	$ 13,396,964	$ 18,548,293
Data Integration and Policy	$ -	$ 43,332
Admin (Operations)	$ -	$ 296,503
Total Target Funds	*$ 30,151,130*	*$ 44,390,416*
Charity Care	*$ 12,115,430*	*$ 12,341,886*
Support and Alternative Services	*$ 4,725,000*	*$ 4,925,000*
Other	*$ -*	*$ 3,146,027*
Total Allocation	**$ 46,991,560**	**$ 64,803,329**

Source: BHHF Accounting Records

During SFY 2005, the thirteen Comprehensive Community Mental Health Centers and four MR/DD providers received about 73% of the Bureau's expenditures made to the eighty-two behavioral providers. The Comprehensive Community Mental Health Centers receive approximately 80% of the adult mental health money, 75% of the children's mental health money, 50% of the MR/DD money, and 72% of the substance use funding. The Bureau provides funds to approximately sixty of the eighty or more licensed providers.

National data compiled by SAMHSA from 2003 shows comparative statewide spending ranging from a high of $229.85 per capita to a low of $10.14 per capita for mental health services. West Virginia data indicates that the state spends approximately $21.83 per capita and that forty-three states spent more money on a per capita basis for mental health.

In SFY 2005, the Bureau spent $18.5M directly on substance use services. Federal substance use block grant funding has remained stable during the period SFY 2002 through SFY 2006 at about $8.6M. State maintenance of effort (MOE) requirements have increased from $6.6M in FY 2002 to about $7.6M in SFY 2005.

Charity care services are paid using a procedure code reporting system with limits on provider reimbursement. Charity care funds pay for Medicaid-like services to individuals who are not eligible for Medicaid. Support and Alternative services are allocated. These funds are also spent on providing services to individuals with mental health, substance use, or mental retardation and similar developmental problems, but the manner of paying these funds makes it difficult to determine how many and what types of populations are served.

Table B-2: FY 2005 State and Federal Funding to Each Comprehensive Community Mental Health Center and MR/DD program

	APPALACHIAN	AUTISM	EASTRIDGE	F.M.R.S.	GREEN ACRES	HEALTHWAYS	LOGAN-MINGO	NORTHWOOD
Adult Mental Health	$193,565.00		$ 710,962	$ 417,395		$ 232,789	$ 392,191	$ 235,775
Children's Mental Health	$45,000.00		$ 38,000	$ 76,000		$ 31,451	$ -	$ -
MR/DD	$103,667.00	$368,450.00	$ 279,300	$ 149,226	$ 210,000	$ 138,984	$ 137,981	$ 152,390
Substance Abuse	$185,488.00		$ 685,718	$ 1,363,777		$ 1,048,575	$ 546,181	$ 123,720
Data Integration and Security	$0.00		$ -	$ -		$ -	$ -	$ -
Admin (Operations)	$0.00		$ -	$ -		$ -	$ -	$ -
Total Target Funds	$527,720	$368,450	$ 1,713,980	$ 2,006,398	$ 210,000	$ 1,451,799	$ 1,076,353	$ 511,885
Charity Care (Uncompensated Care)	$562,101.00	$100,000.00	$ 819,208	$ 1,300,886	$ 100,000	$ 338,857	$ 998,839	$ 941,136
Support and Alternative Services	$194,775.00		$ 347,613	$ 403,380		$ 151,845	$ 172,354	$ 262,958
Total Allocation	$1,284,596	$468,450	$ 2,880,801	$ 3,710,664	$ 310,000	$ 1,942,501	$ 2,247,546	$ 1,715,979
2004 Population Size of Catchment Area	75,013		152,835	153,601		56,292	63,891	97,180
% of Total State Population Size	4.13%	0.00%	8.42%	8.46%	0.00%	3.10%	3.52%	5.35%

