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SUBSTANCE USE DISORDER AND MEDICAID
MANAGED CARE RECOMMENDATIONS

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SUBSTANCE USE DISORDER AND MEDICAID

BACKGROUND AND OVERVIEW

During the 2022 West Virginia Regular Legislative Session the legislature passed, and the Governor signed into law, Senate Bill 419. The legislation's aim was to implement a pilot project whereby payment for the substance use disorder (SUD) residential treatment benefit in the Medicaid Program be performance-based. Based on testimony and presentation of the legislation during committee meetings, the legislature generally desired a shift from traditional payment methods (paying for a certain length of stay in treatment) to payment for those services based on short-term and long-term results which were outlined in the legislation.

The concept of performance-based contracting (also referred to as value-based contracting) through managed care organizations (MCOs, who manage West Viginia's Medicaid Program) partnerships with SUD providers was generally accepted by various parties. However, after attempts to implement portions of the legislation, it became apparent that providers were not suited to execute the measures outlined in S.B. 419. Subsequently, MCOs could not find willing provider-partners. There were several barriers to implementation which are outlined later in this document.

Regardless of the challenges and setbacks to implementation, there remained interest from the legislature, MCOs, providers, and the Bureau for Medical Services (BMS) to deliver a performance-based program. The MCOs, through the West Virginia Association of Health Plans (WVAHP), sought time to explore alternatives to the measures outlined in S.B. 419. It assembled a task force of the SUD experts and team members from each member-health plan. Presented herein is the product of that task force.

This document provides policymakers another view of the SUD benefit, including: a look at the early focus on access to SUD residential treatment beds, a discussion of the challenges to implementing the measures outlined in S.B. 419, a proposal for different performance measures which can be the basis for performance payment, and recommendations for policy changes.

The WVAHP and its members present our findings and recommendations to assist policymakers, providers, and BMS find a path forward that will continue to produce better results for those with substance use disorder.

SUD SNAPSHOT – A SHIFT FROM ACCESS TO QUALITY

As West Virginia was facing the effects of a drastic increase in overdoses for the past several years, among the priorities was to increase access to treatment beds. In 2017, for instance, the Legislature supported a specific effort to add capacity to drug treatment by allocating $24 million in opioid settlement dollars to the effort.[1]

For residential treatment in the West Virginia Medicaid Program the effort was no different. In July 2019, there were only 648 Medicaid-approved residential treatment beds in the state. Three years later, in July 2022, that number grew by 103% to 1,315 beds. The number of beds grew another 20% from 2022 to 2023. As of the publication of this document, there are 1,610 Medicaid-approved SUD residential treatment beds in the state.

Medicaid-Approved SUD Residential Treatment Beds

	July 2019	July 2022	July 2023	Current
Approved Beds	648	1,315	1,579	1,610

An increase in residential treatment beds, though, created concerns in some communities across the state. Municipalities raised issues surrounding increased homelessness, vandalism, the need for more police resources, and patients with no ties to the community being discharged with no place to go.[2] Some municipalities took unilateral action against SUD residential treatment providers such as banning additional facilities.[3]

Sentiments around residential treatment began to take on a different tone among stakeholders after hearing concerns from West Virginia communities. Conversations related to the number of residential treatment beds available in West Viginia subsided and discussions regarding the quality of care at residential treatment providers (some, not all) increased. During the 2023 Regular Session of the West Virginia Legislature, it passed a bill that placed requirements and limitations on substance use treatment

[1] West Virginia lawmakers back more addiction treatment (whsv.com)

[2] West Virginia lawmakers learn about Parkersburg residential addiction recovery moratorium | News, Sports, Jobs - News and Sentinel

