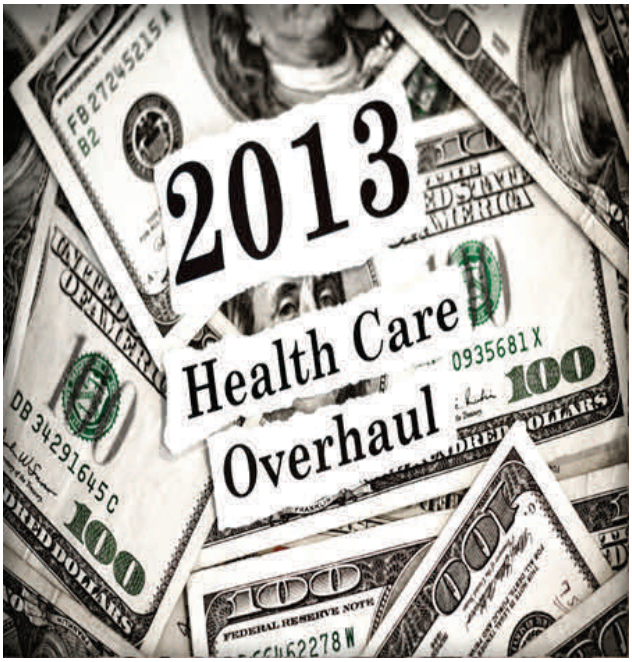

Creating a Sustainable, Strategic Health Care System in West Virginia

Report Submitted to
Governor Earl RayTomblin

Public Works LLC

Februray 27, 2013

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CREATING A SUSTAINABLE, STRATEGIC HEALTH CARE SYSTEM IN WEST VIRGINIA

OVERVIEW

West Virginia is in the midst of a health care crisis. At times, this crisis announces itself loudly through headlines about increasing health insurance premiums, unsustainable Medicaid budgets, and negative health statistics. At other times, its burden is felt more quietly, by West Virginians who suffer daily from chronic conditions that could have been prevented, who skip care they cannot afford, or who have faced the loss of loved ones from all-too-common killers like heart disease and substance abuse.

West Virginia's health care crisis comes down to two deeply intertwined facts:

- **West Virginia has some of the highest health care costs in the country** – borne by individuals, families, businesses, and the state government. West Virginia has the tenth highest private health insurance premiums in the nation, and in the eight years between 2003 and 2011, private health insurance premiums rose 62 percent -- three times faster than wages – leaving residents of West Virginia paying premiums that exceeded the median incomes of a quarter of the state's workers.[1] By contrast, West Virginia's Medicaid budget has grown at a rate less than or equal to the national average since 2001.[2] Nonetheless, the program has grown, and the Medicaid budget remains a key concern for policymakers. Most recently, West Virginia's Medicaid spending (including the state and federal share) grew by 5.5 percent per year on average between 2007 and 2010, largely due to enrollment growth caused by job loss.[3]

- **West Virginia consistently has some of the nation's poorest health outcomes, and residents have difficulty finding the care they need**. West Virginia ranks fourth among states in public health funding per person,[4] however residents experience high rates of chronic diseases like diabetes, obesity and heart disease. West Virginia ranked 48th among states in overall health care outcomes in 2012, 48th in diabetes, 49th in percentage of adult smokers, and 48th in obesity. Despite West Virginia's high and rising health care costs, access to appropriate health care also remains a challenge. In 2010, nearly 18 percent of the state's residents, or 254,000 people, reported not seeing a doctor due to cost.[5]

These facts are *not* due to a lack of effort to address West Virginia's health care challenges; indeed, there are many dedicated health care professionals, state health agency employees, individuals and communities who are dedicated to finding solutions. West Virginians have the strength, resources and conviction to meet their health care challenges head-on. But those resources are not being used to their best effect.

Governor Earl Ray Tomblin therefore directed **Public Works** to conduct an extensive review of West Virginia's health care challenges and opportunities. While our review focused specifically on the Department of Health and Human Resources and the Medicaid program, the key lesson from this review is that West Virginia's health care challenges are systemic. Simply put, addressing isolated programs or cutting individual budget line-items will not lower costs or increase access to quality care over the long term. If West Virginia is to have an effective health care system that can successfully reverse the high health care costs and poor outcomes that have plagued the state for so long, it is going to require a strategic vision that informs and shapes all, more specific changes in the healthcare system. This strategic vision for West Virginia's health care system should be centered around the three, interrelated goals of Better Health, Better Care, and Lower Costs. Concrete steps should then be taken within the context of this vision both to address high-cost health conditions that significantly impact West Virginians' health and quality of life, and to improve the overall health and healthcare of West Virginia families which will in turn lower total costs.

With a health care system aligned around these objectives – both on the provider side and on the payee side, where the state government itself is a major player – West Virginia state government can then better focus on increasing its own efficiencies at the departmental, bureau, and programmatic levels.

This report therefore is divided into two major sections:

1. **Section 1: A New Strategic Vision for West Virginia's Health Care System** discusses major health care policy and program design recommendations that will establish a health care system that both focuses spending on evidenced-based initiatives that will have a positive impact on health outcomes and focuses healthcare and wellness efforts on producing outcomes that themselves will lower overall costs.

2. **Section 2: DHHR Performance Review Findings and Recommendation** identifies 78 recommendations with an estimated savings of $56.7 million to improve operations, save money, draw-down additional federal revenue, or simply make state government work more efficiently and effectively to ensure resources are focused on priority needs.

In these ways, West Virginia will use its health care dollars both more effectively and more efficiently to make West Virginia a healthier state.

1. A NEW VISION FOR WEST VIRGINIA'S HEALTH CARE SYSTEM

West Virginia's health care system is stuck in a vicious cycle. For years, rising health care costs have been a serious concern for West Virginia lawmakers, health officials, businesses, and families. Yet, for all the increases in health care costs, West Virginians are not getting any healthier; in fact, the state has ranked last or near-last in health outcomes for years. While Medicaid, as the state's largest health program, is a major concern for lawmakers seeking to balance the budget, a focus solely on Medicaid will not address the problems in the rest of the system. Attempts to reduce costs by cutting provider rates or reducing benefits are met with stiff resistance – and while they may save money in the short term, they do not ultimately solve the problem of poor health, nor do they help West Virginians obtain access to needed care that can keep them healthy and productive. Moreover, cuts in the Medicaid program can lead to cost-shifting that raises private insurance premiums. Stakeholders repeatedly emphasized the need to bring multiple health care payers together – including Medicaid, the Children's Health Insurance Program (CHIP), the Public Employees Insurance Agency (PEIA), and private insurance – to get a better handle on lowering costs and improving health throughout the state.

Despite the efforts of many dedicated individuals, attempts to address the problem at the state level have been fragmented and at best make only a small dent in West Virginia's overall health care problem. Often, these efforts consist of small pilot projects or new programs that rarely yield results; those that do yield results are often not replicated or brought to scale. In part, this is due to a lack of capacity among West Virginia's health agencies to do any more than manage their day-to-day operations; in part, it is also due to a lack of clear, common goals and clear lines of accountability. As a result, money is spent, the budget suffers, and businesses and families pay more – but the population as a whole does not get any healthier.

In interview after interview, stakeholders told **Public Works** of the dire need for strategic direction for West Virginia's health care system – one that better harnesses existing resources within state government, actively solicits the expertise of West Virginia health care professionals and providers, and uses better health information technology and data analysis to spend West Virginia's health care dollars more wisely. Most importantly, stakeholders emphasized the need for a sustained effort that yields results over time. This section lays out a vision for that new strategic direction.

An efficient and effective health care system must be built on three inter-related goals:

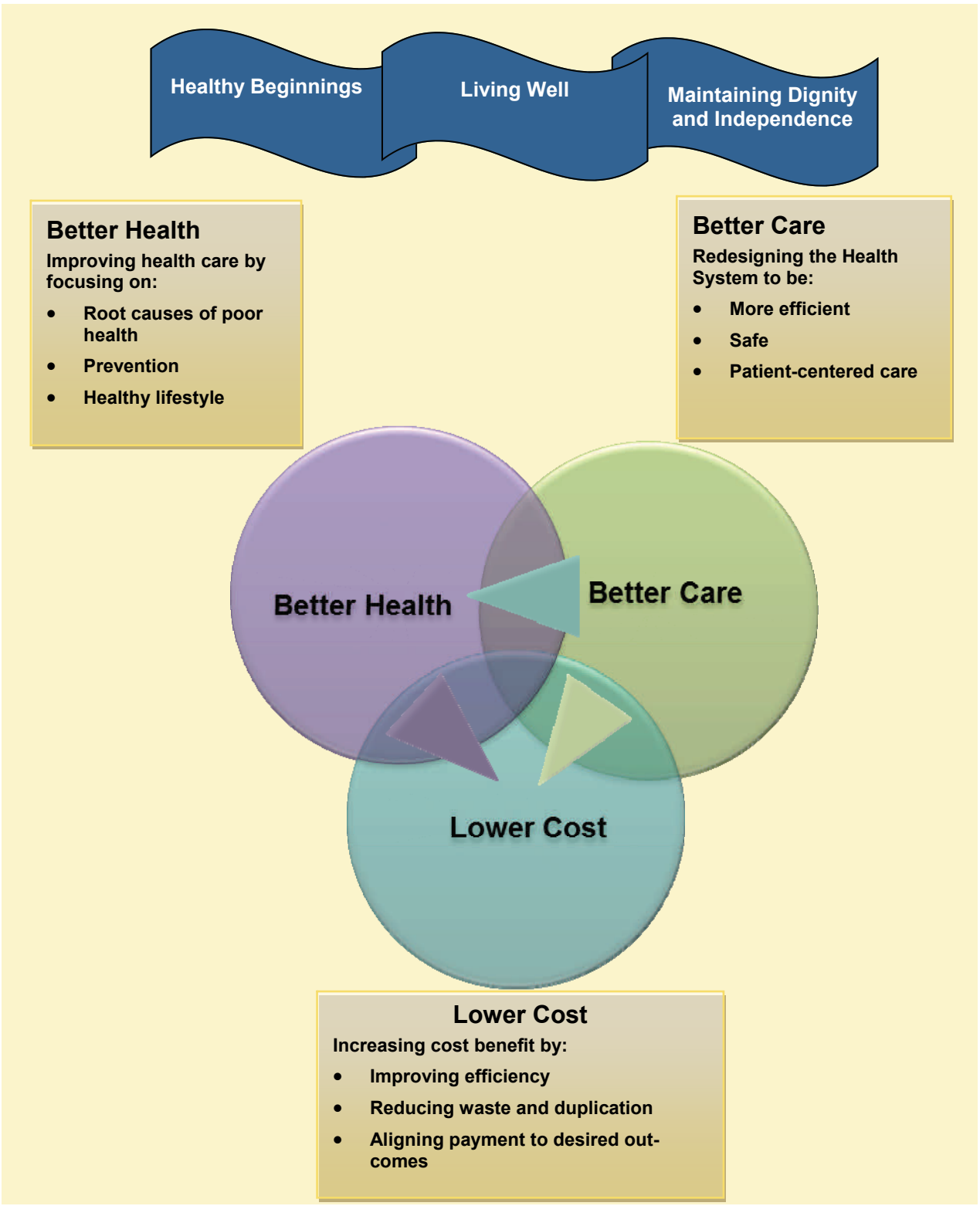
- **Better health**: West Virginians can reach improved health and productivity through a renewed focus on addressing the root causes of poor health, including lack of preventive care, physical inactivity, and poor nutrition.

- **Better care**: West Virginians should always get the right care, in the right place, at the right time. Yet, there is widespread agreement that the health care system as currently structured results in both missed opportunities for care and the provision of unnecessary, and sometimes harmful, health care services.

- **Lower costs**: West Virginia can lower the total cost of health care per person throughout the system – including Medicaid, CHIP, PEIA and private insurance – by improving the efficiency of care and reducing waste and duplication.

As depicted in the following diagram, these goals are interdependent. Better health care – through improved efficiency, reduced duplication, and higher quality – is necessary both to improve health outcomes and reduce costs.

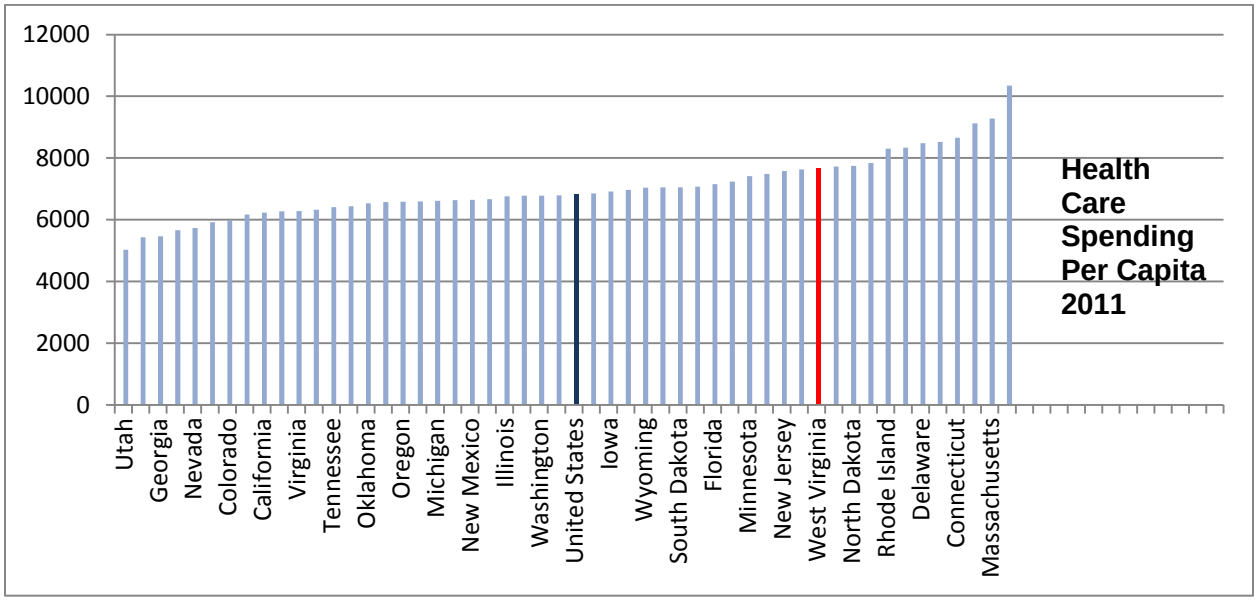
Meeting the Triple Challenge in Health Care Transformation



However, costs cannot be reduced without concrete, strategic steps to improve overall health outcomes – especially with respect to common, high-cost chronic health conditions. Simply focusing on one goal or one program at a time will not solve the problem. For example, squeezing Medicaid provider rates or cutting benefits – while a potential short-term fix for the state budget – could reverberate into the rest of the health care system, raising private health insurance costs for individuals and businesses. West Virginia's state government can lay the groundwork for achieving these goals through improving coordination within government and with health care providers and other stakeholders; by setting clear goals and metrics, and by increasing accountability for achieving them.

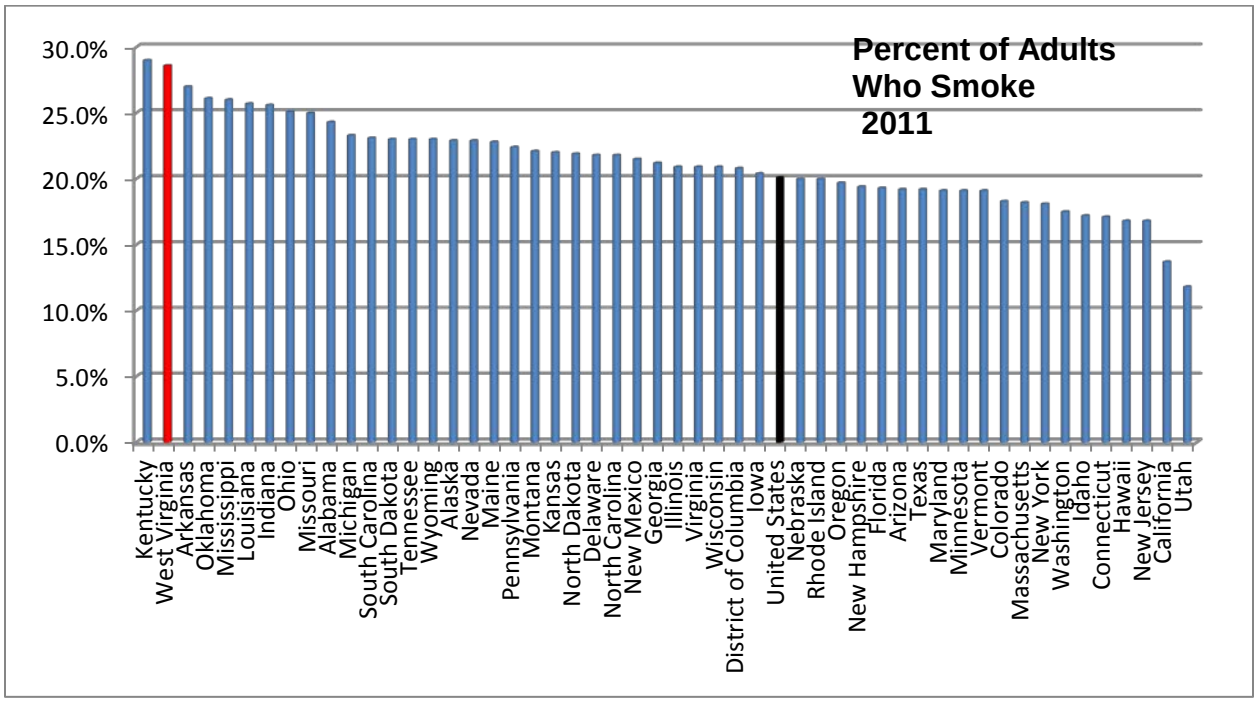
1.1. Better Health

Health care dollars spent in West Virginia should yield results – through improved health outcomes, better quality of life, and higher patient satisfaction. Yet, although West Virginia ranks 4th in overall public health spending, including federal and state dollars, the state has significantly higher rates of preventable chronic conditions than the national average, and ranks 48th in overall health outcomes among states. [6]