	POTOMAC CENTER	POTOMAC HIGHLANDS	PRESTERA	SENECA	SOUTHERN HIGHLANDS	UNITED SUMMIT	VALLEY	WESTBROOK	ALL CENTERS
Adult Mental Health	$ 35,000	$ 189,926	$ 2,413,427	$ 303,610	$ 280,302	$ 739,615	$ 659,894	$ 822,520	7,626,971
Children's Mental Health	$ -	$ 38,000	$ 3,282,500	$ -	$ -	$ -	$ 129,977	$ 38,000	3,678,928
MR/DD	$ 410,000	$ 229,652	$ 969,687	$ 144,903	$ 563,636	$ 351,219	$ 823,707	$ 415,465	5,448,267
Substance Abuse	$ -	$ 63,220	$ 5,268,925	$ 267,935	$ 617,190	$ 920,280	$ 1,313,499	$ 992,456	13,396,964
Data Integration and Security	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
Admin (Operations)	$ -	$ -	$ -	$ -	$ -	$ -	$ -		-
Total Target Funds	$ 445,000	$ 520,798	$ 11,934,539	$ 716,448	$ 1,461,128	$ 2,011,114	$ 2,927,077	$ 2,268,441	$ 30,151,130
Charity Care (Uncompensated Care)	$ 100,000	$ 378,311	$ 2,120,657	$ 1,053,831	$ 1,267,225	$ 662,626	$ 843,656	$ 528,097	12,115,430
Support and Alternative Services	$ -	$ 207,581	$ 1,241,851	$ 208,678	$ 303,139	$ 300,054	$ 480,476	$ 450,296	4,725,000
Total Allocation	$ 545,000	$ 1,106,690	$ 15,297,047	$ 1,978,957	$ 3,031,492	$ 2,973,794	$ 4,251,209	$ 3,246,834	$ 46,991,560
2004 Population Size of Catchment Area		81,330	471,020	80,006	111,494	114,785	186,429	171,478	1,815,354
% of Total State Population Size	0.00%	4.48%	25.95%	4.41%	6.14%	6.32%	10.27%	9.45%	100.00%

Source: BHHF Accounting Records

Table B-2 shows that provider funding is concentrated in larger providers in the state. Out of the approximately $64M in Bureau expenditures, about $35.4M or 55%, was spent by the largest seven providers. The Bureau funded the largest provider (Prestera) at approximately $15.3M, about three and half times larger than the next provider, Valley, which received approximately $4.3M. Three of the thirteen received between $3.0M and $4.0M apiece and the next highest three received between $2.0M to $3.0M apiece. The four MR/DD programs received the least of the Bureau's expenditures since their funded is focused on MR/DD programs.

Table B-2 also compares the percent of the Bureau's funding that is received by each Comprehensive Community Mental Health Center with the percent of the State's population that is in the Comprehensive Community Mental Health Center's geographic region and shows the variation between funding and population size. The largest variation is with Prestera, the state's largest Comprehensive Community Mental Health Center, which receives approximately one-third of the funding and has one-quarter of the state's population in its catchment area.

Target Funding Grant Agreements

Table B-2 also shows that approximately $30M is given to the Comprehensive Community Mental Health Centers and MR/DD agencies as grant agreements. Over the years the Bureau has exercised its leadership by identifying the need for particular services in certain geographical areas and then "targeting" grant funds to develop programs to address these needs. The behavioral grant program is authorized contractually from year to year. Service specific information is contained in contractual language rather than administrative regulation.

Providers tend to get the same amount of funds they received in the previous year to operate the same programs; change occurs largely through negotiations. Providers are reluctant to see funding levels drop and sometimes resist the cuts through political channels. For the Comprehensive Community Mental Health Centers, this level funding has the advantage of retaining consistent funding for the same programs and the disadvantage that no inflation increases are built into next year's funding so programs deteriorate over time.