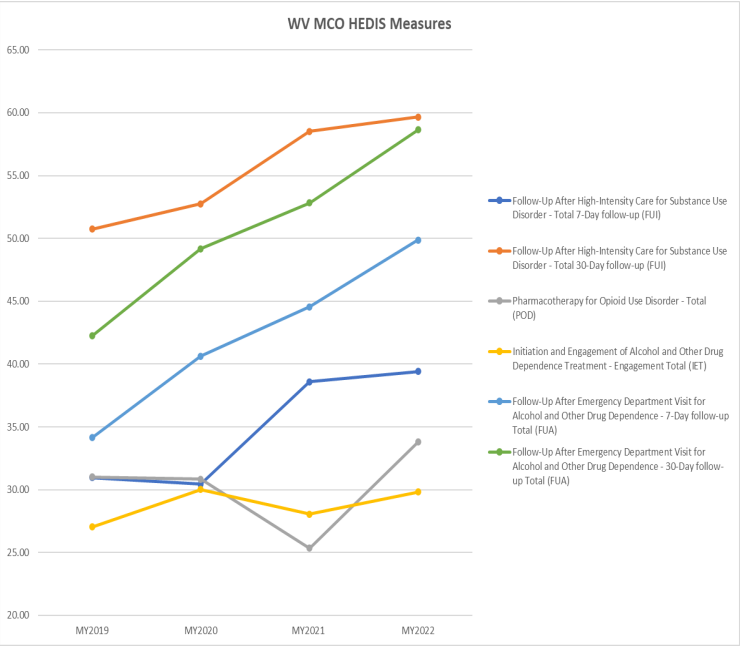
[3] City of Parkersburg Says No to More Drug Treatment Centers, Sober Living Homes - West Virginia Public Broadcasting : West Virginia Public Broadcasting (wvpublic.org)

beds.[4] Passage of the bill, along with S.B. 419 during the 2022 Regular Session, marked a clear shift of focus from access to ensuring and incentivizing quality care.

Additionally, BMS granted MCOs the authority to contract with residential treatment providers effective July 1, 2022. Prior to this point, due to concerns over access to beds, BMS required MCOs to contract with all licensed and Medicaid-credentialed residential treatment providers. MCOs continue to evaluate their SUD residential treatment networks. Some providers have not been renewed due to quality concerns or oversaturation in certain geographic areas.

MCOs in West Virginia did not manage the SUD benefit until July 1, 2019. Before then, the SUD benefit was in fee for service within the Medicaid Program. MCOs have made progress on key quality measures as evidenced by the National Committee on Quality Assurance (NCQA) HEDIS® scores, which compare health plans nationally on a multitude of categories. Specifically, West Virginia MCOs have improved performance as it relates to follow-up appointments after high intensity care for SUD (FUI), follow-up appointments after emergency department visits for SUD (FUA), Pharmacotherapy for Opioid Use Disorder (POD), and the initiation and engagement of alcohol and other drug dependence treatment (IET).

The chart details the average HEDIS® scores of the MCOs and depicts the steady increase since managing the SUD benefit in 2019. In fact, during the most recent measure year (2022), the West Virginia MCOs scored in the 95th percentile among national health plans for follow-up appointments after emergency department visits for SUD, both on the 7-day and 30-day measure. The MCOs also scored in the 95th percentile for the initiation and engagement of alcohol and other drug dependence treatment. Finally, the MCOs scored in the 66th percentile for the remaining measures.



[4] Bill limiting substance use treatment beds in West Virginia counties completes legislative action | News, Sports, Jobs - News and Sentinel

S.B. 419 CHALLENGES

S.B. 419 provides a framework for the concept of performance-based, or value-based, contracting in relation to the SUD residential treatment benefit within the Medicaid Program. Passage of the legislation caused stakeholders to evaluate the SUD program from a different perspective and generated necessary attention on quality of care, not just access to treatment. The WVAHP agrees with this approach even though barriers to implementation were realized after passage. An evaluation of most consequential barriers is provided.