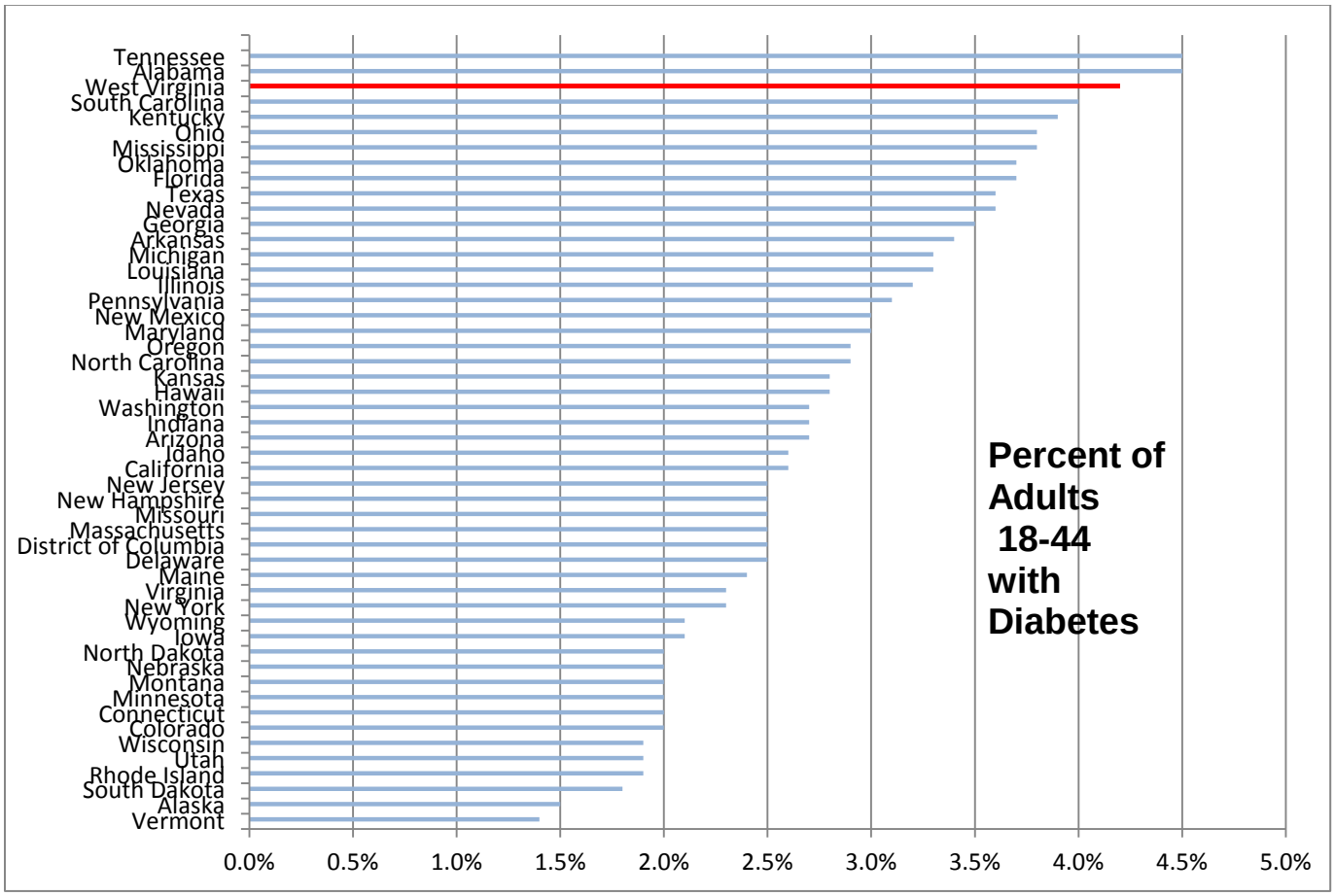
Simply paying for more tests, procedures, and time at the doctors' office will not necessarily lead to better health outcomes – but health outcomes also suffer when individuals are unable to access appropriate care. Moreover, while strategically targeted public health investments can yield a return on investment;[7] spending on multiple, fragmented programs does not necessarily yield good outcomes for West Virginians.

West Virginia has the second highest percent of adults who smoke in the country – second only to Kentucky.



Source: Kaiser Family Foundation analysis of the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System Survey Data (BRFSS), 2011. Information about the BRFSS is available at http://www.cdc.gov/brfss/index.htm.

West Virginia ranks third in adults with diabetes – Tennessee and Alabama are the only states with higher rates.



Source: Centers for Disease Control and Prevention: National Diabetes Surveillance System. Available online at: http://apps.nccd.cdc.gov/DDTSTRS/default.aspx. Retrieved 2/3/2012. U.S. totals available at http://www.cdc.gov/diabetes/statistics/prev/national/figbyage.htm.

Changing the course of these statistics will require much more than instituting isolated new programs or making minor changes to existing ones. Moreover, the state government in West Virginia cannot do this alone, nor can it control every factor that leads to better health. However, the state can and should be strategic in how it sets priorities for factors that *can* be controlled, particularly for illnesses and conditions where there are proven solutions. In this report, we recommend that West Virginia focuses on bringing together multiple stakeholders, including state government, public health experts, and clinicians, to set concrete goals for improving health outcomes and to match resources to these goals.

Other states are beginning to take control of improving the health of their residents through a coordinated and strategic approach:

- Louisiana, ranked 49th in health outcomes by America's Health Rankings, is taking action to achieve the ambitious goal of improving Louisiana's ranking to 35th over the next ten years. During the 2012 session, both the Louisiana House and the Senate passed a bill directing the Louisiana Department of Health and Hospitals to submit a report to the legislature that addresses the issue of raising Louisiana's health ranking.[8]

- Recent experience in Maine provides another example of what can happen when stakeholders from around the state pull together to prioritize health improvement initiatives. MaineHealth, an integrated system of health care providers serving nearly 975,000 people, created a new way to bring stakeholders together around prioritizing high-cost health conditions through MaineHealth's Health Index program. The Index tracks progress on seven key health priorities, including tobacco use, obesity, childhood immunizations, preventable hospitalizations, cancer deaths, cardiovascular deaths, and prescription drug abuse and addiction. The methodology for tracking these conditions was created by an advisory committee of clinicians, representatives of hospitals, state and local government, community partners, and other experts. Maine now exceeds the national average in childhood immunization, the rate of cardiovascular deaths in Maine saw the third largest decrease in the U.S., and the state's cancer deaths have fallen.

There are tremendous opportunities for improving health and reducing costs by focusing on the most common, costly, and preventable health care conditions in West Virginia. Besides what can be learned from other states' experiences, there are existing models for success in West Virginia, such as the Perinatal Collaborative, which successfully reduced unnecessary pre-term deliveries from 21 percent of births in January 2009 to 8.5 percent of births in August 2009.[9]

Leaders involved in West Virginia's health care system repeatedly pointed out the need for more coordination among state agencies in order to more successfully establish and meet goals for better health outcomes. However, the state has been stymied in these efforts by fragmented, duplicative programs and the lack of a strategic goal-setting entity. While originally intended to serve this purpose, the Governor's Office of Health Enhancement and Lifestyle Planning (GOHELP) was widely viewed by stakeholders as lacking the authority and resources to effectively coordinate health policy strategy for the state. Instead, stakeholders expressed concern that planning resources and data capabilities were fragmented and not being used to achieve a common vision.

1.2. Better Care

Better care means that patients get the right care, in the right place, at the right time. In health care, high costs are not necessarily tied to high quality. Conversely, poor quality of care – such as lost test results, unnecessary procedures, and medical errors – often leads to higher costs, as well as inconvenience and even harm for patients. For example, better care means that a person with a chronic disease like diabetes gets help managing his condition so it does not become worse and lead to more expensive care. Better care means that patients who need an expensive test like a CT scan get that test, but it also means that the results are shared among a patient's doctors so that the patient does not have to have an unnecessary repeat test. Better care means that if a West Virginian needs hospital care, she gets it – but it also means that

when she leaves the hospital, her doctors and nurses get the right information and work as a team to make sure that her condition is managed and she does not need to go back.[10]

With West Virginians shouldering the burden of higher and higher health care costs, including higher premiums, deductibles, and cost sharing, it is vital that West Virginians get the right care, in the right place, at the right time – instead of spending their time and money on duplicative or ineffective care.

According to the National Council on State Legislatures,

> "Payment reform offers a powerful tool for controlling health care spending and often supports changes in the delivery system. Traditionally, Medicaid providers have been reimbursed on a fee-for-service (FFS) basis, which compensates for every service, test or procedure provided. Rather than reward volume, payment reform models seek to reward value and create financial incentives for health care providers to focus on primary and preventive care, improve access, and adopt more effective, efficient models of care delivery to improve quality and reduce costs."[11]

Leading health systems, as well as the federal government and many states, are engaged in health care improvement efforts – also known as "delivery system reform" or "payment reforms" – that aim to change the way they pay for health care so that it is more coordinated, cost-effective, and higher-quality. These efforts frequently involve setting new quality metrics as well as bringing health care providers together to find solutions to challenging health care problems. For example, the Partnership for Patients is a national, public-private partnership in which over 3,700 participating hospitals are working to make hospital care safer, more reliable, and less costly by reducing preventable hospital-acquired conditions by 40 percent compared to 2010, and by reducing preventable hospital readmissions by 20 percent compared to 2010.[12] To date, 33 hospitals and other health care organizations in West Virginia have pledged to join the Partnership for Patients.[13] Other examples of delivery system reforms include accountable care organizations, bundled payments, patient-centered medical homes, multi-payer models, and targeted payment policies (such as not paying for medical errors). These reforms share the goal of aligning incentives to pay for more coordinated, appropriate care while reducing unnecessary, unsafe, and duplicative care.

The federal government is already moving ahead to put in place new metrics and resources for high-quality care. For example, the new Center for Medicare and Medicaid Innovation is providing significant federal funding to states and health care organizations to improve care. In addition, Medicare has put new programs in place to reward health care providers for using health information technology and provide higher-quality care, and in some cases, penalize those that do not meet quality metrics for preventable errors.[14] More broadly, the National Quality Strategy for Quality Improvement in Health Care has been created to move national health care programs towards the goals of better care, healthy people and communities, and more affordable care. [15]

These initiatives have two important implications for West Virginia. First, they mean that significant new federal resources are available to test new ways to improve health care in West Virginia – but the state and its health care providers must have the capacity to apply for and

monitor these programs.[16] Second, they mean that West Virginia health care providers and health plans are already, and increasingly, being held accountable for new quality metrics for their Medicare and Medicaid patients. West Virginia's health care providers and payers can both maximize the impact of these federal quality initiatives by working together to determine the most important priorities for West Virginia and making sure, where possible, health care providers have a common, streamlined set of quality and payment metrics for conditions that are a high priority in West Virginia.

Numerous states are currently pursuing various delivery system reforms, and while there are ongoing efforts in West Virginia, more can be done. Since 2006, twenty-five states have implemented new payment systems or revised existing ones so that primary care providers can function as patient-centered medical homes, in which providers are typically paid an extra fee to coordinate care and held to certain quality standards. In West Virginia, efforts to establish medical homes include a PEIA pilot with Cabin Creek health system, and the ongoing Bureau for Medical Services effort to file a State Plan Amendment to establish health homes for individuals with bipolar disorder (for which the state would receive a 90 percent federal match). Additional delivery system reform efforts include a multi-stakeholder initiative to reduce unnecessary early labor inductions and reduce hospital-acquired infections. Medicaid programs are also beginning to use payment reforms to achieve better outcomes. For example, West Virginia's Medicaid managed care contracts prohibit payment to providers for preventable conditions such as hospital-acquired conditions not present on hospital admission, the wrong procedure performed on a patient, and procedures performed on a wrong patient or body part.

Delivery system reform is not a static activity, but rather one that requires a "rapid learning health system" – one in which there is ongoing, sustained efforts to monitor, assess, and act upon health care cost, quality and outcomes data. To that end, various agencies in West Virginia have been working to develop data resources to aid in this endeavor. They include: an All-Payer Claims Database under construction through the Department of Insurance; a data warehouse under construction via Medicaid, with expected delivery date in October 2013; an upgrade of the state's Medicaid Management Information System (MMIS), and the West Virginia Health Information Network. However, according to stakeholders, these resources are not yet being actively utilized to set priorities for delivery system reforms.

Without the infrastructure for a "rapid learning health system" in West Virginia, and the leadership to support it, the state runs the risk of falling victim to a fragmented approach in which delivery system reform initiatives are pursued in a piecemeal fashion, without the coordination between providers, payers, and other stakeholders that is so vital to successful cost reduction and quality improvement.

1.3. Lower Costs

Numerous national studies have identified high levels of waste and inefficiency in the overall health care system. Rising health care costs are a significant national concern, with health spending taking up a larger and larger share of GDP – up to 21 percent by 2023, based on current projections. According to the Institute of Medicine, the nation's independent medical advisory organization, an estimated $750 billion (or 30 percent of our nation's health care budget) is wasted because of inefficient delivery of care, including duplicated or inappropriately

provided tests and procedures, missed opportunities for prevention, excessively high prices, and excessive administrative costs, among other factors.[17]

The actual level of savings in West Virginia from delivery system reform efforts would depend on the nature of the initiatives pursued, the sustainability of those initiatives for providers and payers, and the ability to continuously monitor and act upon health care cost, quality, and outcomes data.

Recent efforts in other states point to the possibility for substantial health care savings resulting from improved care. For example, Cuyahoga County, Ohio was able to prevent nearly 3,000 hospitalizations for patients with common cardiovascular conditions through an increased focus on measuring and improving patient-centered primary care for its residents with chronic medical conditions.[18]

It is time for West Virginia to move towards a new strategic vision for lowering health care costs: one that comes from better health and better care, as well as eliminating waste and inefficiency. The alternative is staying stuck in the never-ending spiral of bad health outcomes, high health care costs, and increasing pressure to cut benefits and provider rates. A brighter future is possible.

Recommendations

Achieving the interdependent goals of better health, better care, and lower costs will require a newly-aligned, more sustainable infrastructure for health care planning and decision-making in West Virginia. However, a vision and an infrastructure are not enough: the state's health care system also needs clear goals and accountability for achieving them. To accelerate efforts to achieve a more efficient and effective health care system and begin to bring tangible benefits to West Virginians, we recommend that Governor Tomblin:

1. Establish clear goals for state agencies, to tackle the highest-cost, yet preventable, health problems in West Virginia, in conjunction with patients, providers, and health care professionals.

2. Streamline state agencies related to health care to make them more efficient and to reduce waste, both within the government and throughout the health care system as a whole.

There is a need for sustained delivery system reform efforts in West Virginia. Leaders and stakeholders in West Virginia have pointed out the need for improved care coordination, reduced use of unnecessary tests and procedures, and better capacity to collect and analyze data on costs and quality of care.

West Virginia's capacity for systematically identifying opportunities to reduce costs and improve quality is hampered by fragmented data sources and initiatives. Existing sources of data on costs and quality of care are difficult to access and not routinely monitored or analyzed. For example, while Medicaid managed care organizations (MCOs) supply BMS with quality measure reports, these are not routinely monitored or used to inform future contracts with MCOs. In addition, while efforts to create new data sources are underway, they are

housed in different agencies and there is no mechanism currently in place to evaluate this information with the goal of reducing health care costs and improving health outcomes, either within Medicaid or in collaboration with other state health care programs.

Opportunities are being lost to leverage the market share of West Virginia's payer community (Medicaid, CHIP, PEIA, other large purchasers) to improve quality and reduce costs. States and the federal government are beginning to invest in so-called "multi-payer" initiatives in which payers come together to prioritize delivery system reform efforts and come up with a common set of quality measures and payment methodologies to send common signals to providers. For example, CMS announced a $275 million State Innovation Models grant opportunity to test innovative payment and service delivery models that have the potential to lower costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), while maintaining or improving quality of care for program beneficiaries, but West Virginia did not apply. While multi-payer initiatives can be complex, there could be opportunities for smaller-scale collaborations given the appropriate infrastructure, resources, and advocacy with the Centers for Medicare and Medicaid Services. At this time, BMS and PEIA are both pursuing medical home initiatives and could align their quality metrics and payment methodologies to reach a broader population. Similarly, Medicaid and CHIP could combine efforts through the Adult Quality Measures grant (application currently in progress) and the CHIP quality measures that have been an ongoing project for several years.

Delivery system reform must involve the provider community. Attempts at delivery system reforms, both in West Virginia and nationwide, have succeeded when they harness the clinical knowledge and motivation of the provider community to improve. West Virginia has already successfully employed the "learning collaborative" model in its Perinatal Collaborative initiative that involves doctors, hospitals, maternal health stakeholders and others in reducing the rate of unnecessary and potentially harmful early labor inductions by over 80 percent in the state. Stakeholders throughout the system expressed the need for this type of collaborative in other critical areas to actively engage community providers to find solutions.

Other states are realizing the potential and promise of harnessing the expertise of state agencies, health professionals, and public health experts to create a new vision for their health care systems. In Arkansas, the Department of Human Services, Medicaid, Arkansas Blue Cross and Blue Shield and QualChoice of Arkansas are jointly working on the *Arkansas Health Care Payment Improvement Initiative* to reward physicians, hospitals and other providers who give patients high-quality care at an appropriate cost.[19] The initiative was developed over the course of a year with significant input from the provider community, and focuses on providing physicians with feedback on how well they are delivering high-quality care for a specific set of episodes of care, or medical conditions, including upper respiratory infections (URI), total hip and knee replacements, congestive heart failure (CHF), attention deficit/hyperactivity disorder (ADHD), and perinatal (birth).[20]

Specifically, Governor Tomblin should convene state agencies, health care payers, providers, public health professionals, and other experts to identify and act upon clear goals for improving health and reducing costs in the following areas:

- **Maternal and Newborn Health:** Medicaid currently pays for over 60 percent of births in West Virginia. Yet, West Virginia faces maternal and newborn health statistics that are

worse than the national average, and there are large disparities between Medicaid and non-Medicaid funded births in the state.[21] The primary drivers of WV's high preterm birth and infant mortality rates are associated with risk factors including poverty, poor health status, behavioral risk factors, and possibly perinatal interventions, in particular non-medically indicated inductions and C-sections prior to 39 weeks gestation. Maternal and newborn health initiatives have the potential to positively improve the health of a significant population within West Virginia's Medicaid program in a relatively short (1 to 2 year) timeframe. There are several possibilities for improving maternal and newborn health in the state, including:

- Leveraging the purchasing power of Medicaid, CHIP, PEIA, and private health insurance companies to stop paying for unnecessary and sometimes harmful labor inductions before babies are full-term. This would sustain and expand on existing successful collaborations in West Virginia to reduce unnecessary early labor inductions.

- Continuing to pursue federal funding opportunities such as Strong Start for Mothers and Newborns[22] to improve maternal and newborn health.

- Reducing West Virginia's high maternal smoking rate – which is a leading contributor to preterm birth and other poor outcomes.

- Ensuring that Medicaid, CHIP and PEIA efficiently reimburse for the administration of synthetic progestin (17P) to reduce preterm delivery in at-risk women.