Core (Discretionary) or Non Target Funds

Discretionary funds such as Support and Alternative Services are spent as the Centers deem appropriate within the guidelines of their grant agreements. There are five core services listed in the Bureau's policies and Comprehensive Community Mental Health Center contracts: Crisis Services, Linkages to Impatient and Residential Treatment Facilities, Diagnostic and Assessment Services, Treatment Services, Provision of Support Services. However, expenditures on these service categories are not typically reported on. This is problematic since the Bureau cannot track actual expenditures for these services.

Comprehensive Community Mental Health Center financial staff interviewed report that some of these funds are used to cover the insufficient reimbursement for both program and administration costs. The most frequently cited example of insufficient program reimbursement is for the skilled medical staff necessary to operate substance use and mental health programs. An example of insufficient reimbursement for administration is the increased costs for utilization management staff to process transactions with APS Healthcare.

State staff report that they do not have a clear picture of how the Comprehensive Community Mental Health Centers spend these allocations, are concerned that a portion of state general funds are used to

"backfill" or compensate for low Medicaid rates, and report that more accountability for specific services and individuals served would be desirable.

Through its Charity Care funding, the Bureau reimburses the Comprehensive Community Mental Health Centers for providing Medicaid-equivalent services to individuals under 200% of the Federal Poverty Level (FPL) who are not eligible for Medicaid. Comprehensive Community Mental Health Centers submit quarterly reports listing these services, by procedure code, and are credited with an amount equal to what Medicaid would have paid for that procedure code if the person were Medicaid eligible. About 50 procedure codes are reported on and the Bureau contracts with the Medicare fiscal intermediary, United Government Services, LLC, to annually audit Comprehensive Community Mental Health Centers to be sure that procedure codes are correctly reported. The following fiscal year, the charity care dollars are prorated to the providers based upon the amount of services provided the previous fiscal year.

This is a quasi fee-for-service approach based on procedure code reporting. This reimbursement methodology is new and is still being phased in. For example, there are "risk corridors" that help providers transitions from the level of their previous charity care allocations to this more procedure code based system. The multi-year project, done with the cooperation of the Comprehensive Centers, has encouraged reporting of specific services and individuals served with charity care. Accountability in Charity Care expenditures has been substantially improved in recent years with the shift to this procedure code basis for reporting eligible services provided to eligible clients.

APPENDIX C: MEDICAID REIMBURSEMENT TO THE COMPREHENSIVE CENTERS

A discussion of the funding received by the Comprehensive Community Mental Health Centers would not be complete without a closer look at their main source of funding, Medicaid revenue. The Centers billed Medicaid using 121 different procedure codes and billed for about 10.5M units of service. Table C-1 shows the Medicaid reimbursement to the Comprehensive Community Mental Health Centers and MR/DD Agencies for Behavioral Health Clinics and Rehabilitation providers ranked by total reimbursement. Table C-2 shows the Medicaid reimbursement to the Comprehensive Community Mental Health Centers and MR/DD Agencies for Home and Community Based Services (HCBS) waiver providers ranked by total reimbursement. A comparison of tables shows the heavy reliance of the Comprehensive Community Mental Health Centers and MR/DD Agencies on Medicaid waiver revenue compared to clinic and rehabilitation revenue.

Table C-1: Medicaid Reimbursement to the Comprehensive Community Mental Health Centers and MR/DD Agencies for Behavioral Health Clinic and Rehabilitation Providers