Providers Not Required to Participate

S.B. 419 requires that a minimum of fifteen percent of MCO contracts with SUD providers be based on performance payment. In subsection (d) it makes clear that providers can "opt-in" and there is no requirement for providers to participate. MCOs made outreach to SUD providers seeking willing participants who would agree to performance payment based on the measures outlined in the legislation. Those efforts were unsuccessful.

To alleviate this barrier, there are two possible approaches: 1) to require participation in the program via legislation, or 2) to adjust the performance measures to factors that focus on the provider processes which can create more incentive to provide quality care. The second option forms the basis of the recommendations outlined later in this document.

MCO Access to Members Varies Widely Among Providers

On many occasions the MCOs are not informed of a member entering treatment until days after. Similarly, MCOs do not receive timely notification of a member's discharge. In extreme, but not rare cases, certain providers outright deny MCO case manager access to members while in residential treatment. All these factors create unnecessary challenges for discharge planning, evaluation of other healthcare needs, arrangements for transportation, connection to community wrap-around services, etc. While this barrier is not uncommon, not every provider is the same. MCO access to members varies widely among providers – some are collaborative while others are not.

The essence of BMS's contract with MCOs is to manage the care of Medicaid members. S.B. 419 outlines various measures that should be tracked for members in SUD residential treatment. Further, the legislation contemplates implementing processes for post-discharge planning. MCO case managers are a critical component to the continuum of care for members with substance use disorder. SUD members are often transient and finding and contacting them is difficult. However, while members are in residential treatment it is the perfect opportunity to connect with members. MCO case managers need access to the member while in treatment instead of being notified after the fact.

Performance Measures Discourage Providers from Treating Members with More Risk, Incentivizes Treatment of Members with Less Risk

An unintended consequence of the performance measures, which would be tied to payment, in S.B. 419 is that residential providers would have less incentive to take members with SUD who have more risk. Members with more risk (no family/community ties, severe health factors, involuntary treatment, etc.) are more challenged to succeed in relation to the measures outlined in S.B. 419 (relapse, employment, transportation, etc.). Conversely, members who have less risk have a greater propensity for success. If payment is tied to the outcomes currently defined in S.B. 419 then residential providers could have more incentive to take members with less risk, leaving those who have more risk with fewer options for treatment.

The WVAHP desires a performance-based, or value-based, contracting approach that emphasizes core processes while members are in residential treatment. Our recommendations for new performance measures will shift away from the consequence of disincentivizing risk and more toward incentive payment for quality care factors which have a greater propensity for members' successful outcomes.

Different Perspectives on Relapse

A major factor within the performance measures outlined in S.B. 419 is relapse. Subparagraph (F) of the legislation requires that part of the performance-based payment measures consider: "Whether patient has relapsed and needed any additional substance use disorder treatment, 30 days post discharge, six months post discharge, one-year post-discharge, two years post-discharge, and three years post discharge."

Relapse is part of the substance use disorder chronic disease. The American Addiction Centers states: "When you go through the difficult recovery journey and come out on the other side clean and sober, you have a lot to feel good about. Yet you may also feel something many others who have walked in your shoes feel: fear of relapsing. After winning that hard-fought battle for sobriety, it can be devastating to consider that it might not last forever. However, it is relatively common to relapse at some point after you get clean. So common, in fact, that relapse is often considered one part of lifelong recovery."[5] Relapse measures are important. However, not every relapse case negates the progress a SUD patient makes after residential treatment.

[5] Addiction Relapse: Risk Factors, Coping & Treatment Options (americanaddictioncenters.org)

Successful Treatment May Cost More

The premise of incentive payments or performance-based payments is that providers will be rewarded for meeting certain criteria around quality of care. These are payments above the standard Medicaid rate for treatment services. Additionally, certain measures outlined in S.B. 419 require additional testing and, therefore, cost. For instance, to determine whether a member remains drug free, as subparagraph (A) contemplates, regular drug testing of the member would be required in an appropriate setting.