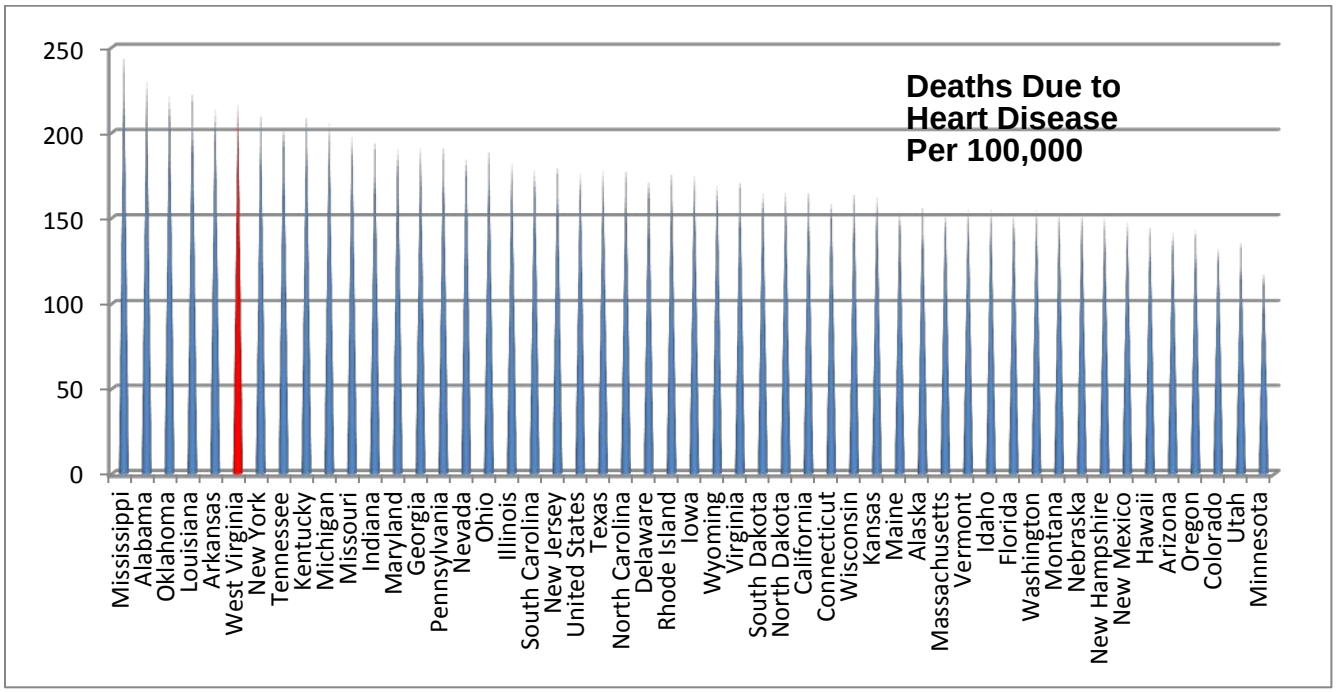
- Continuing to invest in the Right from the Start program for new at-risk mothers, to help improve the chances of a healthier second pregnancy.

- Aligning Medicaid, PEIA and CHIP payment signals to encourage all West Virginia hospitals to become accredited as "Baby-Friendly Hospitals" that promote early and sustained breastfeeding, which is important for prevention of childhood illnesses including obesity and diabetes[23]. This initiative is supported by the major national pediatric and maternal health groups. Currently there are 150 Baby-Friendly hospitals in the United States; none in West Virginia[24]. To become accredited, hospitals must incorporate ten steps into their clinical practice to encourage and educate mothers to breastfeed. Medicaid, PEIA and CHIP (along with private payers) could provide a small quality bonus payment to hospitals for achieving these 10 steps, or reduce payments to those that do not achieve this designation by a specified date.

Improving maternal and newborn health can save money while improving the quality of life of the youngest West Virginians. The Institute of Medicine estimated in 2005 that the average direct cost of medical care for a preterm infant in the United States is $33,200, with the majority (85 percent) of this cost being incurred during the first year of life. The cost per infant increases to $51,600 when maternal medical care costs ($3,800), early intervention costs ($1,203), special education costs ($2,150), and lost household productivity costs ($11,215) are considered.[25] According to the Campaign for Tobacco-

Free Kids, newborn health care costs attributable to maternal smoking – one of the leading causes of preterm birth –could be as high as $2 billion per year, with the costs of each smoking-affected birth averaging $1,142 to $1, 358.[26] States that have invested in reducing maternal smoking have found that the programs have more than paid for themselves; for example, California's program saved an estimated $20 million just in the first two years.[27] In West Virginia, reducing the rate of pre-term birth from 9.5 percent to the national average of 8.2 percent (based on 2008 figures) could result in 280 fewer preterm births and a savings of $9.3 million to the overall system. Assuming Medicaid pays for 60 percent of births, the state would save approximately $1.5 million in its state share of Medicaid dollars.

- **Reducing Heart Attack and Stroke:** Every year there are an estimated 2 million heart attacks and strokes in the U.S. These two conditions are the most common cardiovascular diseases in the country.[28] In West Virginia, 9.2 percent of adults reported that they have had a heart attack, and West Virginia ranks 47th among the states in deaths from cardiovascular disease. According to the Centers for Disease Control and Prevention, heart disease is the leading cause of death in West Virginia and accounted for more than one in four deaths in the state. Stroke is the third leading cause of death in the state, after cancer.[29] The good news is that there are proven ways to reduce heart attack and stroke, along with the suffering and death associated with these conditions. The bad news is that too many West Virginians are not benefiting from them. West Virginians are at high risk for heart disease and stroke, with 33 percent of adults in West Virginia reporting high blood pressure (hypertension) and 42 percent of those screened reported high blood cholesterol, which puts them at greater risk for developing these serious illnesses.



The Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, Division of Vital Statistics, National Vital Statistics Report Volume 60, Number 3, December 2011, Table 19. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_03.pdf.

To help more West Virginians and their health care providers reduce heart attacks and strokes, the West Virginia Cardiovascular Health Program, led by the West Virginia Division of Health Promotion and Chronic Disease, has been working towards implementation of the Million Hearts™ campaign, a national initiative whose goal is to prevent one million heart attacks and strokes nationally over five years through 2017[30]. Million Hearts™ aims to prevent heart disease and stroke by emphasizing cardiovascular health across patients, providers, communities, and other stakeholders. Rather than working on isolated programs, Million Hearts™ consolidates and streamlines proven measures to reduce these devastating illnesses, promoting the "ABCS" of clinical prevention (appropriate aspirin therapy, blood pressure control, cholesterol management, and smoking cessation) as well as healthier lifestyles and communities. These seemingly simple measures require coordination among public health officials, clinicians, payers, health information technology and quality improvement specialists, and community stakeholders. Governor Tomblin can catalyze efforts to prevent heart attacks and strokes in West Virginia by setting the stage for these stakeholders to set measurable goals, a plan for achieving them, and regular progress updates. This can be accomplished through the clinical, payer, and healthy lifestyle councils discussed in the next section.

Reducing heart disease and stroke in West Virginia can lower health care costs for these severe and disabling illnesses. Nationally, heart disease and stroke cost $444 billion in health care costs and lost productivity, and account for 17 percent of medical

spending.[31,32] In addition, heart disease and stroke are among the leading causes of disability in the United States, with nearly 4 million people reporting disability from these causes. [33] Reducing heart disease and stroke will therefore reduce not only the immediate hospitalizations and other medical care associated with these diseases, but the long-term costs associated with disabilities.

- **Improving Care for Seniors by Reducing Preventable Falls and Hospital Stays:** West Virginia ranks 49th among states in its rate of preventable hospitalizations among seniors ages 65 to 99.[34] Although West Virginia does not directly pay for the medical costs of seniors in the Medicare program, there are three very important reasons to focus on improving care for the state's seniors. First, West Virginia is second only to Florida in the percentage of its population over 65, and the population is aging.[35] Transforming the health care system must account for the needs of the senior population. Second, in West Virginia, Medicaid serves 156,000 aged and disabled individuals, at an annual cost of $1.854 billion. [36] Although these individuals comprise 37.6 percent of the state's Medicaid population, they consume 76.2 percent of West Virginia's Medicaid benefits. [37] Finally, West Virginia Medicaid pays for nursing home benefits, cost sharing, and other services (used by 80,000 Medicare beneficiaries in the state.

  Seniors with both Medicare and Medicaid are particularly vulnerable to "churning" between nursing facilities and hospitals. Nursing facility residents often experience potentially avoidable inpatient hospitalizations, which are expensive and increase the risks of additional unnecessary transitions between care settings and complications such as infections, medication errors, and further functional decline.[38] The Center for Medicare and Medicaid Innovation is currently supporting efforts in several states to reduce potentially avoidable inpatient hospitalizations among seniors for Medicare and Medicaid, but no entity in West Virginia was chosen for this initiative.[39] Medicare is already putting in place financial penalties for hospitals with relatively high rates of unnecessary readmissions, and the Medicare Payment Advisory Commission (MedPAC) has recommended to Congress that a similar policy be extended to skilled nursing facilities with relatively high readmission rates.[40] Since West Virginia hospitals are already working to come into compliance with the new Medicare payment rules around readmissions, and there is a possibility that similar policies will be put in place for nursing home payments, Governor Tomblin should help West Virginia's nursing homes to get ahead of the curve by making preventable hospitalizations one of the early focus areas for health care improvement in the state.

  Another promising area for improving care for seniors is to stop preventable falls. Right now, one out of three people 65 and older falls each year, and over two million are treated in emergency departments annually for fall injuries. Moreover, injuries resulting from falls can be debilitating – one in five leads to a head injury or fracture -- and lead to admissions to the hospital or nursing home.[41] Fortunately, health care providers can use readily available, proven methods to help their patients prevent a devastating fall.[42] Common goals and metrics for preventing falls among West Virginia's seniors, combined with an accountable infrastructure, could spare West Virginia seniors from significant pain and suffering due to falls. According to the National Council on Aging:

> "In addition to pain and suffering, and the high cost of rehabilitation, falls with or without injury also carry a heavy quality of life impact. A growing number of older adults fear falling and, as a result, often self-limit activities and social engagements. Resulting limitations can result in further physical decline, depression, social isolation, and feelings of helplessness."

The above health care conditions are just a few examples of the poor health care outcomes that today lead to all too many preventable deaths, long-term disabilities, daily suffering, and high health care costs among West Virginians. When stakeholders are brought together to collaborate over the long term, as is happening in other states, they may well identify other high-cost conditions that can be mitigated with proven measures. Transforming West Virginia's health statistics will not be easy, but it will lead to a brighter future and lower health care costs for the state. However, it will take more than the establishment of isolated programs. By harnessing the expertise of multiple stakeholders from the public health, payer, and health care professional community, supported by an infrastructure for data analysis and quality improvement, West Virginia can begin to target its highest-cost health problems in a systematic way.

Reducing harmful and preventable admissions to hospitals and nursing homes in West Virginia can not only improve the quality of life for seniors, but can also reduce costs system-wide. According to the Centers for Medicare and Medicaid Services, approximately 45 percent of hospital admissions among those receiving either Medicare skilled nursing facility services or Medicaid nursing facility services could have been avoided, accounting for 314,000 potentially avoidable hospitalizations and $2.6 billion in Medicare expenditures in 2005. There are 82,000 beneficiaries in West Virginia who are dually eligible for Medicare and Medicaid. Of these, 50,000 receive the full scope of Medicaid benefits whereas 32,000 receive help with their Medicare cost-sharing and premiums from Medicaid. [43] Altogether, these beneficiaries account for $1 billion in Medicaid spending, or 41 percent of the state's spending on Medicaid benefits. [44] If Medicare is paying for preventable hospitalizations among West Virginia's seniors, chances are Medicaid is paying for them too. Reducing falls among West Virginia's seniors could also save significant amounts of money. Direct medical costs for fall injuries total over $28 billion annually. Hospital costs account for two-thirds of the total. By 2020, the annual direct and indirect cost of fall injuries is expected to reach $54.9 billion.[45] This is money that West Virginians could keep in their pockets – while keeping seniors healthier and more independent.

While these reforms are necessary and long overdue, they will not happen easily or overnight. They will also require a significant realignment of incentives in the current system. For example, while reducing premature births, heart attacks, and unnecessary hospitalizations for nursing home residents are important to the well-being of West Virginians, the reality is that health care providers are currently paid based on how many heart attack patients or premature babies they treat. As a result, providers lose money for doing the right thing and keeping West Virginians healthy enough to stay out of the hospital or nursing home. West Virginia should move its health care system from one that pays health care providers for each test, treatment, or hospital admission to one in which health care providers do not lose money for doing the right thing, but

instead have the resources and incentives to work towards better overall health for the population.

One way for West Virginia to begin to realign these incentives is to use some of the existing money it spends on supplemental payments for hospitals through the Medicaid program in a more focused way. These Medicaid supplemental payments are typically meant to compensate hospitals for uncompensated care, as well as boost provider payments. The two most significant forms of supplemental payments are Disproportionate Share Hospital (DSH) payments and Upper Payment Limit (UPL) payments. DSH payments are meant to compensate hospitals for providing care to a significant number of Medicaid patients and uninsured individuals. UPL payments, which are not required under federal law, refer to an "upper payment limit" above which states may not receive federal matching dollars. Nationally, Disproportionate Share Hospital (DSH) Payments and Upper Payment Limit (UPL) payments represent more than one-third of Medicaid fee-for-service payments to hospitals, and hospital payments constitute 23 percent of all Medicaid spending.[46] Although supplemental payments are an important revenue stream for hospitals, they are often unrelated to the actual services or quality of care provided to patients. [47] Because this spending is related to patient volume rather than care outcomes, it can create incentives for hospitals to increase, rather than decrease, admissions. As part of the initiatives outlined above, West Virginia could begin to leverage its supplemental payments to purchase higher-value care from hospitals by tying some of the funds to improvements in care delivery.

2. DHHR PERFORMANCE REVIEW FINDINGS AND RECOMMENDATIONS

In drafting this report, **Public Works** had two tasks:

- To make recommendations for reducing the state's Medicaid costs, and
- To review the efficiency and capacity of the Department of Health and Human Resources and the programs it runs.

These two tasks are inter-related: West Virginia cannot achieve an efficient and effective health care system unless its Department of Health and Human Resources is efficient and effective as well. DHHR must possess the capacity, the clear direction, and the accountability mechanisms to be a meaningful participant in the effort.

The previous section outlined a new vision for West Virginia's health care system – one that encompasses the Medicaid program as well as PEIA, CHIP, and privately insured individuals and begins to pave the way towards a lower-cost system for everybody. The remainder of this report focuses on the results of **our comprehensive review of DHHR to identify ways that the department can work more effectively and efficiently to realize this vision and produce these outcomes**.

The following sections identify 78 recommendations with potential General Fund savings or new revenue of $56.7 million. The findings and recommendations are the result of a comprehensive review of DHHR operations conducted by the **Public Works'** team from August 2012 to present.

The team reviewed numerous documents and reports, conducted on-site interviews of DHHR managers and staff, requested information on data points not available in existing reports, interviewed key stakeholders and Legislators, and researched best practices from around the country to identify successful programs and operations that could be applied to West Virginia.

The data gathering effort was not without its problems. While the department worked hard to provide data requested, our team experienced many of the shortcomings in data expressed by Legislators and others in our review. While DHHR staff and management tried to meet our data requests, there were instances where it just was not available. This data availability issue, addressed throughout this report, is an indication of the critical need for the department to establish a quality improvement function that focuses full-time on gathering and analyzing data to improve outcomes for the thousands of citizens who rely on the department for critical services.

The following table summarizes the recommendations and estimated savings/revenue potential if our recommendations are implemented. Dollar figures could not be calculated for all recommendations, but even these recommendations will help to improve the efficiency of department operations, especially in allowing the reassignment of staff to focus on critical core mission activities.

DHHR Performance Review
Summary of Recommendations and Estimated Savings

	Estimated State Savings/Revenue	
	Year 1	5 Year
DHHR Department-Wide		
Re-align West Virginia's Health Care System	Efficiency/process improvement recommendation	Efficiency/process improvement recommendation
Reduce staff turnover in the department, fill critical vacancies and reduce overtime spending	$2,100,000	$10,500,000
Management and Accountability		
Revamp its grant identification, application and monitoring policies and procedures to increase grant applications and improve management and oversight of grants	$10,000,000	$50,000,000
Review travel spending and reduce spending where appropriate	$937,500	$4,700,000
Standardize rates for psychiatric and forensic evaluations	$535,000	$2,700,000
Reduce the number of boards and commissions related to health and human services	Efficiency/process improvement recommendation	Efficiency/process improvement recommendation
Increase performance management and quality improvement efforts in all bureaus	Efficiency/process improvement recommendation	Efficiency/process improvement recommendation
Bureau for Medical Services		
Reorganize its program integrity activities to improve management and oversight of fraud detection and prosecution	Efficiency/process improvement recommendation	Efficiency/process improvement recommendation
Use all the tools available to states to increase collections of fraudulent or incorrectly made Medicaid payments	$6,400,000	$32,000,000
Establish a broker system to manage non-emergency medical transportation	$1,450,000	$7,250,000
Bureau for Public Health		
Expand economic development incentives for healthy communities	Efficiency/process improvement recommendation	Efficiency/process improvement recommendation
Review DPH fee schedule, increase fees that do not cover the cost of the service, and link future increases to the Consumer Price Index	$680,000	$3,400,000
Eliminate the Primary Care Center Mortgage Subsidy	$700,000	$3,500,000
Create More Flexible Health Funding	Efficiency/process improvement recommendation	Efficiency/process improvement recommendation
Increase its performance management and quality improvement efforts in all bureaus	Efficiency/process improvement recommendation	Efficiency/process improvement recommendation

	Estimated State Savings/Revenue	
	Year 1	5 Year
Bureau for Children and Families		
Organize the Bureau for Children & Families to improve service delivery, accountability, effectiveness and efficiency	$1,600,000	$8,000,000
Implement a centralized intake system for child abuse and neglect referrals	$318,672	$1,600,000
Revise staffing and caseload assignments to more efficiently deploy staff around the state	$1,600,000	$8,000,000
Reduce administrative layers in field office operations	$1,200,000	$6,00,000
Implement plans to increase the IVE penetration rate	$23,400,000	$117,000,000
Increase oversight and improve accountability in the Social Necessary Services (SNS) program	$5,300,000	$26,500,000
Reduce out-of-state placements of children and build the capacity for the services required within the state	$519,000	$2,600,000
Bureau for Behavioral Health & Health Facilities		
Increase opportunities to more effectively integrate behavioral health care and primary care	Efficiency/process improvement recommendation	Efficiency/process improvement recommendation
Develop and implement a strategy and timeline for modifying, and eventually ending, court oversight of behavioral health services under the Hartley litigation	Efficiency/process improvement recommendation	Efficiency/process improvement recommendation
Implement proven interventions to reduce incarcerations when substance abuse is a factor	TBD	TBD
Maximize federal matching funds for mental health and substance abuse services	Efficiency/process improvement recommendation	Efficiency/process improvement recommendation
TOTAL	**$56,740,172**	**$283,750,000**

2.1. Department Overview

The Department of Health and Human Resources was created in 1989 via the consolidation of previously independent agencies boards and commissions. The five main functional bureaus of the department are:

- Bureau for Behavioral Health and Health Facilities (BHHF)
- Bureau for Child Support Enforcement (BCSE)
- Bureau for Children and Families (BCF)
- Bureau for Medical Services (BMS)
- Bureau Public Health (BPH)

In addition to the functional units, there are several other units within the Office of the Secretary providing administrative, legal, technological and other support functions for the department as a whole. There is also an Office of the Inspector General that is charged with promoting and ensuring the integrity for department programs.