Procedure Code	Name of Code	Number of Claims	Units Billed	Paid Amount
H0036	Community Psychiatric Supportive Treatment	11,560	411,688	$ 6,110,281
H0031	Mental Health Assessment by non-physician	37,748	41,979	$ 4,569,153
H0004	Supportive Group Therapy	77,085	405,784	$ 3,612,008
T1017	Targeted Case Management	117,227	302,661	$ 3,318,409
H0032	Mental Health Service Plan Development	39,381	130,193	$ 1,684,543
90862	Pharmacologic Management	40,611	40,776	$ 1,500,877
H2015	Comprehensive Community Support Services	47,111	764,969	$ 1,342,161
A0120	Transportation	64,548	155,403	$ 1,106,002
90801	Psychiatric Day Interview	6,216	7,355	$ 675,392
W0354	Crisis Stabilization	829	9,627	$ 527,453
H0040	Assertive Community Treatment (ACT)	21,277	21,464	$ 490,456
H2012	Day Treatment	5,670	39,436	$ 400,866
G9008	Physician Care Coordinated Oversight Service	13,008	14,267	$ 376,740
T1019	Personal Care Services	9,077	62,350	$ 320,093
W0352	Clinical Evaluation	2,719	6,889	$ 297,570
W0350	Targeted Case Management	10,234	28,970	$ 290,596
H0019	Residential Childrens' Services	1,088	2,151	$ 250,585
H2019	Behavior Management Implementation	2,605	15,542	$ 220,631
H2014	Skills Training and Development	4,733	45,462	$ 183,590
W0480	Individual/Family Therapy	2,434	5,158	$ 151,658
A0160	Clinical Travel	14,100	275,166	$ 132,815
H2011	Crisis Intervention	1,106	7,973	$ 114,102
W0472	Treatment Planning	2,992	9,887	$ 102,422
W0363	Community Focused Treatment	3,131	15,701	$ 100,132
96100	Psychological testing	816	1,856	$ 88,422
W0482	Group Therapy	2,475	9,813	$ 70,391
W0471	Physician/Licensed Psychologists Participation	1,871	2,562	$ 70,020
S0215	Non-emergency transportation	3,298	76,902	$ 61,572
H2010	Comprehensive Medication Services	2,180	3,173	$ 56,672
W0360	Not Available	661	5,039	$ 49,610
All Other	N/A	8,984	42,647	$ 1,041,085
	TOTAL	**556,775**	**2,962,843**	**$ 29,316,308**

Source: West Virginia MMIS Data

Table C-2: Medicaid Reimbursement to the Comprehensive Community Mental Health Center and MR/DD Agencies for Home and Community Based Service Waiver Providers (MR/DD)

Procedure Code	Name of Code	Number of Claims	Units Billed	Paid Amount
T2017	Residential Habilitation	86,801	2,598,468	$ 26,815,927
T2021	Qualified Mental Retardation Professional	97,437	1,759,484	$ 13,434,197
T1005	Respite Care	13,253	458,885	$ 8,660,286
T1016	Case Management	47,141	600,738	$ 5,569,169
S5135	Adult Companion	6,948	245,633	$ 5,253,378
A0160	Clinical Travel	27,337	979,702	$ 3,474,022
T1003	Nursing Services	6,683	88,817	$ 1,789,306
A0120	Transportation	53,972	272,864	$ 1,573,967
T1000	Nursing Services	1,437	22,235	$ 1,142,561
W0222	Community Residential Habilitation	4,417	53,278	$ 880,748
T2015	Prevocational Training	2,581	82,006	$ 751,868
W0234	Agency Residential Habilitation	1,565	25,599	$ 607,409
W0301	Service Coordination	4,390	50,129	$ 431,731
W0106	Respite Care	643	15,928	$ 413,792
T2019	Supported Employment	3,188	80,289	$ 410,611
W0202	Adult Companion	600	14,291	$ 315,693
W0217	Day Habilitation	1,015	24,778	$ 312,600
T1002	Nursing Services	2,692	27,964	$ 291,637
W0225	Qualified Mental Retardation Professional	1,985	12,864	$ 255,033
W0107	Respite Care	960	18,469	$ 252,241
W1510	Clinical Travel	1,554	58,439	$ 240,041
W0216	Nursing Services	678	6,791	$ 240,000
W0235	Residential Habilitation	765	13,109	$ 193,498
W0236	Residential Habilitation	839	12,528	$ 143,222
W0224	Qualified Mental Retardation Professional	1,437	9,982	$ 137,447
W0233	Qualified Mental Retardation Professional	1,121	3,440	$ 126,314
W0237	Residential Habilitation	799	9,081	$ 121,141
W0218	Day Habilitation	834	14,431	$ 107,210
S5165	Environmental Accessibility Adapta tions	165	4,010	$ 89,131
H0019	Residential Childrens' Services	948	961	$ 79,227
All Other	N/A	3,628	39,181	$ 4,670,851
	TOTAL	**377,813**	**7,604,374**	**$ 78,784,258**