S.B. 419 implies that there will be expected savings from the pilot program. For instance, subsection (f) states: "the MCO may develop a shared saving methodology through which the substance use disorder residential treatment facility shall receive a defined share of any savings that result from improved performance." While overall costs to the social services sector may decrease over time (i.e., costs for incarceration, child protective services, foster care, etc.), it is not unlikely that improved quality performance will increase the cost for treatment.

RECOMMENDED PERFORMANCE-BASED MEASURES

The WVAHP proposes the following measures to form the basis for performance-based, or value-based, payment contracts with providers in relation to the SUD benefit. These measures represent a step forward from the current payment environment and a necessary step prior to reaching the capacity to implement the measures contemplated in S.B. 419. These measures reflect payment for the processes which are known to lead to better outcomes.

Each MCO recommends developing metrics around these measures. However, one of the strengths of the West Virginia Medicaid Program is that there is variation within each health plan. Therefore, these performance measures do not limit an MCO introducing additional criteria or strategies to manage the care for members with substance use disorder. The recommended strategy is to introduce commonality among providers while allowing each MCO to explore different approaches.

PERFORMANCE MEASURE #1

Providers Execute Adequate Discharge Planning and Notification

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A critical component to successful outcomes for a Medicaid member is ensuring that a member is connected to care post residential treatment. The WVAHP believes strongly that discharge planning should occur on or soon after day one of treatment. Accompanying this is adequate and timely notification to the MCO of a member's admission and the involvement of case managers in the discharge planning process. One of the challenges identified by the MCOs is that certain providers infrequently notify MCOs that members are in treatment, much less coordinate discharge planning with MCOs.

PERFORMANCE MEASURE #2

Providers Assess and Plan for Treatment of Behavioral Health Conditions that are Comorbid with SUD

Measure #2 is, in part, already contemplated in S.B. 419 outlined in subparagraph (D), which states: "Whether substance use disorder residential treatment facility has arranged medical, substance use, **psychological services**, or other community-based supports for the patient and whether the patient attended, 30 days post discharge, six months post discharge, one-year post-discharge, two years post-discharge, and three years post-discharge;" While members are in the care of residential treatment facilities, providers should assess and make arrangements for treatment of psychological conditions that are commonly coexisting with substance use disorder.

The authors of an article in Drug and Alcohol Dependence conclude: "…results suggest that best practice rehabilitation treatment **integrates mental health treatment** and provides continuity of care post-discharge."[6] Post-discharge services are critical to the short-term and long-term treatment of patients with substance use disorder as contemplated with Measure #1. In addition to post-discharge planning, providers who qualify for performance-based payment will need to ensure adequate behavioral health services are provided while patients are receiving treatment in their residential facilities.

PERFORMANCE MEASURE #3

Providers Grant Access to Medication-Assisted Treatment (MAT)

Medication-assisted treatment (MAT) is a common and effective treatment tool for patients with substance use disorder. After residential treatment, patients may still experience triggers associated with their addiction. MAT helps insulate patients by reducing urges and triggers. Residential treatment providers should consider utilizing MAT where appropriate.

According to recent studies, introducing MAT in appropriate circumstances can reduce mortality rates associated with substance use disorder. One study shows that "compared with patients receiving MAT, untreated participants had higher risk of all-cause… and overdose mortality…, and discharged participants had higher risk of all-cause death… and overdose death…."[7] Therefore, this performance measure will evaluate whether providers grant appropriate access to MAT during residential treatment of SUD.

PERFORMANCE MEASURE #4

Providers Evaluate Members for Other Health Factors

Medicaid members with substance use disorder often suffer from other related and unrelated health conditions. While a member is in the care of a residential treatment facility, providers who qualify for performance-based payment will assess the member for other health conditions and make referrals for treatment. Specifically, MCOs suggest the evaluation of and referral to treatment of reproductive health conditions, HIV, Hepatitis C, and dental issues.