DHHR's $4 billion annual budget includes:

- $2.7 billion (67.6 percent) in federal funds.
- $838.8 million (21 percent) in state general fund.
- $453.2 million (11.4 percent) in special funds.

The department's budgeted spending and the number of positions (FTEs) by fund for fiscal year 2012 is shown below.

Budgeted FTEs, Personal Services & Benefits and Other Expenses
FY2012

	FY 2012 Budgeted FTEs	Personal Services and Benefits	Other Expenses
General Fund	3,633.52	$174,396,074	$721,034,542
Federal Fund	2,394.05	$115,907,088	$2,579,487,717
Appropriated Special Fund	113.5	$7,011,951	$351,398,352
Non-Appropriated Special Fund	188.7	$11,465,179	$118,176,659
Total	**6,329.77**	**$308,780,292**	**$3,770,097,270**
Less Reappropriated		($93,449,340)	
Total		**$3,985,428,222**	

The single largest component of the budget is from federal funds for its portion of non-payroll medical services (Medicaid), which is for the most part delivered via private medical care providers throughout the state. The budgeted amount for that component was $2.6 billion or about 65 percent of the entire budget.

To carry out its mission the DHHR has 6,330 authorized positions of which 2,394 (37.8 percent) are federally funded. As of October 2012 more than 600 of the authorized positions were vacant. The following table displays expenditures and authorized positions (FTE) organized by bureau.

Expenditures and FTEs by Bureau/Office
FY2012

Bureau/Unit	Total FTEs 11/31/11	Fiscal Year 2012 Budgeted	Fiscal Year 2013 Requested
Office of the Secretary	278.4	$25,750,336	$25,577,127
Deputy Secretary for Administration	253.63	$51,902,886	$43,421,733
Behavioral Health and Health Facilities	1,867.1	$343,010,986	$264,898,489
Child Support Enforcement	483.1	$59,288,885	$35,305,524
Children and Families	2,550	$519,848,602	$518,890,074
Medial Services	100	$1,756,098,526	2$,725,592,190
Public Health	712.54	$299,885,772	$277,931,730
Health Care Authority	54	$21,712,933	$19,797,186
Human Rights Commission	31	$1,843,300	$1,843,300
Less: Reappropriated		($93,914,004)	
Total	**6,329.77**	**$3,985,428,222**	**$3,916,257,353**

The Office of the Secretary and the Office of the Deputy Secretary for Administration house centralized leadership and administrative functions are. Reporting directly to the DHHR secretary are heads of units that handle certain administrative functions:

- Office of Communications.
- Office of Human Resources management.
- Legal Services.
- Federal and State Policy.

Also within the Office of the Secretary is the Office of the inspector General, which is included with administrative units in this department review.

Other administrative functions are within programs that report directly to the Deputy Secretary for Administration. The Deputy's main function is to plan, coordinate, safeguard and oversee the daily financial and administrative operations for the department. These include accurate and timely reporting of revenue and expenditures, quality and cost efficiency information, technology systems and operations support (property management, security, purchasing, and payroll).

Within the five bureaus that compose the main functional areas of the agency are additional administrative units with similar functions to handle payroll, human resources processing, purchasing, IT, legal, finance, etc.

A. Re-Align West Virginia's Health Care System

Issue Statement	West Virginia should re-align its health care infrastructure to address the three-part strategic goal of better health, better care, and lower costs.

Background

The preceding discussion outlined a new strategic vision for West Virginia's health care system: one that is focused on better health, better care, and lower costs. In order to achieve this vision, West Virginia must realign its health care infrastructure to better use the resources and capacity not only of existing state agencies, but also of stakeholders such as providers, payers, and public health professionals. The following recommendations are aimed at executing this realignment.

West Virginia's Health Care Infrastructure

While this review focused on the Department of Health and Human Resources, West Virginia's health care infrastructure is much broader than that single department. In addition to DHHR, the state has a number of other state agencies, private and non-profit health care providers and payers, and other entities who together make up the state's health care infrastructure.

Currently, the West Virginia Department of Health and Human Resources consists of five separate agencies which report to the Office of the Secretary. Several other state agencies and programs also play an important role in West Virginia's health system: the Child Health Insurance Program (CHIP), the Public Employees Insurance Agency (PEIA), the WV Offices of the Insurance Commissioner (WVOIC), and the West Virginia Health Care Authority (WVHCA). In 2006, the West Virginia legislature created the Governor's Office of Health Enhancement and Lifestyle Planning (GOHELP), a cabinet-level agency intended to coordinate health system improvement efforts among the various state agencies.

The structure of a state agency is just one factor in determining how effective an agency is. However, the way an agency is organized can be a catalyst for strategically enhancing the capacity to fulfill day-to-day responsibilities, while working towards a larger strategic vision for the state.

Findings

West Virginia's health care agencies are largely focused on day-to-day operations and emergencies, with little capacity to collaborate on new efforts or the broader vision of improving health outcomes in West Virginia. Throughout our cross-cutting review, we found numerous examples of missed opportunities for strategic planning towards reducing health care costs and improving health outcomes in West Virginia – despite isolated efforts by agencies to implement forward-thinking initiatives. For example:

- Though the state has received over $10 million in recent federal public health grants, they are not being leveraged to produce demonstrable improvements in public health

- Key payer agencies (Medicaid, CHIP, and PEIA) do not have an established structure or mandate to establish common quality and outcomes metrics with each other or with private insurers.

- Agencies do not have a common set of data tools and measurements to strategically identify and tackle the underlying causes of high health care costs in the state.

- Leaders and stakeholders in West Virginia find the size, structure and budget of DHHR "unwieldy". Stakeholders expressed frustration with the difficulty of getting a handle on DHHR's operations and budget.

- Some of West Virginia's health agencies are overburdened, while others are underutilized. The Bureau of Medical Services has 83 FTE slots (although we have been told only 62 of them are truly filled),of 100 allocated positions, to manage the day-to-day operations of the state's $3.08 billion dollar Medicaid program, implement court orders, fulfill federal requirements, and proactively take advantage of other funding and technical assistance opportunities. DHHR currently has filled 5,744 positions of 6,334 that are allocated. Therefore, the BMS personnel allocation represents between 1.4 percent and 1.6 percent of DHHR's personnel, to handle the equivalent of 71.7 percent of its budget (SFY2013, recommended allocation). By contrast, key leaders and stakeholders felt that the capabilities of other agencies are not being maximized. For instance, stakeholders across the board reported that while GOHELP was intended to serve as a health policy and planning hub for the state, it has not realized this goal. In addition, stakeholders felt that the resources of the West Virginia Health Care Authority, which conducts initiatives in quality improvement, health information technology, and data analytic initiatives, could be maximized if applied more consistently to all of the state's health care programs.

- Stakeholders are not consistently engaged in planning and decision-making by DHHR. There were indications that DHHR does not have a consistent way to engage stakeholders or maximize resources they may be able to offer.

- Leaders and stakeholders largely believe that DHHR lacks a workforce strategy to replace senior personnel when they retire.

Recommendations

We recommend establishing clear lines of accountability within the Department of Health & Human Resources for achieving the three-part health system vision, while folding in the capabilities of other state agencies to develop shared, sustainable and strategic tools and resources for West Virginia's entire health care system.

Specifically, we recommend that the Department of Health and Human Resources be organized into strategic groups supported by common resources:

> **The Bureau of Medical Services, Bureau of Behavioral Health and Health Facilities, and Bureau for Public Health, along with the Bureau for Senior Services, should establish a core set of goals focused on the highest-cost beneficiaries and report to a Deputy Secretary of Health**. Because so much of state Medicaid spending is driven by behavioral health needs, preventable chronic disease, and the aging of the population, this grouping would be better able to focus on addressing the most costly and prevalent health care conditions in the state in a coordinated manner.
>
> **The Bureau for Child Support and the Bureau for Children and Families should likewise work together and be directly accountable to a second Deputy Secretary,** and continue to coordinate with the other bureaus where there is an intersection with state health care programs.

To support these efforts, the **Governor's Office should** establish an infrastructure in West Virginia to continuously identify ways to achieve the three-part vision of better health, better care, and lower costs. The Governor should:

1. Establish a new **Office of Health Care Improvement** to support all state health agencies. This office would be a strategic hub for improving health outcomes and quality, and containing costs system-wide. Specifically, it should be charged with overall strategic planning, data collection and analytics, advancing programs and policies that improve health outcomes and quality and contain costs. It should include units charged with: 1) Data and Analytics; 2) Health IT; 3) Strategic Planning; and 4) Stakeholder Engagement. The resources of GOHELP and the West Virginia Health Care Authority should be included this new entity, with a significantly expanded role for the data analytic and quality improvement activities currently conducted by the Health Care Authority.

2. Establish a **Clinical Advisory Council** to leverage the clinical expertise of health care professionals in the state. This Advisory Council would consist of individual health professionals, medical directors of the key health care programs (Medicaid, CHIP, PEIA), and representatives from health care professional societies. It would be charged with advising the Governor's office, the legislature, and the Department of Health and Human Resources on the best ways to improve clinical care for common, high-cost health conditions.

3. Establish a **Payment Advisory Council**, consisting of representatives from the key public and private health care purchasers, to establish clinically relevant, high-priority areas for cost containment and quality improvement. This Advisory Council would work with the Clinical Advisory Council to make changes in payment policies for public and private health plans aimed at improving outcomes and lowering costs for common, high-cost health conditions.

4. Continue the existing **Governor's Healthy Lifestyle Coalition**, which would be charged with advising on public health priorities, as well as coordinating with the Clinical Advisory

Council and Payment Advisory Council to ensure that public health, clinical care, and health insurance coverage are aligned to improve outcomes for specific conditions.

Savings/Revenue Estimate

Agency reorganizations alone do not necessarily save money. However, over the long run, it is critical that West Virginia's health care agencies be structured in such a way that they can continuously focus on strategic opportunities to contain health care costs and improve quality.

B. Improve Human Resource Management

Issue Statement	DHHR should work with the State Division of Personnel to develop a plan to reduce staff turnover in the department, fill critical vacancies and reduce overtime spending.

Background

DHHR is a large organization requiring a well-trained workforce to provide services to some of the most vulnerable citizens of West Virginia. When a workforce is unstable – with high turnover rates, excessive use of overtime or carrying vacancies that go unfilled for months – the strain on the organization and staff can produce poor morale, an inability to focus resources on critical services, and insufficient longer-range planning.

The cost of turnover can be measured in terms of reduced customer satisfaction, loss of expertise, poor morale or services being provided by less than fully-trained and experienced workers. Other costs can be calculated in real dollars such as the cost of:

- Recruiting
- Interviewing
- Hiring
- Orientation
- Training
- Compensation and benefits while training
- Lost productivity
- Lost productivity
- Administrative costs

Findings

According to the U.S. Bureau of Labor Statistics, the average non-farm monthly turnover rate is 3.3 percent.[48] In DHHR the turnover rate approaches 30 percent department-wide. The turnover rate in BCF is 36 percent for CPS workers, 35 percent for Economic Service Workers, 35 percent for Nurse II's; BMS is operating a $3 billion program with 62 filled positions out of an authorized level of 100.

This volatility in the DHHR workforce results in significant and costly resources being spent to maintain an adequate workforce complement. The department:

- Has more than 600 vacant positions, a figure that has remained fairly constant in the last several years.
- Must process between 12,000 and 15,000 Personnel Action Forms per year that require 11 approvals for processing.
- Has a cumbersome process to hire staff with approvals and bottlenecks at numerous steps both within DHHR and WVDOP.
- Requires approximately three months or more to fill a position.
- Relies on overtime to meet service delivery requirements.

Vacancies by Bureau

Unit	FTEs	Number of Vacant Positions	Percent of Vacancies by Bureau	Percent of All Vacancies
Office of Secretary	278.4	35 IG 14	17.6%	8.1%
Deputy Secretary for Administration	253.6	34	13.4%	5.6%
Behavior Health & Health Facilities	1,867.1	209	11.2%	34.4%
Child Support Enforcement	483.1	50	10.4%	8.2%
Children and Families	2,550	167	6.5%	27.2%
Medical Services	100	18	18%	3.0%
Public Health	712.5	80	11.2%	13.2%
Total	**6,329.8**	**607**	**9.6%**	

Note: For consistency in reporting, we use the BMS vacancy number reported to the legislature in this chart. At time of writing, however, BMS report it has 38 vacancies.

The Bureau for Behavioral Health and Health Facilities, responsible for staffing eight facilities on a 24/7 basis, provides a good snap shot of the magnitude of the problem. As noted in the following table, in 2012 six of the eight health care facilities experienced a vacancy rate (exceeding 10 percent) and two had rates 13 percent or higher.

2012 Vacancy Rates in BHHF Facilities

Facility	Budgeted	FTE	Filled	Vacant	Vacancy Rate
BHHF Central	86	86.00	75	11	13.00%
Bateman	393	392.10	368	25	6.40%
Sharpe	456	456.00	410	46	10.10%
Welch	300	298.80	281	19	6.30%
Hopemont	184	183.60	161	23	12.50%
Lakin	180	180.00	161	19	10.60%
Manchin	81	80.60	71	10	12.30%
Withrow	191	191.00	164	27	14.10%
BHHF Total	**1,871**	**1,868.10**	**1,691**	**180**	**9.60%**

Another example of the unstable work environment is the reliance on overtime, especially in certain bureaus. DHHR spent $7.12 million on overtime in fiscal year 2012, up from $6.3 million in 2011 (an increase of 12.9 percent) and up from $5.2 million in 2010 (a two year increase of 35.8 percent). Reasons are numerous and vary by bureau and office, but much can be attributed to the 600 unfilled positions and constant turnover of staff.

The following tables show the usage of overtime by bureau in fiscal year 2012 and growth over the last two years.

2012 Overtime by Bureau

Unit	FTEs	Percent of FTE Total	Spending FY 2012 Overtime	Percent of Overtime Total
Office of Secretary	278.4	4.4%	$58,149	0.8%
Deputy Secretary for Administration	253.6	4.0%	$112,227	1.6%
Behavior Health & Health Facilities	1,867.1	29.5%	$4,834,476	67.9%
Child Support Enforcement	483.1	7.6%	$49,036	0.7%
Children and Families	2,550	40.3%	1$,928,423	27.1%
Medical Services	100	1.6%	$5,547	0.1%
Public Health	712.5	11.3%	$131,272	1.8%
Total	**6,329.8**		**$7,119,131**	

Source: DHHR, October 2012

Overtime Spending – FY 2010 to 2012

	2010	2011	2012	Percent Increase 2010-2012
Office of the Secretary	$8,801	$42,508	$58,149	560.7%
Deputy Secretary for Administration	$106,475	$135,838	$112,227	5.4%
Public Health	$140,698	$122,148	$131,272	-6.7%
Children & Families	$1,277,046	$1,717,134	$1,928,423	51.0%
Child Support Enforcement	$66,443	$47,571	$49,036	-26.2%
Medical Services	$11,072	$3,970	$5,547	-49.9%
Behavioral Health & Health Facilities	$3,631,181	$4,233,972	$4,834,476	33.1%
Total	**$5,241,715**	**$6,303,142**	**$7,119,131**	**35.8%**

Source: DHHR, October 2012

As indicated in the preceding tables, overtime varies significantly by bureau.

- The Bureau for Children & Families and the Bureau for Behavioral Health & Health Facilities account for 95 percent ($6.8 million of $7.1 million) of department spending on overtime.
- The Bureau for Behavioral Health and Health Facilities (BHHF) consumes 8.6 percent of the total department spending, has 29.5 percent of the total staffing and accounts for almost 68 percent of overtime in 2012.
- The Bureau of Children and Families (BCF), which has the most FTEs (2,550 or 40.3 percent of total department staffing), accounted for more than 27 percent of department overtime spending.
- Overtime within BCF increased by 51 percent in the last two years.
- Overtime in in BHHF increased by 33 percent.
- The remainder of the department's use of overtime increased by 6.8 percent over the same two year period.

Recommendations

DHHR and the Division of Personnel, with oversight by the Governor's Office, should establish an emergency intervention team to fill critical vacancies in the department immediately.

The emergency intervention team should identify specific interventions to reduce turnover.

Savings/Revenue Estimate

Numerous studies from the private sector have estimated the cost of turnover. The Society for Human Resource Management estimates that it cost $3,500 to replace one entry-level worker.[49] Some other estimates range from 30 to 50 percent of the annual salary of an entry-level employee, 150 percent for middle-level, up to 400 percent for high-level or specialized employees.[50]

Using the most conservative estimate of $3,500 to replace one entry-level worker, it can be estimated that DHHR is spending $6.7 million per year in excessive costs attributable to the turnover rate. A 30 percent turnover annually requires the department to recruit, hire and train approximately 1,900 staff.

By reducing DHHR turnover by 50 percent – to a 15 percent rate – the department would save $3.4 million annually. Reducing the turnover rate to levels reported by the Bureau of Labor Statistics (3.3 percent) would save the department almost $6 million.

	State	Federal	Total
Year One	$2.1 million	$1.3 million	$3.4 million
Five Years	$10.5 million	$6.5	$17 million

Note: The exact federal share is not known at this time. We use 37.5 percent based on the split of state/federal funds for Personnel Services in the department-wide budget.

C. Improve Department-Wide Management and Accountability

Issue Statement	DHHR should revamp its grant identification, application and monitoring policies and procedures to increase grant applications and improve management and oversight of grants.

Background

Numerous grant opportunities are available to state governments through various federal offices as well as private foundations. The Administration for Children and Families announced it would be offering over $16 billion in grant opportunities for federal fiscal year 2013. Likewise, the Substance Abuse & Mental Health Services Administration announced millions of dollars in grant opportunities for such tasks as suicide prevention, underage drinking prevention, and comprehensive system planning for children and families with serious emotional problems. Every division within the federal Center for Medicare and Medicaid issues billions of dollars of grant opportunities for states.

States that have organized their grant application and monitoring process have identified a substantial return on investment. Iowa conducted a pilot in 2008, dedicating one staff person in the Governor's Office to assist departments in applying for grants. In one year, the state was able to successfully apply for $32 million in grants.

The National Governors Association (NGA) recognized the Maryland Governor's Grant Office (GGO) as a national model. In FY 2011, Maryland state agencies received $9.9 billion in federal grant dollars for 508 separate grant programs. The GGO also helped Maryland agencies in reducing their federal grants audit findings, with the total number of federal audit findings for FY11 down 38.8 percent from FY10. In the health field, the Maryland GGO has helped track and coordinate health care reform grant application notices and deadlines through a work group affiliated with the Maryland Health Care Reform Coordinating Council. As of the end of 2011, approximately 14 federal grant awards have been secured for Maryland state agencies.[51]

Findings

In West Virginia, DHHR's grant application process is highly decentralized, uncoordinated and haphazard. There is uncertainty, confusion and inconsistency in identifying, applying for, and managing grants in DHHR bureaus Staff in all bureaus expressed frustration and concern that they do not have sufficient training to apply for or monitor grant programs; all bureaus also expressed an opinion that the department is missing out on funding opportunities.

Areas needing improvement can be divided into two categories: 1) identification and application and, 2) start-up, monitoring and oversight.