Source: West Virginia MMIS Data

Medicaid data also highlights disparities in the provision of mental health services by the network of Comprehensive Community Mental Health Centers. A review of billing records for individual Centers shows that only two provided Assertive Community Treatment Services (H0040), eight provide Community Psychiatric Support (H0036), and seven provided Day Treatment (H2012).

The table below shows the revenue, excluding approximately $11.2M in ICFs/MR revenue received by each of the Comprehensive Community Mental Health Centers and MR/DD Agencies during SFY 2005 from Medicaid. Comprehensive Community Mental Health Centers receive Medicaid revenue for providing four types of services: rehabilitation, behavioral health, MR/DD wavier, and ICFs/MR services. The table shows the concentration of revenue in the larger providers. The top three providers get about

36% of all Medicaid revenue received by the Comprehensive Community Mental Health Centers, not counting ICFs/MR payments.

Table C-3: Medicaid Revenue by Provider in SFY 2005

	Medicaid Revenue in SFY 2005					
Name of Behavioral Health Care Provider	**Clinic and Rehab.**	**% of Clinic and Rehab.**	**MR/DD**	**% of MR/DD**	**Total**	**% of Total**
Northwood Health Systems	$ 9,436,334	32.2%	$ 6,659,891	8.5%	$ 16,096,225	14.9%
Seneca MH/MR Council	$ 1,221,122	4.2%	$ 10,467,848	13.3%	$ 11,688,970	10.8%
Autism Services Center	$ 32,414	0.1%	$ 11,064,434	14.0%	$ 11,096,848	10.3%
Prestera Center for Mental Health	$ 6,184,333	21.1%	$ 2,261,555	2.9%	$ 8,445,888	7.8%
Westbrook Health Services, Inc	$ 1,645,997	5.6%	$ 6,510,306	8.3%	$ 8,156,303	7.5%
Valley Health Care Systems	$ 1,109,117	3.8%	$ 6,211,972	7.9%	$ 7,321,089	6.8%
United Summit Center, Inc.	$ 2,001,480	6.8%	$ 5,071,045	6.4%	$ 7,072,524	6.5%
Southern Highlands Community Mental Health Center	$ 1,676,446	5.7%	$ 4,159,909	5.3%	$ 5,836,355	5.4%
ARC of Three Rivers	$ 11,203	0.0%	$ 5,774,767	7.3%	$ 5,785,970	5.4%
HealthWays, Inc.	$ 160,494	0.5%	$ 5,335,758	6.8%	$ 5,496,251	5.1%
Eastern Panhandle Mental Health Center	$ 842,071	2.9%	$ 3,510,158	4.5%	$ 4,352,229	4.0%
FMRS Health Systems	$ 2,058,090	7.0%	$ 2,189,229	2.8%	$ 4,247,318	3.9%
Appalachian Community Health Center	$ 1,394,436	4.8%	$ 2,689,147	3.4%	$ 4,083,584	3.8%
Logan-Mingo Area Mental Health	$ 999,918	3.4%	$ 2,817,003	3.6%	$ 3,816,921	3.5%
Potomac Highlands Guild	$ 441,675	1.5%	$ 2,754,326	3.5%	$ 3,196,001	3.0%
Green Acres Regional Center	$ 612	0.0%	$ 976,826	1.2%	$ 977,438	0.9%
Potomac Center	$ 100,567	0.3%	$ 330,083	0.4%	$ 430,650	0.4%
Total	**$ 29,316,308**	**100.0%**	**$ 78,784,258**	**100.0%**	**$ 108,100,566**	**100.0%**

Source: West Virginia MMIS Data