[6] The effectiveness of residential treatment services for individuals with substance use disorders: A systematic review - ScienceDirect

[7] Ma, J., Bao, YP., Wang, RJ. *et al.* Effects of medication-assisted treatment on mortality among opioids users: a systematic review and meta-analysis. *Mol Psychiatry* **24**, 1868–1883 (2019). https://doi.org/10.1038/s41380-018-0094-5

PERFORMANCE MEASURE #5

Providers Assess Social Determinants of Health/Health Risk Assessments

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In addition to health risks, Medicaid members with substance use disorder often face social issues which can expose them to greater risks for addiction and hinder treatment. As a condition for performance-based payment, providers should use a formal tool for assessing social determinants of health and reporting the results to care managers. The MCO health risk assessment is one such tool that providers may use but is not required.

PERFORMANCE MEASURE #6

Providers Grant Access to and Practice Adequate Engagement with MCO Case Managers

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The most frequently discussed barrier among MCOs for facilitating successful member outcomes is SUD provider resistance to MCO case manager access. These case managers exist to coordinate healthcare services for members. Because members with substance use disorder are often transient and difficult to contact the MCOS case manager's engagement is vital. Timely notification and access will assist MCOs in connecting with Medicaid members in treatment.

PERFORMANCE MEASURE #7

Providers Grant Members Access to Narcan and Provide Adequate Training

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Part of the challenge nationally and in West Virginia is to prevent overdose deaths. Providers who include Narcan and member-centered training as part of their program will be eligible for performance-based pay. Studies show that community distribution of Narcan to recent users, their friends, and family can significantly reduce the number of overdose deaths. [8]

[8] Naloxone for Opioid Overdose: Life-Saving Science | National Institute on Drug Abuse (NIDA) (nih.gov)

POLICY CHANGES

The WVAHP recommends the following policy adjustments to S.B. 419, or other statutes, to facilitate the changes outlined in this document.

Policy Recommendation	Detail/Description
Adjust the performance measures.	§9-5-29(d)(3) outlines the performance measures by which the task force must use for performance-based contracting with providers. The WVAHP is recommending adjusting these measures, as outlined above.
Clarify that the American Society of Addiction Medicine (ASAM®) criteria[9] shall be the standard/protocol for residential treatment and evaluation.	The current legislation is silent as to the standard of care for substance use disorder residential treatment. Clarifying that the ASAM® criteria shall be used will set clear guidelines and expectations on treatment and evaluation for performance measures. Providers shall be required to adequately train their employees on the application of ASAM® for treatment as a condition of licensure.
Require providers to grant access to MCO case managers as a condition of receiving Medicaid reimbursement for SUD residential treatment.	Connecting the MCO case manager with the Medicaid members, and their involvement in the discharge, planning, and care management process is critical to ensuring continuity of care. Possible solutions include making this requirement a condition of licensure or Medicaid provider credentialing.

[9] About the ASAM Criteria https://www.asam.org/asam-criteria/about-the-asam-criteria

CONCLUSION

Now is the appropriate time to emphasize quality measures as it relates to the substance use disorder benefit in the Medicaid Program. While challenges inhibited progress on implementing the measures outlined in S.B. 419, it was the impetus - along with a policy change to give MCO contracting authority, creating licensure requirements for SUD residential treatment providers, and providing parameters around bed expansion – for the conversation surrounding successful implementation of quality measures tied to payment.

The MCOs welcome discussion around performance-based payment measures to be used for value-based contracting. The adjusted measures outlined in this document are proposed as a basis for value-based contracts with substance use disorder residential treatment providers. While each measure is important and contributes to the quality-of-care Medicaid members should receive, the measures are presented in order of importance from the MCOs' perspective.

The WVAHP and its members are committed to discussing our findings with relevant stakeholders – including legislators, SUD providers, and BMS officials – in the coming weeks. The WVAHP desires successful implementation of quality measures to better facilitate a healthier West Virginia.