Grant Identification and Application

DHHR does not currently have a coordinated approach to seeking grant funding. New grant opportunities are typically identified by staff in each bureau who take the initiative to approach senior bureau staff for approval to proceed with a grant application.

Once a decision is made at the bureau level, the approval process expands to a cumbersome and lengthy process that adds inordinately to the time needed to complete a grant application. The approval process for most on-going grants is the same as for a new grant, even if applications are straightforward renewals or continuations. Additionally, there is often no differentiation in processing based on the size of a grant; a grant for a few thousand dollars receives the same scrutiny as one that involves millions of dollars.

Grant approvals require a total of seven signatures on the GM-01, the three-page Grant/Contract Preliminary Application Questionnaire: three at the bureau level and the remainder either within DHHR or other offices outside of DHHR. While the form is available for electronic downloading, the signatures are required on a paper copy that moves sequentially through various offices. Substantive changes may be made by a reviewer without the knowledge of the staff who prepared the application. At the same time, grant applications are often sent back to the originator for minor non-substantive (e.g., grammatical) changes.

The decision *not* to pursue a grant often occurs at the bureau level before the GM-01 form is created preventing a coordinated, strategic effort at the department level to decide how and when grant applications should be pursued.

Grant Start-up, Monitoring and Oversight

Once a grant award is made, there are numerous complications in project start-ups that sometimes prevent DHHR from implementing and operating the grant as expected by the federal grantor. Such issues may be:

- **Hiring grant-funded personnel:** The delays in hiring state employees apply to grant-funded positions also, often taking three to six months for the State Office of Personnel to approve grant job classifications. For example, there is a five-year grant award made two years ago that was not fully staffed at the time of this review.

- **Purchasing restrictions:** Federal grants are often designated for very specific purposes or purchases. In these situations, the federal agencies issuing the grant provide guidance to recipients explaining legislative and executive intent for the program and direction on how to spend the funds. West Virginia purchasing regulations, however, often restrict grant expenditures. For example, measuring cups could not be purchased for WIC recipients through a grant from USDA because state purchasing officials deemed such purchases to be "incentives" or promotional goods which are prohibited in current purchasing rules. Similarly, the state WIC office submitted a grant proposal to provide pocket calculators to WIC recipients so they could do simple calculations in the grocery store when determining whether ingredient quantities were allowed under their WIC benefits. USDA approved the West Virginia grant application for this project, however State purchasing authorities did not allow the purchases to be made with the federal funds designated expressly for this purpose.

  In another instance, a grant providing funding to purchase 900 e-readers to encourage parents to read to children was not approved by the State's Office of Technology and grant funds had to be returned to the federal government.

  As shown in these examples, West Virginia has forfeited federal funding for worthwhile initiatives because of the inconsistent and complex approval process.

- **Sub-grantees:** The approval process to award grants to sub-grantees can be lengthy as well. According to page 9 of DHHR Policy 3801 "Award and Monitoring of Sub-recipient Grants", DHHR annually distributes approximately 900 grants to over 400 different organizations, with Federal and state-appropriated awards totaling more than $100 million dollars. These awards are made through approximately 20 different spending units, in over 140 assistance programs, spread throughout DHHR and administered by a variety of bureaus, offices and divisions, each with a unique organizational and management structure.

  Funds to sub-grantees are reported by staff to remain unspent because of discrepancies between federal and state purchasing and contracting language. For example, at the time of this review, a $2 million grant was unspent for a year because of unaddressed concerns over the contract language. Other issues with sub-grantees include:

- Some grants provided through state legislative appropriations specify the amount and grant recipient specifically, eliminating any opportunity for competitive procurement and binding the program staff to specific grantees.

- There are inconsistencies in required performance measures. Contracts with sub-grantees may not have sufficient guidelines in place to ensure quality performance. For example, some sub-grantees are awarded contracts in perpetuity without a periodic competitive procurement process. This is especially a concern for sub-grantees that are specified in state legislation. In other cases, sub-grantees may continue to receive federal funds when they are disbarred by the state and may no longer receive state funding. At the time of this review, two contract recipients/grantees repeatedly failed to provide services in accordance with sub-grantee agreements, yet DHHR continues to renew their contracts.

- Difficulties in the timely transmission of funds has forced some sub-grantees to secure a line of credit to cover expenses before a grant renewal is approved.

- The change order process (allowing changes to sub-grantee agreements) is problematic and can take almost nine months in some cases. Yet change orders are necessary for sub-grantees when the grant year is differs from the state fiscal year. In that case, the sub-grantee budget is divided into two budgets to align with the State fiscal year. If the sub-grantee needs to shift money from one category of its budget to another or to adjust spending by budget year, a change order is required. When these approvals take an inordinate amount of time (reported to be about 9 months), sub-grantees are prevented from spending funds they have already been awarded. Small local health agencies have limited budgets and delays in change orders mean that they may not have time to spend the additional funds by the end of their contract.

- **Monitoring grant spending:** Grant activities and expenditures are not adequately monitored by staff responsible for grant management because they do not have access to spending information. Without timely reports on levels of spending, it is not possible for grant managers to know if a grantee is under- or over- spending. There are reported instances of grantees overspending and others where money had to be returned to the federal government because it was not spent before the end of the grant period.

- **Monitoring, compliance and evaluation:** Federal and state grants typically require periodic evaluations of grantee performance and fiscal compliance. DHHR has an automated grant management tool called CRM; however, it is not universally used. There is also a department-wide policy for monitoring grants (#3801) that is not clearly understood or implemented within the department. Grant management responsibility varies and may involve staff within a bureau, or staff in a DHHR office, or both. Monitoring a grant program is time-intensive and paperwork-heavy and is a burdensome process for staff. At least one bureau outsources the vast majority of its grant evaluation work, including grantee technical assistance, to West Virginia University and Marshall University. There is no consistent policy or approach for decisions responsibility for grant oversight

Recommendations

DHHR, in conjunction with the Governor's Office, should develop a coordinated strategy for pursuing and assessing grant opportunities.

DHHR should revise administrative procedures for reviewing and approving grant applications.

DHHR should allow program managers access to budget information critical to managing grants.

DHHR, in conjunction with the Purchasing Division, should expedite the contract change order process to allow grantees to access funds more readily throughout the budget year.

DHHR should enhance grant contract terms and compliance standards to ensure timely and satisfactory performance deliverables. Contracts should also be reviewed to make sure that State proprietary interests in infrastructure and equipment are maintained.

DHHR should review options to conduct grant evaluation and technical assistance work internally at a lower cost than contracted evaluation work.

Savings/Revenue Estimate

While the number of missed grant opportunities is unknown, West Virginia has an opportunity to expand programs and services through grant funding and ensure that grant funds are used for the intended purposes. If DHHR is successful in obtaining grant funds for one-third of the level achieved in Iowa or Maryland, it could increasing revenue by about $10 million. This does not include savings that could be generated by better grant management – avoiding having to return money to the grantor, ensuring timely implementation, and monitoring and evaluating in-house rather than contracting for these services.

The costs of not improving the grants process include:

- Forgone revenue for programs and services that can benefit West Virginia residents
- Inefficient use of staff time in attempting to obtain State approval for grant applications and grant purchases, and oversight of sub-grantees

	State	Federal	Total
Year One	$10 million		$10 million
Five Years	$50 million		$50 million

Issue Statement	DHHR should review travel and reduce spending where appropriate.

Background

The mission of DHHR--providing services to children, families and vulnerable adults in the community, and operating state-owned facilities throughout the state--requires a workforce that is stationed in local offices around the state and that must also be able to travel to clients as needed. The three main reasons for travel are:

- Visits to client homes or other facilities to confirm eligibility or the need for services, observe care being provided, and investigate allegations.
- Attendance at meetings at headquarters or district offices, or other sites.
- Participation in training or other professional development opportunities within the state or in other states.

All travel must be approved in advance. State employees generally have to use state contracted rental cars to drive to locations and pay for meals and hotels when needed while on travel status. They are later reimbursed for out-of-pocket expenses, although repayment may take months.

Findings

DHHR spending on travel increased 35 percent in the past two years -- $6.1 million in 2012 compared to $4.5 million in FY 2010. Travel spending by bureau is shown below.

DHHR Travel Spending by Bureau/Office
FY 2010-2012

Bureau/Office	2010	2011	2012	Percent Increase 2010 to 2012
Administration	$128,943	$121,461	$127,614	-1.0%
Office of the Secretary (includes Inspector General)	$229,139	$727,179	$777,771	239.4%
BPH	$913,642	$1,079,922	$1,319,660	44.4%
BHHF	$179,331	$182,405	$273,061	52.3%
BCF	$2,803,864	$2,986,712	$3,208,292	14.4%
BCSE	$235,744	$258,933	$327,076	38.7%
BMS	$19,871	$51,660	$72,853	266.6%
Total Travel	**$4,510,534**	**$4,510,534**	**$6,106,327**	**35.4%**
Travel w/o OIG	**$4,281,395**		**5,328,556**	**24.5%**

Source: DHHR, October 2012

Noteworthy in the preceding exhibit is the increase in spending in the Office of the Secretary. Most (95.3 percent) of that increase is attributable to the Office of the Inspector General, where auditing and investigation activities, which require a considerable amount of travel, accelerated in 2011.

- Removing OIG travel, the department as a whole still shows an increase of 24.5 percent in the same time period ($1,047,161).
- Administration is the only unit that did not increase travel.
- BMS' travel spending increased by 266.6 percent.

Spending on travel for training has increased significantly in certain bureaus/offices in the past two-year period. Of the $6.1 million spent on travel in 2012, $2.3 million (38 percent) was for travel associated with training activities. The following exhibits show spending for travel and training-related travel for each DHHR bureau/office. It also shows spending on out-of-state travel for training and the amount spent per FTE in each of the units.

FY 2012 DHHR Travel Spending by Bureau

	Spending by Bureau/ Office	Percent of Total	Percent of FTEs
Office of the Secretary (including OIG)	$777,771	12.7%	4%
Deputy Secretary for Administration	$127,614	2.1%	4%
BHHF	$273,061	4.5%	29%
BCSE	$327,076	5.4%	8%
BCF	$3,208,292	52.5%	40%
BMS	$72,853	1.2%	2%
BPH	$1,319,660	21.6%	11%
Total/ average	**$6,106,327**		

Source: DHHR, October 2012

FY 2012 Training-Related Travel

	Total for Training	Percent of Travel for Training	Percent for Out of State Training	Training per FTE	Out of State Training per FTE
Office of the Secretary (including OIG)	$129,828	5.7%	36%	$466.34	$169.86
Deputy Secretary for Administration	$50,083	2.2%	25%	$197.47	$50.19
BHHF	$92,544	4.0%	9%	$49.57	$4.44
BCSE	$142,040	6.2%	2%	$294.02	$7.21
BCF	$1,041,149	45.3%	1%	$408.29	$2.66
BMS	$55,815	2.4%	76%	$558.15	$422.48
BPH	$784,916	34.2%	60%	$1,101.57	$665.45
Total/ average	**$2,296,374**	**100%**	**26%**	**$362.79**	**$94.00**

Source: DHHR, October 2012

As shown in the preceding exhibits:

- As would be expected (since the Bureau for Children and Families accounts for 40 percent of staff in DHHR), BCF accounts for 52.5 percent of department travel expenditures and 45.3 percent of all training-related travel spending.
- Spending in other bureaus, however, is not in line with department averages and percent of staffing.
- Travel for training also shows a wide spread among bureaus – 45.3 percent of BCF's travel spending was for training; 34.2 percent of BPH's spending was for training; other bureaus/offices had much smaller percentages.
- Training costs per FTE ranged from just under $50 in BHHF, to more than $558 in BMS and to over $1,000 in BPH.
- Out-of-state training costs per FTE varied from a low of $2.66 in BCF to a high of $665 in BPH.

It should be noted, that the training-related travel is also a function of the high turnover rate in some bureaus. With certain units experiencing turnover of a third of their workforce every year, training of new employees becomes the main task of department training staff.

Of even more significance is that travel for training not only varied widely among bureaus/offices, but also shows a significant variance in growth rate by bureau in the past two years. The following exhibit shows spending on out-of-state travel for fiscal years 2010, 2011 and 2012 and the change over the two year period between 2010 and 2012.

DHHR Out-of-State Training-Related Travel
FY 2010 -2012

Bureau /Office	2010	2011	2012	Spending 3-Years	Change 2010-2012
Office of the Secretary	$22,511	$52,911	$47,288	$122,710	110%
Administration	$1,216	$7,156	$13,387	$21,759	1001%
BPH	$313,595	$396,239	$474,156	$1,183,990	51%
BHHF	$4,591	$3,960	$10,223	$18,774	123%
BCF	$2,105	$10,392	$6,795	$19,292	223%
BCSE	$7,769	$4,882	$3,485	$16,136	-55%
BMS	$7,667	$8,545	$42,248	$58,460	451%
Total	**$359,456**	**$484,086**	**$597,582**	**$1,441,124**	**66%**

Source: DHHR, October 2012

While the department average spending on travel for out-of-state training increased by 66 percent over the two-year period, five of the bureaus/offices experienced a growth rate that more than doubled over that timeframe.

Of the over $1.4 million spent on out-of-state training by DHHR over the three years, $1.2 million (82.2 percent) was spent by the BPH. Although BPH's growth in spending of 51 percent was modest compared to most other bureaus, it is by far the largest user of funds for out-of-state travel.

DHHR was not able to provide any information that would allow for a more detailed analysis of the reason for increases. It should be noted, however, that with the additional grants and funds provided through ACA it may have been necessary for increased travel to Washington D.C. for training required of grantees. Obviously, this is required travel; what is not clear is how much of the significant increase is attributable to required grant training.

Recommendations

DHHR should work with each Bureau Commissioner to review travel spending to ensure travel is necessary to support the department's mission.

DHHR and each bureau should put in place a plan to reduce travel spending. Reducing employee turnover across the department should help lower the need for spending on training-related travel.

DHHR should ensure that an effective and efficient out-of-state travel approval process is in place to be certain that travel is appropriate and required.

Year-to-year increases in travel budget should be no more than five percent unless required to comply with new laws (particularly at the federal level) or produced by policy initiatives like the recent uptick in audits and investigations conducted by the Office of Inspector General.

Savings/Revenue Estimate

Rolling back travel spending to 2010 levels would save about $1.5 million.

	State	Federal	Total
Year One	$937,500	$562,500	$1.5 million
Five Years	$4.7 million	$2.8 million	$7.5 million

Note: The exact federal share is not known at this time. We use 37.5 percent based on the split of state/federal funds for Personnel Services in the department-wide budget.

Issue Statement	The department should standardize rates for psychiatric and forensic evaluations.

Background

West Virginia courts often order psychiatric and/or forensic evaluation of children and parents of children in state custody. Psychological evaluations are either covered by Medicaid if the individual is eligible for Medicaid or through state general funds if they are not. The state pays the same rates as Medicaid: currently $50.56 per hour.

A forensic evaluation may include a psychiatric evaluation, a risk assessment determination and/or a determination of competence. Forensic evaluations are not covered by Medicaid, so there is no Medicaid rate for the state to use as a comparison for determining the appropriate level of reimbursement.

The Bureau for Children and Families and the Bureau for Behavioral Health and Health Facilities pay significantly different rates for psychiatric evaluations of children and adults, averaging $331 and $2,100, respectively. These rates have been in place for several years and have not been reviewed for consistency or appropriateness since.

Findings

Psychiatric evaluations that are not paid by Medicaid are referred to in DHHR as “special” and/or “forensic” evaluations. BHHF has an outdated policy that outlines the types of evaluations that may be ordered by a court and paid by BHHF. BCF does not have a written policy that defines special or forensic evaluations.

Of the 604 evaluations conducted on families involved with BCF during a 12-month period ending in November 2012, some are paid through Medicaid, some are paid solely with state general revenue funds, and some are paid in part by Medicaid and in part by state general funds. For example, an evaluation may be ordered by a court to determine if a person has a behavioral health condition (paid by Medicaid) and whether they are fit to parent (not covered by Medicaid and paid by BCF).

BCF spent $198,000 in state general revenue funds in a one-year period ending in November 2012 to fully or partially fund 599 special and/or forensic evaluations at an average cost of $331. BHHF coordinated 540 forensic evaluations in 2012 at a cost to the state general fund of $1.2 million and an average cost of $2,101.

The manuals and documents in use in BCF and BHHF are outdated and/or undated and do not provide sufficient information to determine the working definition of “special” and “forensic” evaluations, the approval process, the billing process, or the review process for these evaluations.

The rationale for determining the cost of the evaluations in BCF is unknown; a document from BHHF indicates that the BHHF maximum rate of $3,000 was set in 2007 by a committee consisting of Counsel from the Attorney General’s Office, two forensic psychiatrists and a forensic psychologist. Although the maximum rate is set at $3,000, the average cost per evaluation is reported to be $2,100 for 2012.

The following table details forensic evaluation rates for 15 states in addition to West Virginia. Among the states the rates range from $200 in New York to $2,000 in Colorado. West Virginia has the highest maximum rates.

Forensic Evaluation Rates by State

State	Cost/Notes
AK	$500 Adults and juveniles
CO	$750 Adult Competency $500 Juvenile Competency $2,000 (Completed by Psychiatrists only)
FL	Evaluators are appointed by individual counties, so rates vary.
GA	$600 Adult competency/sanity evaluations. In the process of renegotiating and, in the interim, are paying $200/hour.
IN	Indiana has no set rates for court ordered evaluations; typically, the evaluators bill the court for each evaluation individually, using their own hourly rate. One county does use a flat fee, which is quite low, and results in very brief and largely inadequate reports.
LA	<$400
MD	$150 for a "screening" of adult competency to stand trial (CST) $250 for a screening of CST and criminal responsibility (CR)-- CR evaluations always include an evaluation of CST $400 for a "definitive" evaluation of CST $995 for a definitive evaluation of CST and CR $995 for an evaluation (always definitive) of a juvenile's competency to proceed $150/hour for time in court when subpoenaed
MO	In Missouri, the Department of Mental Health, by statute, provides one evaluation for competency, responsibility or both at no cost upon Order of the court. The evaluations are completed by forensic examiners who are employees of the DMH.
NC	North Carolina does not use a specific payment schedule for forensic evaluations. Traditionally private forensic evaluators in North Carolina billed at their customary hourly rate and submitted their bill to the presiding judge who in turn authorized a full or partial payment. In 2011 the Office of Indigent Defense Services established a fee schedule for forensic expert services based on hourly rates. The specific hourly rate is based on the expert's are of expertise and years of experience.
NY	$200 maximum for competency ($50 for evaluation plus each court appearance), not including travel expenses Competency evaluations are conducted at the county level. The statute itself is quite dated. Some counties have salaried court clinic examiners or contract with private evaluators to conduct competency evaluations, thereby avoiding the rate issue. Criminal responsibility is assessed by independent evaluators; rates vary considerably.
OK	The hourly rates range from $150 at the lowest to $425 for private forensic psychiatrists. This is very low and for the private sector only. The evaluators at the Oklahoma Forensic Center are provided as a part of the Outpatient Service to the state and the court. They received no revenue for those.
TN	Adult: $300 Competency only $300 Mental condition at the time of the crime $600 + MCO $600 Juvenile: $300 Basic $300 Additional forensic issues $600 Psychosexual
UT	$500 General CST $750 for complicated of more involved cases
VA	$400 Competency alone (adult) $400 Competency alone (juvenile) $500 Sanity alone $750 Combined competency & sanity
WI	$1,220/evaluation. Criminal responsibility reports are done by independent evaluators (non-state staff) and the cost varies from county to county. The same is true for juvenile competency evaluations.

Source: West Virginia Department of Health and Human Resources. Undated.

Recommendations

DHHR should establish one clear set of definitions, policies, and procedures for processing forensic evaluations within DHHR.

DHHR should standardize the payments for psychiatric evaluations in BCF and BHHF. A new ceiling should be set that applies to all forensic evaluations in the state and should be set somewhere between the current average rates paid by BHHF and BCF.

DHHR should identify one point of accountability for oversight, rate-setting, and review of expenditures.

DHHR should coordinate all forensic evaluations within one office to ensure consistency among providers, payments, and the review process.

Savings/Revenue Estimate

This recommendation will increase efficiencies within the department by establishing accountability and a single point of oversight for forensic evaluations. The average rate for the 15 states noted above is $580. If DHHR standardizes its rates to pay $700 per evaluation (a higher rate for BCF but significantly lower for BHHF) the net savings would be $535,000 for the General Fund since these are evaluations not paid for by Medicaid.

	State	Federal	Total
Year One	$535,000		$535,000
State Five Years	$2.7 million		$2.7 million

Issue Statement	West Virginia should reduce the number of boards and commissions related to health and human services.

Background

The consolidation of DHHR in the 1990's included the establishment of several boards and commissions that are administratively part of the department but that also have some autonomy in their authority to conduct business. Over the last two decades, other boards have been created by the legislature to address narrowly defined health or human service concerns.

Findings

As shown in the chart below, there are now 35 boards and commissions that are related to DHHR. These boards and commissions can be divided generally into five categories:

- Advisory – 14 are charged with advising the department in the design and implementation of programs to address specific concerns.
    - Care Home Advisory Board
    - Comprehensive Behavioral Health Advisory Board
    - Developmental Disabilities Council
    - Early Childhood Advisory Council
    - Early Intervention Interagency Coordinating Council
    - Health Enhancement and Lifestyle Planning Advisory Board
    - Healthy Lifestyle Coalition
    - Interagency Council on Homelessness
    - Medical Malpractice Advisory Panel
    - State Rural Health Advisory Panel
    - Support Enforcement Commission
    - Screening, Brief Intervention, Referral and Treatment Policy Steering Committee
    - Statewide Independent Living Council
    - Women's Commission

- Licensing/Regulatory – eight have licensing and/or regulatory authority over certain professions or services.
    - Center for Nursing Board of Directors
    - Family Protection Services Board regulates shelters
    - Board of Hearing Aid Dealers
    - Medical Imaging & Radiation Therapy Technology Board of Examiners establishes licensing requirements of imaging schools
    - Board of Nursing Home Administrators Licensing
    - Board of Registration for Sanitarians
    - Board of Respiratory Care licenses respiratory care professionals
    - Board of Social Work licenses social work professionals

- Funds administration – four administer trust funds, can distribute money and make loans, or have the authority to provide funds to individuals or families affected by a traumatic event.
    - James "Tiger" Morton Catastrophic Illness Fund
    - Children with Autism Trust Fund
    - Hospital Finance Authority
    - Traumatic Brain and Spinal Cord Injury Rehabilitation Fund Board

- Autonomous groups – six groups are independent, having varying degrees of authority to contract, hire personnel, make purchases, etc.
    - Health Care Authority
    - Health Benefit Exchange Governing Board
    - Health Insurance Plan Board
    - Health Information Network
    - Human Rights Commission
    - Commission for the Deaf and Hard of Hearing

- Review authority over catastrophic events – three groups are charged with reviewing deaths in certain instances, tracking and reporting instances, assessing risk factors, and promoting public awareness and prevention strategies.
    - Child Fatality Review Team
    - Domestic Violence Fatality Review Team
    - Maternal Mortality Review Team

These 35 groups sometimes overlap in areas of review or authority. Most importantly, there is no indication that communication around common issues, health concerns or approaches to the design and funding of health care initiatives is coordinated in any way.

Boards and Commissions Purpose and Authority

	Purpose	Source
Council on Aging	**Advisory Board** to the Commissioner of the Bureau of Senior Services.	§16-5P-7
Care Home Advisory Board	**Advisory Board for the Governor and Legislature** on personal care homes and residential board and care homes.	§16-5T-1
Tiger Morton Catastrophic Illness Commission	**Advisory Board to Legislature:** Makes recommendations for expenditures from the "James 'Tiger' Morton Catastrophic Illness Fund" to provide a source of economic assistance to the citizens facing catastrophic illness.	§16-5Q-1
Center for Nursing Board of Directors	**Governing Board of the WV Center for Nursing.**	§30-7B-5
Child Fatality Review Team	**Review of deaths of children:** Identify trends, patterns and risk factors; Provide statistical analysis regarding the causes of child fatalities in West Virginia; promote public awareness; provide training; established under the Office of the Chief Medical Examiner.	§49-5D-5
Children with Autism Trust Board	**Qualifies and oversees trust accounts** for children with Autism.	§44-16-3
Comprehensive Behavioral Health Advisory Board	**Advisory Board for the Governor and Legislature:** Produces annual report on the current behavioral health system of care.	§16-42-3 (3)(f)
Developmental Disabilities Council	**Advisory Board** authorized and funded by the Federal Developmental Disabilities Assistance and Bill of Rights Act. Administratively supported by the WV DHHR. Mission is to assure that West Virginians with developmental disabilities receive the services, supports and opportunities they need to achieve independence, productivity, integration and inclusion into the community.	EO March 6, 1972
Domestic Violence Fatality Review Team	**Reviews deaths resulting from suspected domestic violence**;. under the Office of the Chief Medical Examiner, produces statistical reports, provides public education and training.	§48-27A-1
Early Childhood Advisory Council	**Advisory Board to the DHHR:** Provides advice on child care program quality rating and improvement system and program review and policies; statute requires the Secretary of the Department of Health and Human Resources to create this Council.	§49-2E-1
Early Intervention Interagency Coordinating Council	**Advisory Board to the DHHR: P**rovides advice and assistance in the development and implementation of early intervention policies.	§16-5K-4
Family Protection Services Board	**Regulates shelters**, including considering applications for new shelters, monitor their operation, and promulgate rules; also advise DHHR and study related issues.	§48-26-301
Health Benefit Exchange Governing Board	**Operates the WV Health Benefit Exchange.**	§33-16G-5
Health Care Authority	**An autonomous authority related to DHHR.**	§16-29B-5
Health Enhancement and Lifestyle Planning Advisory Council	**Advisory Board to the Governor's Office of Health Enhancement and Lifestyle Planning** on policies and procedures relating to the delivery of health care services or the purchase of prescription drugs.	§16-29H-5
Health Information Network	**A public-private partnership** under the oversight of the Health Care Authority to promote the design, implementation, operation and maintenance of a fully interoperable statewide network to facilitate public and private use of health care information in the state; electronic access to educational materials, labs, x-rays, etc; provides registry for vital statistics; prescription drug tracking; disease management etc. Its board of directors is an independent, self-sustaining board.	§16-29G-1
Health Insurance Plan Board	**Operates the West Virginia Health Insurance Plan** which is an instrumentality of the state and a public corporation.	§33-48-2

Healthy Lifestyle Coalition	**Advisory Board to DHHR:** The Office of Healthy Lifestyles within DHHR is required to establish this Coalition to assure consistency of the public health and private sector approach to dealing with programs that address the problems that affect overweight and obese individuals; to provide a forum for discussing the issues that affect healthy lifestyles and to identify best practices that can be replicated.	§5-1E-3
Hospital Finance Authority	**Makes hospital loans**, be sued, enter contracts, adopt rules & regulations, solicit funding, charge fees, hold property, etc. The authority is a body corporate and a governmental instrumentality of the state.	§16-29A-4
Board of Hearing Aid Dealers	**Licensing Board** for hearing aid dealers.	§30-26-3
Interagency Council on Homelessness	**Advisory Board to the Governor.**	EO 4-07
Maternal Mortality Review Team	**Reviews the deaths** of all infants and women who die during pregnancy, at the time of birth or within one year of the birth of a child; under the Office of Maternal Child and Family Health.	§48-25A-2
Medical Imaging & Radiation Therapy Technology Board of Examiners	**Licensing Board** establishes licensing requirements, administers examinations, sets procedures for approval / rejection, provides standards for approved imaging schools, etc.	§30-23-5
Medical Malpractice Advisory Panel	**Advisory Board to the State Board of Risk and Insurance Management**, which it is created under. Provides advice on medical professional liability insurance as well as the insurance of state property, activities and responsibilities	§29-12B-4
Board of Nursing Home Administrators Licensing	**Licensing Board** to license and oversee Nursing Home Administrators.	§30-25-4
Board of Registration for Sanitarians	**Licensing Board** for sanitarians (someone qualified and certified to enforce public health sanitation laws and environmental sanitation regulations).	§30-17-4
Board of Respiratory Care	**Licensing Board** establishes licensing requirements, administers examinations, sets procedures for approval / rejection, maintain records, etc.	§30-34-3
Board of Social Work	**Licensing Board** establishes licensing requirements, administers examinations, sets procedures for approval / rejection, maintain records, etc.	§30-30-4
State Rural Health Advisory Panel	**Advisory Board to the Vice Chancellor of Health Sciences** related to the rural health initiative and to oversee and coordinate implementation of those policies and procedures.	§18B-16-6
Statewide Independent Living Council	**Advisory Council** organized to meet the requirements of the Federal Rehabilitation Act..	§18-10M-6
Support Enforcement Commission	**Advisory Board to the Legislature:** Reviews child support guidelines; in the DHHR, but is independent and not subject to DHHR control or supervision.	§48-17-101
Traumatic Brain and Spinal Cord Injury Rehabilitation Fund Board	**Advisory Board to the Legislature & Division of Rehabilitation Services:** Administers expenditures from the Fund; used for case management, rehabilitative therapies, attendant care, etc.	§18-10K-2
Commission for the Deaf and Hard of Hearing	**Outreach Services** for the hearing-impaired, their caretakers, and others re: information on education; living skills; educational, vocational, and recreational opportunities; coordinates statewide interpreter services for courts, state and local legislative bodies, and others.	§5-14-3
Human Rights Commission	**Investigates complaints of discrimination:** Requests hearings before an administrative law judge; subpoenas witnesses; Promotes harmony and equality among races; works with community groups; Executive Director of the Commission is a salaried employee appointed by the Governor, and the Commission can hire paid staff.	§5-11
Women's Commission	**Advisory Board to DHHR** studies the status of women, recommends ways to overcome discrimination, promotes ways to help women develop skills and continue education; etc.	§29-20

Boards and Commissions Membership

Title	Total Members	Public Agency	Elected Officials	Private/ Other	Description
Council on Aging	15	5		10	No more than 5 citizen members from the same political party. No more than six members for the same gender. Membership shall be geographically balanced. Governor appointees made with advice and consent of Senate.
Care Home Advisory Board	7	1	2	4	Governor shall appoint members with advice and consent of Senate.
Tiger Morton Catastrophic Illness Commission	6			6	Appointments made by Governor with advice and consent of Senate and the ombudsman of the DHHR who serves as a non-voting ex officio member. Members of public must be active in community affairs. No more than 5 members from same political party. Nurse must be a licensed nurse.
Center for Nursing Board of Directors	13	2		11	Must include representative of a bachelor or higher degree program, and associate degree program. Employers of nurses must include a director of nursing and a health care administrator. Nurses must include a licensed nurse from a rural health care facility; two registered professional nurses engaged in direct patient care; and a licensed practical nurse engaged in direct patient care. The Sec DHHR and the Workforce Office are ex officio members.
Child Fatality Review Team	15	7		8	Members are appointed by the Governor. Attorneys must be prosecuting attorneys or their designees. Law enforcement official cannot be a member of the State Police. One social worker must be a child protective services worker employed in investigating reports of child abuse or neglect; the other employed in public health. One doctor must specialize in pediatric or family medicine; the other in pediatric critical care medicine. Appointments are made by the Governor from nominees provided by various oversight bodies.
Children with Autism Trust Board	9	3		6	Doctor may be a psychiatrist. Attorney must have experience with trusts.
Comprehensive Behavioral Health Advisory Board	15			15	Members appointed by Governor from nominees provided by various oversight agencies. Not-for-profit members must be from organizations that provide residential or nonresidential care for children. +One public member must be a consumer of behavioral health services; the other must be a child advocate nominated by FAST.
Developmental Disabilities Council	32			32	Members are appointed by the Governor and include citizens and family members of citizens with disabilities, and State and private organizations concerned with the provision of services to people with developmental disabilities.
Domestic Violence Fatality Review Team	18	6		12	Attorneys must be prosecuting attorneys or designees; one law enforcement member must be county-level, and one must be local municipality police office; one doctor must specialize in family or emergency medicine, and one must specialize in obstetrics and gynecology; one social worker must be adult protective service worker employed in investigating reports of adult abuse or neglect, and one employed in medical social work; members selected by Governor from nominees.

Early Childhood Advisory Council	5		Statute does not require a certain number of members; lists the types of members that should be included (i.e., legislators, advocates, etc.).
Early Intervention Interagency Coordination. Council	10		At least 15 members appointed by Governor plus ex officio members presenting specific agencies serving infants and toddlers with developmental delays; public members must be parents of children up to six years old with developmental delays; legislators must include one rep and one senator; the provider of professional development must be from higher education; regulatory agencies member representatives of each agency involved in provision of or payment for early intervention services.
Family Protection Services Board	5		Members appointed by Governor with advice and consent of Senate.
Health Benefit Exchange Governing Board	10		Members of the public appointed by the Governor with the advice and consent of Senate and must represent: individual health care consumers, small employers, organized labor, insurance producers, representative of payers, and representative of health care providers.
Health Care Authority	3		Members of the public are appointed by the Governor with the advice and consent of Senate; no more than 2 can be from the same political party; one must have a background in health care finance or economics; one must have previous employment in human services, business administration, or related fields; and one shall be a consumer of health services.
Health Enhancement and Lifestyle Planning Advisory Council	16		Members shall be appointed by the Governor with advice and consent of the Senate
Health Information Network	17		One public member must work in health insurance for a WV-based company; CEO of a WV corporation working with stakeholders on the use of IT to improve health care.
Health Insurance Plan Board	6		The majority of the board must be individuals not representative of insurers or health care providers.
Healthy Lifestyle Coalition			Membership not specified; members should be representatives of state agencies, community organizations, and other entities with an interest or expertise in obesity.
Board of Hearing Aid Dealers	5	5	Established in WVC. Members are appointed by the Governor with the advice and consent of Senate.
Hospital Finance Authority	7		Members of the public are appointed by Governor with the advice and consent of the Senate.
Interagency Council on Homelessness			Reported to be inactive; membership outlined in the Executive Order
Maternal Mortality Review Team	19		Specified hospital staff include the Director of Obstetrics, Director of Neonatal Intensive Care, and the Director of Pediatrics at each of the state's tertiary care hospitals; any other person the team thinks would assist with the review of a case.
Medical Imaging & Radiation Therapy Technology Board of Examiners	9		Appointed by Governor with advice and consent of Senate.
Medical Malpractice Advisory Panel	7		Appointed by Governor with advice and consent of Senate.

Board of Nursing Home Administrators Licensing	8	1	7	Members are appointed by the Governor with the advice and consent of Senate. The Secretary of the WV DHHR is a non-voting member.
Board of Registration for Sanitarians	8	1	7	Members are appointed by the Governor with the advice and consent of Senate. Secretary of the WV DHHR is a non-voting member.
Board of Respiratory Care	7			Appointed by the Governor with the advice and consent of Senate; physicians must meet respiratory care requirements listed in statute.
Board of Social Work	7			Appointed by the Governor with the advice and consent of Senate; different types of social workers are specified in the statute.
State Rural Health Advisory Panel	14			Appointed by the Governor in consultation with the Vice Chancellor for Health Sciences; public members must represent each of the consortia of primary health care education sites; rural health care provider specialties listed; health science schools representatives; "other" member is a "site coordinator."
Statewide Independent Living Council	6			Non ex officio membership not specified beyond: one director of an Independent Living Center; the Governor shall select appointments from among the nominations submitted by organizations representing a wide range of individuals with disabilities and other interested groups, as coordinated by the council, by and with the advice and consent of the Senate. These members may include other representatives from Centers for Independent Living, parents and guardians of individuals with disabilities, advocates of individuals with disabilities, representatives from the business and educational sectors, representatives of organizations that provide services for individuals with disabilities and other interested individuals, as appropriate to the purpose of the council.
Support Enforcement Commission	9			One member of the public must be experienced as a public administrator, one must be an employer experienced in withholding support payments, one must be an obligor, and one must be an obligee.
Traumatic Brain and Spinal Cord Injury Rehab Fund	23			
Commission for the Deaf and Hard of Hearing	17			Members are appointed by the Governor with the advice and consent of Senate.
Human Rights Commission	9			Appointed by the governor with the advice and consent of the Senate.
Women's Commission	18			State college representatives shall be the Director of the Division of Personnel and the Chancellor of the Board of Directors; appointees are by the Governor with the advice and consent of Senate.

Recommendations

West Virginia should revamp its boards and commissions to align them with the new structure of the department and with the goals of the health care system. In particular:

- Consolidate five advisory groups into the **Healthy Life Style Coalition**. Groups that might be consolidated include:
  - Comprehensive Behavioral Health Advisory Board
  - Early Childhood Advisory Board
  - Health Enhancement and Lifestyle Planning Advisory Board
  - State Rural Health Advisory Panel
  - Screening, Brief Intervention, Referral and Treatment Policy Steering Committee

- Consolidate the three groups that deal with catastrophic events into the **Clinical Advisory Council**. Groups that might be consolidated include:
  - Child Fatality Review Team
  - Domestic Violence Fatality Review Team
  - Maternal Mortality Review Team

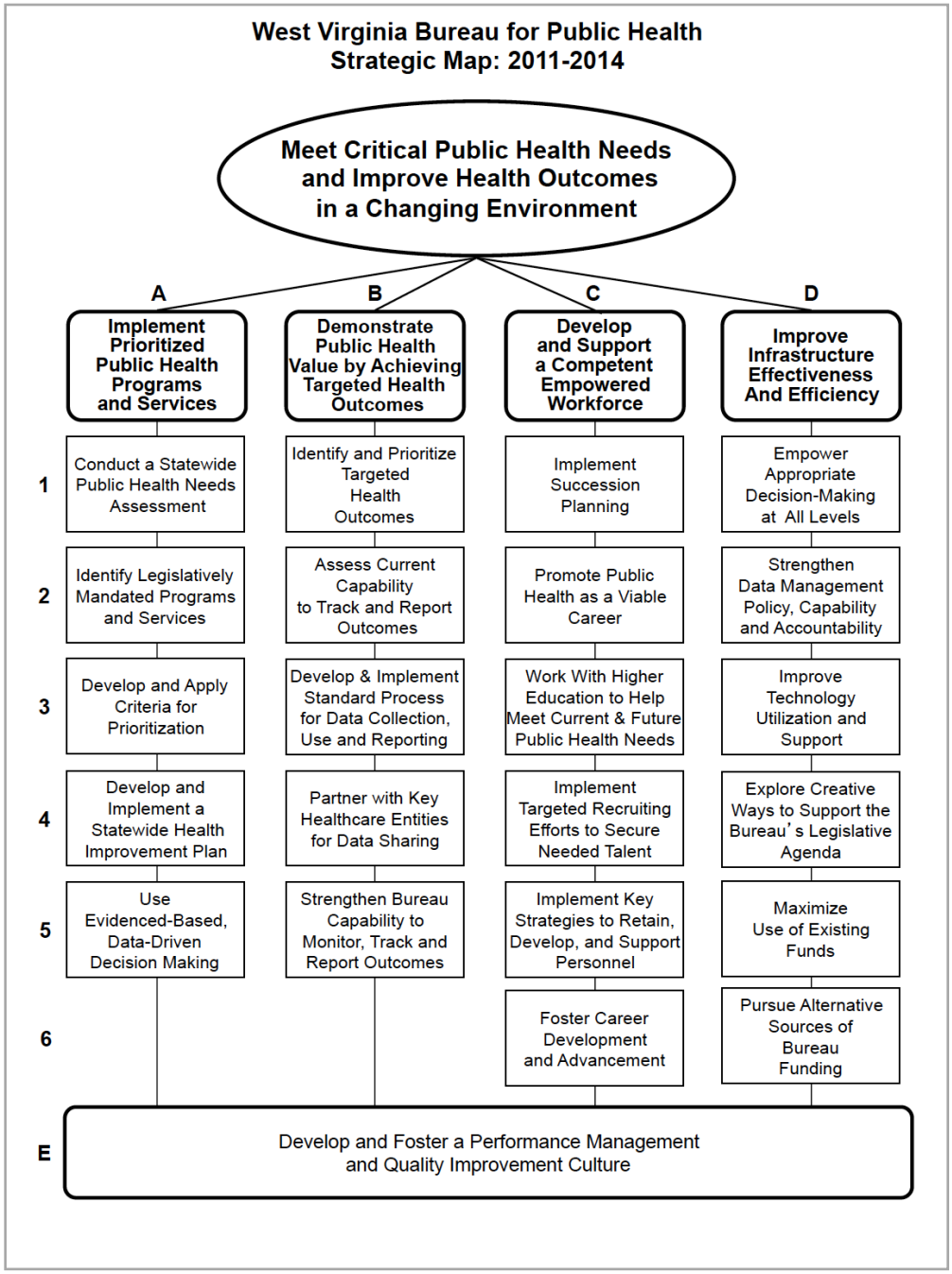
Estimated Savings/Revenue

While there may not be significant savings from improved management of the boards and commissions, it will allow for a more efficient and effective use of the expertise in these groups.

Issue Statement	DHHR should increase its performance management and quality improvement efforts in all bureaus.

Background

Over the last two years, the Bureau for Public Health has engaged in purposeful strategic planning to focus its work and promote performance management and quality improvement. In September 2012, the Bureau released an updated BPH strategic map (below) that lays out top-level goals and objectives for the agency for 2011-2014.



Source: Bureau for Public Health

Some BPH divisions have been reorganized to focus personnel and resources on policy priorities. In particular, BPH has taken steps to reorganize its efforts to address chronic disease. The Division of Health Promotion & Chronic Disease recently put into place a new organizational structure with functional crosscutting design that has been commended by CDC officials for increasing integration of chronic disease prevention efforts.

BPH also brought on a new Director of Performance Management & Systems Development to lead the Bureau's efforts to improve program efficiency and effectiveness. In October 2012, BPH was able to dramatically streamline its internal travel approval process based on the evaluation and recommendations of the BPH Quality Improvement team.

Findings

The Bureau for Public Health should be commended for its efforts to improve efficiency and focus limited resources (both personnel and financial) on top policy priorities.

Some of BPH's initiatives (particularly those related to performance management and quality improvement) should serve as models for the other DHHR bureaus.

While the Bureau for Public Health has been reorganized in recent years, there are still programs and funding streams that should be considered for realignment/consolidation. For example, the Bureau's hemophilia program is housed within Epidemiology while all other condition treatment programs are currently under Maternal, Children & Family Health.

Recommendations

Increase performance management and quality improvement efforts in all bureaus of DHHR.

Continue to align BPH offices, programs, and funding with the Bureau's strategic plan.

Savings/Revenue Estimate

While there may not be significant savings from improved performance management, it will allow for a more efficient and effective operation of each bureau and the department as a whole.

2.2. Bureau for Medical Services

The Bureau for Medical Services administers programs aiding the most vulnerable West Virginians. Over 400,000 West Virginians – from newborns to the frail elderly – rely on Medicaid to provide them with access to needed care. Despite the efforts of many dedicated individuals, however, the agency as currently structured is ill-equipped to handle the types of reforms needed to achieve the goals of better health and better care at a lower cost. The Bureau for Medical Services has only 62 employees to handle the state's $3 billion Medicaid program – insufficient to handle day-to-day operations, let alone new initiatives. BMS has relied on the use of contractors over many years to make up for the insufficiency of in-house staff.

For example, the Bureau has put significant effort over the last eighteen months into a proposed State Plan Amendment to improve care and lower costs for some of the most expensive Medicaid beneficiaries in several counties in the state. While such efforts are precisely the kind that are needed to move West Virginia's health care system in a new direction, stakeholders repeatedly expressed concerns that promising demonstration projects in West Virginia are rarely brought to scale or completed. The agency simply needs more capacity to pursue these types of initiatives in a faster, more comprehensive manner in order to have a real impact on the health of West Virginians.

Medicaid is also facing the unprecedented need for coordination with other agencies and with stakeholders to achieve its mission. Under the federal Affordable Care Act, all states must meet new requirements to streamline their Medicaid eligibility and enrollment systems in cooperation with health insurance exchanges. In addition, multi-agency initiatives are necessary to achieve the types of system-wide change and economies of scale necessary in a small state. No longer is it possible for Medicaid to remain in its own "silo." But coordination takes time and effort.

Beyond the major role BMS should play in designing and managing the reforms to the health care system discussed above, the bureau should pursue initiatives to improve its efficiency, save money and draw down as much federal revenue as possible. It cannot be overemphasized, however, that without significant attention to the systemic issues currently plaguing BMS--particularly its workforce--it will be a challenge for the Bureau for Medical Services to undertake any new initiative.

Issue Statement	DHHR should reorganize its program integrity activities to improve management and oversight of fraud detection and prosecution of health care programs.

Background

As required by federal law, DHHR has an Office of Inspector General (OIG) charged with ensuring the integrity of the department's programs and operations, including the

delivery of benefits and services to eligible state residents. The Inspector General's office in West Virginia includes six units:

- Investigations and Fraud Management (IFM).
- Medicaid Fraud Control Unit (MFCU).
- Board of Review.
- Office of Health Facility Licensure and Certification (OHFLAC).
- Olmstead Office.
- Quality Control Unit (QC).

Of these six units, two are responsible for anti-fraud activities: IFM and MFCU.

- IFM includes:
    - Criminal Investigations Unit (CI) is responsible for conducting intra-agency investigations involving allegations of inappropriate employee activity. The CI Unit also investigates complaints against non-Medicaid providers, vendors or grantees.
    - Repayment Investigative Unit, also known as Claims and Collections, is responsible for determining certain recipient benefit overpayment claims, negotiating repayment agreements, imposing sanctions, where warranted, and collecting overpaid benefits.
    - Front-End Fraud Unit performs pre-certification reviews of applicant eligibility on certain cases as a means of reducing and preventing recipient abuse or fraud before it occurs.

- MFCU is the federally recognized health care oversight entity. It is certified annually by the US Department of Health and Human Services to conduct statewide investigations of health care providers that are suspected of defrauding the Medicaid program. This unit also investigates complaints of abuse or neglect in health care facilities and complaints of misappropriation of patients' private funds in Medicaid facilities. Through a quality assurance effort, it monitors and evaluates various DHHR programs and assists other agency program integrity staff in developing plans for integrity efforts and plans improving performance.

Unique to West Virginia are some additional units within OIG:

- The Office of Health Facility Licensure & Certification's (OHFLAC) mission is to ensure healthy environments for clients, patients and resident within health care facilities by enforcing state licensure rules and federal certification requirements. Facilities and services that fall under OHFLAC jurisdiction include hospitals, home health programs, hospice, certain outpatient facilities such a birthing centers, dialysis units, therapy, nurse aide programs, nursing home and assisted living residents.

- The Quality Control (QC) Unit conducts statewide reviews to enforce eligibility requirements for applicants of benefits. Programs included in the reviews include the Supplemental Nutrition Assistance Program (SNAP), West Virginia Works, and Medicaid. SNAP and Medicaid QC reviews are required by the federal

government, which provides matching funds. In May 2012, the SNAP QC was reviewed by the US Department of Agriculture and received high praise for its compliance with federal requirements and outstanding performance.

- The Olmstead Office and Olmstead Council, established in 2003, serve to help implement activities to improve the long-term care (LTC) system by helping to remove barriers to community living for individuals with disabilities and chronic illnesses. The goal is to reduce reliance on institutional care and move toward more community-based LTC services, as required by the U.S. Supreme Court's *Olmstead* decision. This unit has a staff on one FTE.

Findings

Having units within OIG that are not directly related to program integrity activities dilutes the core mission of the office and distracts management from focusing on continuously improving program integrity efforts. Three units within OIG are not related to the core mission – OHFLAC, the Board of Review and the Olmstead Office. OHFLAC's role is regulatory in nature; the Board of Review serves to provide a fair and impartial hearing process to DHHR customers and providers who think they have been aggrieved by a DHHR action and; the Olmstead Office and Council deal with planning, advising, recommending improvements and updating the Olmstead plan.

Finally, the DHHR has no internal audit unit. Internal audit units are designed to provide agency management with independent and autonomous staff who review internal program actions, policies, and performance, and provide management with recommendations for improvement in all aspects of performance, compliance, efficiency and effectiveness. IA units may be independent, reporting directly to the agency head, or part of an OIG structure (as long as the unit has direct access to the agency head and/or governing board).

Recommendations

The QC function, while not exactly one that involves investigations and audits, does promote the integrity of department programs with its reviews of eligibility determinations as required by federal law. As such it is appropriately placed within a unit that is independent of the functional unit.

Functions not related to the core mission of the OIG should be moved to a more appropriate place in the DHHR organization.

- The Office of Health Facility Licensure & Certification's (OHFLAC) should be moved to the Bureau of Behavioral Health & Health Facilities. Many of its activities of the unit involve compliance and compliance review related to facilities and would be more appropriately placed in the bureau that deals with facilities.

- The Olmstead Office, the Olmstead coordinator and Olmstead Council should be moved to the Bureau of Behavior Health &

Health Facilities. BHHF has responsibility for programs designed to improve long-term care, reduce reliance on institutions and increase community alternatives so that those requiring care can receive it in the community. The Olmstead functions are oriented towards service rather than enforcement.

- The Board of Review should be relocated within DHHR as a separate unit reporting directly to the secretary to ensure the unit is independent and free from any real or apparent conflict of interest.

  Although the mission of the Board of Review is to preserve the integrity of DHHR programs, its location within the OIG (and for that matter the DHHR) undermines perceptions of its impartiality. In recent years, other states have consolidated all state agency administrative hearing processes into a single state agency, where hearing officers or administrative law judges conduct process previously conducted across multiple agencies. This effort can save money by reducing the need for each such agency to have its own team of hearings judges, attorneys and support staff.

The DHHR Secretary should create a small internal audit unit to help ensure internal compliance, improve performance, provide agency management with resource to help improve the effectiveness and efficiency of all department units, and to help OIG focus on its core mission of program integrity.

Savings/Revenue Estimate

These recommendations can be implemented with existing personnel. Improved operations of the OIG and better coordination among all units responsible for the identification, investigation and prosecution of fraud will result in increased revenue. The precise amount; however cannot be identified – estimates are combined with possible savings and increased revenue discussed below.

Issue Statement	West Virginia should use all the tools available to states to increase collections of fraudulent or incorrectly made Medicaid payments.

Background

Section 1936 of the Social Security Act requires states to collect information from and screen providers, operate surveillance and utilization review programs, establish fraud and abuse prevention activities, and report and actively combat fraud and abuse.

The federal government began a concentrated effort to identify and prosecute providers for Medicaid fraud and reduce incorrect payments with the passage of the Deficit Reduction Act of 2005. The Affordable Care Act put in place additional tools federal and state agencies have to strengthen anti-fraud efforts.[52]

According to the National Association of Medicaid Fraud Control Units, the typical return on investment for Medicaid fraud activities is 9 to 1 – for every one dollar invested in auditors and investigators nine dollars is recovered.[53] West Virginia does slightly better at 10 to 1; for every one dollar spent, the state sees a return of $10.

In fiscal year ending June 30, 2012, the MFCU opened 32 provider fraud investigations and closed 30. There were three criminal prosecutions and three convictions. The criminal cases resulted in $125 in fines and $33,242 in Medicaid restitution ordered. Civil cases for fraud resulted in more than $8.9 million in total recoveries assessed.

Findings

It is estimated that between three and 10 percent of Medicaid payments to providers are fraudulent or incorrect. Given the size of West Virginia's Medicaid program ($3 billion) that means between $90 million and $300 million is possibly being misspent annually. West Virginia program integrity activities recovered about $14.8 million in FY 2011.

In West Virginia, program integrity activities are conducted by the DHHR Office of Inspector General and in the Bureau for Medical Services in the Office of Quality and Program Integrity (QDPI) and the Medicaid Fraud Control Unit (MFCU).

Medicaid Fraud Control Unit Staffing

A review of the most recent federal Medicaid State Integrity Assessment (SPIA) report dated October 2009 indicates that DHHR spent $1.54 per enrollee on Medicaid integrity activities, as compared to a national average of $7.95. The same report indicated DHHR had seven auditors or 1.8 per 100,000 enrollees while the national average was 2.7 per 100,000. The Legislature authorized eight additional auditor positions in 2011 for the Medicaid Fraud Control Unit which would bring its per capita number in line with national averages. But these positions remain unfilled as of the writing of this report.

Once these additional auditors are hired and fully trained, recoveries are estimated to increase by $6 to $8 million per year.

Office of Quality and Program Integrity

The OQPI is a seven person unit with a director, administrative assistant and five reviewers whose main focus is on providers of services used by Medicaid clients. At one time the unit had 17 staff.

In addition to the in-house staff, the federal government now requires all states to have a contract with a private vendor to provide recovery audit services. A new two-year contract with a Recovery Audit Contractor (RAC) was recently awarded.

Suspected areas of abuse such as excessive services, up-coding, and unbundling are discovered through a variety of methods including billing and coding reviews, data mining and complaints. When reviewers complete an audit and have evidence of incorrect or fraudulent payments, demand letters are sent to the provider for repayment. Once money due is set up for repayment, the case is turned over the Bureau's finance unit for collections and other actions including placing liens on provider property and/or establishing of repayment plans. Providers have due process rights and can appeal determinations. Appeal hearings are handled by the OIG's Board of Review if no agreement can be reached.

There are other actions and legal authority available to states that are not now part of the West Virginia system of fraud detection and recovery.

Additional Actions and Legal Authority – Best Practices from Around the Country

States are developing more vigorous approaches to prevent and detect fraud in the Medicaid program. For example, states are:

- Conducting monthly meetings of fraud units and Inspectors General to share information on various program areas.
- Communicating with other MCOs and the Fee-for-Service program providers when an MCO terminates a provider for cause.
- Developing data mining plans to identify provider types at risk for payment errors.
- Developing lists of Medicaid providers who have met at least one of four conditions in the prior six months – providers new to Medicaid, providers who terminate their participation, providers who terminate their Medicaid number and receive new numbers, and providers with at least one active member who received a new number.
- Launching public awareness campaigns to educate the public.

- Creating web-based education modules for Medicaid providers to meet federal requirements for the education of their employees on reporting waste, abuse, and fraud as required under the federal Deficit Reduction Act.

- Requiring providers to have surety bonds at time of application for certification as a Medicaid provider. At the very least, this requirement could be established for providers who are administratively sanctioned as a condition for their continued participation in the program.

West Virginia's BMS and OIG are interested in doing more to increase fraud detection and prosecution. In fact, the data warehouse IT project currently in development will allow the offices to conduct data mining activities as noted above. Other activities should be reviewed for possible development in the state as well.

There are four additional legal recourses DHHR should have at its disposable for the detection and recovery of Medicaid funds spent fraudulently.

False Claims Act

Many states have become more aggressive in prosecuting fraud. In 2005, Congress created an incentive for states to enact false claims acts. Many states have embraced certain provisions of the federal False Claims Act known as the *qui tam* provisions that allow citizens to file legal actions in response to fraud schemes and to receive a reward if the action is successful. Penalties for violating the Federal False Claims Act can be up to three times the value of the False Claim, plus from $5,500 to $11,000 in fines, per claim.

States that have a false claims act with provisions such as *qui tam* that are similar to the provisions of the federal False Claims Act are entitled to an increased share (10 percent) of any recovery for Medicaid program losses. West Virginia does not have a False Claims Act that would permit it to claim this increased share of recoveries.

Successor Liability

In most states when a corporation or limited liability company sells or transfers its principal assets to another new or existing company, the successor company is not liable for the former corporation's debts and other liabilities. Companies committing fraud sometimes avoid liability by such transfers of assets.

DHHR has been unable to collect fraudulent payments once a provider goes out of business and/or its assets are transferred to another company, even if the transfer serves only to protect the fraudulently obtained funds from the state.

Enacting legislation to give the state the ability to impose the liability for overpayments based on fraud on to a successor company would eliminate this protection.

Subrogation

West Virginia statues allow the state to recoup what was spent through the Medicaid program on medical care on behalf of an individual when money is recovered through an award to an injured party. The statute allows for the recoupment of money designated for medical costs only. There are instances, however, when an award does not specify the portion designated for medical costs. West Virginia's Medicaid statutes currently do not address ways to define costs when the award is silent on the proportion designated for medical costs. In addition, the state does not have sufficiently strong and specific language requiring attorneys to notify Medicaid in a timely manner when settlements are decided.

In a letter to the Governor's General Counsel in September 2012, a West Virginia law firm estimated that the state may be missing the opportunity to collect between $30 and $50 million a year because of the defective language in the current statute.

The notice requirements and subrogation of funds should also apply to any medical payments made through other state programs on behalf of an individual. The Tiger Morton Catastrophic Illness Commission is one example. Currently, the commission has no legal authority to recover medical payments from an individual who collects from an insurance or legal settlement that covers the cost of medical paid by the commission. The FY 2013 budget for the commission is $1.6 million. With the authority to collect from awards made to an individual, the commission could recoup some of this payout.

Third Party Liability

When insurance companies or other payers of services or benefits (such as Medicaid or Medicare) pay a provider on behalf of a beneficiary or pay a beneficiary directly, the payer of the benefits is generally entitled to pursue reimbursement from a third party that is liable for the payments, such as another party's insurance company in the case of an automobile accident, on-the-job injury, or as a result of a lawsuit.

Cause of Injury	Possible Third Party Liable
Auto accident	Auto insurance company
Job-related injury	Employer's Workers' Compensation insurance
Intentional injury	Lawsuit, court-ordered settlement
Illness	Private/employer provided health insurance

In these cases the beneficiary or his or her attorney is legally required to let the state Medicaid agency know when an injury-related lawsuit is filed, so the state can determine if it should pay for services or seek reimbursement from a third-party. Federal law requires states to ensure Medicaid beneficiaries use all other resources available to them to pay for medical care before seeking assistance from Medicaid. A state's program is only required to pay after all third parties have met their obligations to pay.

If a state program has paid a claim submitted by a provider for services to a medical client, under federal law and state laws the state Medicaid authority is mandated to seek reimbursement from any third party who injured the state's Medicaid client.

Administrative Penalties

A provider convicted of Medicaid fraud is barred from participation in any federally funded health care program for a minimum of 10 years. If, however, a provider settles a fraudulent claim with the Medicaid Surveillance and Utilization Review Unit, no penalties are assessed. While the state recoups (millions of dollars in a year) the payments made incorrectly or fraudulently, it does not impose any administrative fines for the admission of wrong-doing. Other states impose such fines, which are permitted under federal law, ranging from $1,000 to $10,000 per incident.

In these instances, providers are not removed from the Medicaid program. Implementing administrative sanctions for lesser offenders or for SURS unit settlements allows DHHR to remove problem providers from the program without the burden of obtaining a criminal conviction.

Recommendations

The Medicaid Fraud Control unit should immediately fill the additional audit positions for which it received budgetary approval for last year.

The Legislature should amend state statutes to give DHHR authority to recover money obtained through fraudulent activities by transferring the debt of a company that has committed fraud to successor companies.

The Legislature should prohibit the transfer of assets from one company to another for 90 days to give DHHR (BMS) the opportunity to audit accounts to ensure the provider owes no money to the state and to give BMS the opportunity to stop transfers when money is due.

The Legislature should amend state Medicaid statutes to ensure the DHHR has all the tools necessary to fully recover money paid on behalf of Medicaid clients when third parties are liable. The amendments should cure any and all deficiencies noted by the US Supreme court in the *Arkansas DHHS vs. Ahlborn* case and by the West Virginia Supreme Court in a 2012 case

The Legislature should pass legislation similar to the federal False Claims Act including *qui tam* provisions to enhance its fraud prevention efforts and to take advantage of incentives offered by the federal government.

The Legislature should provide DHHR with the authority to impose administrative sanctions on providers.

Estimated Savings/Revenue

Estimated savings are based on the following assumptions:

- $6 million increase in fraud recoveries from filling vacant auditor positions. Filling the seven appropriated auditor positions is estimated to increase recoveries at a minimum of $6 million.
- $15 million increase in recoveries from correcting subrogation language in current statute. This is about one-half of the minimum estimate provided to the Governor's Office.
- $10 million based on the state enacting a false claims act, successor liability legislation and implementing the administrative activities permitted under federal law.
- Revenue to the state is based on a state/federal split of 72.04 percent federal and 27.96 percent state.

	State	Federal	Total
Year One	$8.7 million	$22.3 million	$31 million
Five Years	$43.5 million	$111.5 million	$155 million

Issue Statement	West Virginia should establish a broker system to manage non-emergency medical transportation.

Background

States are required to make NEMT available to Medicaid beneficiaries to assure their access to medically necessary services. States have increased the use of transportation broker services since 2001, when federal legislation was enacted to permit states to provide transportation through broker services. There are now 38 states that use brokers to manage NEMT.

A study of the Georgia and Kentucky NEMT programs conducted by the University of South Carolina reported that broker services increased access to care while reducing transportation expenses. Researchers also found a reduction in hospitalizations of children and for diabetic adults, suggesting providing transportation could improve health outcomes.[54]

There is a growing body of evidence nationally that indicates that fraud and abuse in the NEMT program is extensive.

- An Office of Inspector General audit of New York State (not including New York City) identified 43 claims out of 100 that were not allowable – equaling almost $13.5 million in federal reimbursement (14 percent) on a total of $97.5 million.[55]

- An Office of Inspector General audit of Texas identified 35 claims out of 100 that were not allowable. The audit identified instances where the beneficiary did not receive a Medicaid-covered service on the date of transportation, billings for trips that were canceled by the beneficiary or a "no-show" and still billed by the transportation provider.[56]

- A report from Virginia Medicaid, in justifying its move to establish a broker system for NEMT, reported that in 2000 it spent $54 million in a $3.1 billion Medicaid program on NEMT. They also found that 19 of 76 cases of provider fraud were related to NEMT.[57]

- Delaware projected spending $20 million per year by 2007, before implementation of cost controls through a broker system. With the implementation of a broker service and other efficiencies, the state actually spends approximately $8 million per year.[58]

- Utah reports a reduction of over $400,000 in NEMT expenditures in the first year of implementation of a broker service in its NEMT program. Spending went from almost $1.8 million to $1.4 million.[59]

- Mississippi estimates a savings of approximately $4 million in its NEMT program based on improved gatekeeping and use of broker services.[60]

Findings

West Virginia operates its NEMT program through each county office. The state program has grown from $17.4 million in 2009 to $18.7 million in 2011 – an increase of 7 percent while Medicaid enrollment increased 5 percent over the same time period. The Bureau of Medical Assistance estimates FY2013 spending of $26.1 million, growing to $31.9 million by FY2018. This represents approximately one percent of the Medicaid budget.

Recommendations

DHHR should be given the authority to issue a Request for Proposals for NEMT broker services.

Savings/Revenue Estimate

Based other state experiences from savings because of improved management and reducing fraud, West Virginia could save approximately 20 percent of its NEMT spending by moving to a broker system to control costs and establish tighter controls.

At projected spending of $26.1 million in FY 2013, total one-year savings could be $5.2 million. West Virginia's federal matching rate is projected at 72.04 percent for FY 2013.

	State	Federal	Total
Year One	$1.45 million	$3.75 million	$5.2 million
Five Years	$7.25 million	$18.75 million	$26 million

2.3. Bureau for Public Health

The West Virginia Bureau for Public Health (BPH) endeavors to have "healthy people in healthy communities" throughout the state. The Bureau's mission is to "help shape the environments within which people and communities can be safe and healthy."[61]

BPH oversees many of West Virginia's health programs and grants as well as several of the state's medical and environmental laboratories. BPH works closely with health providers and local health departments throughout the state, particularly during recent implementation of the Patient Protection and Affordable Care Act (ACA).

The Bureau is made up of eleven subdivisions, including:

- Center for Threat Preparedness
- Health Statistics Center
- Office of the Chief Medical Examiner
- Office of Community Health Systems and Health Promotion
- Office of Emergency Medical Services
- Office of Environmental Health Services
- Office of Epidemiology and Prevention Services
- Office of Laboratory Services
- Office of Maternal, Child and Family Health
- Office of Nutrition Services
- Office of Performance Management and Systems Development

The Bureau's FY2013 State budget appropriation was $83,360,103.[62]

Issue Statement	In conjunction with the Bureau for Public Health, State agencies should expand economic development incentives for healthy communities.

Background

Community health initiatives have long been acknowledged as one of the most effective – and cost-effective – ways of improving health conditions. One recent study suggested that community-based prevention has saved $600 billion nationally over 25 years.[63] And, more targeted initiatives aimed at changing health-related behaviors and encouraging more proactive utilization of treatments have achieved impressive specific results. New York City's recent comprehensive campaign to reduce heart disease claimed a 33 percent reduction in the disease along with a 16 percent reduction in strokes, and improved life expectancy. North Carolina's statewide "Healthy Carolinians" initiative (a program of the Care Share Health Alliance), which encourages individual counties to pursue community health projects customized for their particular needs, has produced an impressive mobilization of resources in various locales.[64]

Such initiatives make sense. After all, communities are essential partners in the effort to effectively address chronic diseases. The scope and impact of such diseases will require changing the places and organizations that touch people's lives every day – county and municipal planning agencies, community and faith organizations, worksites, health care organizations, housing providers, and schools. To reverse unfavorable trends in the prevalence and consequences of chronic diseases, local communities have to address such issues as affordable and accessible healthy food options, safe places for physical activity, and the need for targeted strategies that address and reduce health disparities.

The national Community Prevention Services Task Force, a private-sector group appointed and supported by the CDC, rigorously studied a variety of approaches, finding some especially effective, including:

- Community-wide campaigns to encourage physical activity and physical fitness;
- Efforts to supply information about child safety seats and to increase local enforcement of related laws;
- "Greenways" programs to help provide convenient opportunities for exercise in rural areas with few sidewalks or paved bike trails; and
- Local media campaigns on health behaviors integrated with distribution of free or reduced-cost products that facilitate healthier living.[65]

The overall lesson learned is that carefully planned and highly visible incentives in a given community can have an impact on residents and health care professionals alike.

West Virginia is clearly a state where healthier behaviors are critical to the reduction of chronic health conditions. The Bureau for Public Health's Division of Health Promotion & Chronic Disease reports that approximately twenty percent of West Virginians currently have a chronic disease, with approximately 90 percent of the state (1.5 million people) having at least one risk factor (poor nutrition, current smoking, no exercise) associated with chronic disease.[66]

As noted earlier, according to the Kaiser Family Foundation, West Virginia has the one of the highest adult obesity rates in the nation,[67] the second-highest percentage of adults who smoke,[68] and the third-highest percentage of adults with diagnosed diabetes.[69] It is also a state with many smaller communities and rural areas that may not have the infrastructure for routine preventive health measures.

The Patient Protection and Affordable Care Act, with its emphasis on preventive health services and chronic disease management, will create significant opportunities for additional federal funding for healthy community efforts, making advanced assessment of resources and needs a wise investment.

To supplement public funds, private foundations such as the Robert Wood Johnson Foundation, the Ford Foundation, the Daniels Fund and the Benedum Foundation have often provided support for community initiatives designed to encourage healthy behaviors.

Findings

The BPH Division of Health Promotion & Chronic Disease has developed several programs and initiatives to promote healthier communities, including:

- Working with local public health and other community agencies to share resources and technical assistance such as grant administration, community assessment training, and project implementation;
- Providing technical assistance to community health centers in establishing and using electronic management systems for Quality Improvement (in partnership with the West Virginia University Office of Health Services Research);
- Partnering with worksites to assess policies for physical activity, nutrition, and breastfeeding;
- Partnering with the West Virginia Department of Education on improving health outcomes in youth;
- Partnering with West Virginia State University to address senior health; and
- Working with local health departments by administering the *Change the Future West Virginia* project that resulted in 110 community policies including: Complete Streets, farmers markets, grocery stores, parks, school physical education and physical activity, and joint use agreements.[70]

West Virginia can and should expand healthy community efforts outside the public health arena by providing funding and technical assistance through other programmatic areas such as economic development.

At present, the Bureau for Public Health is making "mini-grants" available to Main Street and ON-TRAC communities around the state. These grants are specifically earmarked for community wellness, healthy food, and active living programs. Funding for the grants is supported with $100,000 from the Benedum Foundation and $50,000 from the State.[71]

West Virginia has received over $11.6 million ($10.2 million for the public sector, $1.4 million for the private sector) in ACA funds for prevention and public health projects.[72] Many of these funds can be used to promote community health initiatives.

Recommendations

BPH should expand its work with the Office of Development to assess all existing community development programs and where possible make healthy community initiatives eligible activities for both grant funding and technical assistance.

Public officials should build upon the model currently established for Main Street and ON-TRAC communities. In particular, the Office of Development-administered (and federally funded) Small Cities Community Development Block Grant program should consider encouraging and/or prioritizing healthy communities programs in its annual awards competition. Given the current budget situation, the State is not likely to be in the position to create new grant awards or financial

incentives. However, it can review all current offerings to make sure that healthy community projects can qualify for existing funding.

BPH and the Office of Development should also consider developing a joint pilot project to establish healthy community initiatives throughout the state funded by federal, state (existing) and private sector sources.

Statewide preparations for implementation of the Patient Protection and Affordable Care Act (ACA) should include a healthy community component utilizing available federal funds.

All statewide health promotion informational campaigns should include a community component that encourages local buy-in and utilizes community resources, including local media.

Savings/Revenue Estimate

This recommendation can be implemented without any additional State funding. Many community outreach and coordination efforts can be funded with ACA and other federal dollars. As mentioned earlier, the State is not likely to be in the position to create large new grant awards or financial incentives for healthy communities. However, policymakers can review all current offerings to make sure that healthy community projects can qualify for existing funding.

It should also be noted that preventive care efforts (like community health initiatives) are expected to create millions of dollars in savings for the state. The Trust for America's Health (TFAH) estimated that West Virginia's ROI for a $10 per person preventive care investment would produce $124.5 million in five years. See the chart below for TFAH's full return on investment projections.

Estimated Return on Investment in Preventive Care, West Virginia

West Virginia Return on Investment of $10 per Person
(Net Savings in 2004 Dollars
Total Annual Intervention Costs (at $10 per person): $18,110,000

	1-2 Years	5 Years	10-20 Years
Total State Savings	$42,300,000	$142,600,000	$156,600,00
State Net Savings (minus intervention costs)	$24,200,000	$124,500,000	$138,500,000
Return on Investment	1.34:1	6.88:1	7.65:1
	Estimated State-Level Savings by Payer		
	1-2 Years	**5 Years**	**10-20 Years**
Medicare Net Savings	$6,540,000	$33,600,000	$37,400,000
Medicaid Net Savings (federal)	$1,710,000	$8,820,000	$9,810,000
Medicaid Net Savings (state)	$635,000	$3,260,000	$3,620,000
Private Payer and Out-of-Pocket Net Savings	$15,300,000	$78,800,000	$87,600,000

Source: Trust for America's Health (5) calculations from preliminary Urban Institute estimates, based on national parameters applied to state spending data. http://healthyamericans.org/

Issue Statement	West Virginia should review the Bureau for Public Health's current fee schedule, increase fees that do not cover the cost of the test or service provided, and link future fee schedules to the Consumer Price Index.

Background

Like virtually all state health agencies, BPH provides licensure services to the health care provider community, and health and environmental testing services for organizations and the general public.

The fee structure for these services has never been comprehensively reviewed and there has been no formal effort to determine whether the current fees support the actual cost to the State in providing them. In other words, the State is inadvertently subsidizing many licensures and tests. In some cases, these subsidies have been increasing for decades, as fees have generally failed to keep up with costs to the State.

In recent years, governments at every level have begun to review fee structures to bring them in line with the actual cost of performing services, and to provide for recoupment of costs in the future. The most commonly used automatic-adjustment measurement is the Consumer Price Index (CPI), which exhibits the cost of a "basket" of goods and services typically purchased by the average consumer. The CPI is widely used by both the public and private sectors for "indexing" salaries, benefits, contracts, taxes, and sometimes even prices. There is widespread public acceptance of the CPI as a measurement of

the “cost of living.” This makes it a convenient indexing device for ensuring that costs do not ever-increasingly outstrip receipts.

Medical costs are part of the CPI “basket,” as are other costs germane to health licensure and testing services such as transportation, education and communications. But, it is not ideal as a measurement of laboratory testing costs, which also reflect medical inflation (typically running significantly higher than the general inflation rate.

Findings

BPH has no systematic process for reviewing and revising licensure and testing fees. (Note: In conjunction with this report, BPH accounting has started a process to compare fees to State costs.)

BPH fees are allowed in different sections of WV Code and administrative rule, with distinct language addressing specific fees (most BPH fees are discussed in the Fees for Service Rule). In only a few cases, BPH can establish or raise fees without direct legislative involvement. For example, the Office of Chief Medical Examiner (OCME) and Newborn Metabolic Screening test fees can be adjusted without legislative action.

Ad hoc adjustments of fees for licenses and testing often face resistance from affected communities, and hide the underlying subsidies and cross-subsidies (use of higher fees for one license or test to offset the costs of others).

The absence of any indexing feature increases the need for frequent cost and subsidy assessments, adding to the cost and complexity of the fee-setting process. The lack of a regular process for comparing costs and receipts for these services also makes it difficult for BPH to determine which tests and licenses it should administer, and in what manner (e.g., through BPH offices and personnel, as opposed to contractors or local intermediaries).

Some BPH-administered tests are provided free of charge (such as rabies tests), which means they are 100 subsidized by the State general fund.

There is precedent in West Virginia for matching fees to costs, and for using the CPI to provide for fee adjustments. By statute, the Office of Health Facility Licensure and Certification (OFLAC) oversees licensure fees for nursing homes, assisted living facilities, and residential care communities based on the size and scope of the licensed entity, with automatic adjustments tied to the CPI.[73] Also, the Code stipulates that all West Virginia hunting and fishing license and stamp fees “shall be computed in a manner that indexes the increases to the Consumer Price Index (All Items).”[74]

Recommendations

> BPH should undertake a comprehensive review of its fee structure for licensures and laboratory tests, with the goal of establishing fees equal to costs, accompanied by indexing to provide automatic adjustments of fees as costs change. Such review should be conducted with all due

oversight from the legislature and executive branch rulemakers and budget officials.

If fee subsidies are deemed necessary as a matter of public policy, they should be rationalized to minimize wide variations, with the exception of those affecting at-need populations or health care operations.

The Consumer Price Index (CPI) should be used to index fees to provide for regular automatic adjustments, with some study given to the possibility of utilizing a more accurate health care inflation index in the future.

Savings/Revenue Estimate

A comprehensive fee study will be necessary to determine appropriate 2013 fee levels for each license/service. The fact that many BPH fees have not been updated in decades (if ever) to keep pace with inflation and health care costs likely means that the State is costing itself significantly in lost revenues each year. West Virginia could recoup millions of dollars by charging fees equal to the cost of the State's services.

The Bureau for Public Health collected approximately $6.8 million in fees during fiscal year 2012, for licensure, testing and other services.[75] If total BPH fee collections increased by just ten percent (which probably far underestimates the current "under-charging"), that could mean $680,000 in additional revenue each year, $3.4 million over five years.

	State	Federal	Total
Year One	$680,000	$0	$680,000
Five Years	$3,400,000	$0	$3,400,000

Issue Statement	West Virginia should eliminate the Primary Care Center Mortgage Subsidy.

Background

For many years, the West Virginia Legislature has included a line item in the Bureau for Public Health's general fund budget to cover mortgage payments of primary care centers around the state. This subsidy was originally created as a mechanism to support health care facilities in economically disadvantaged or rural areas.

The "Primary Care Centers Mortgage Finance" line item remains in the BPH budget and is distributed to Primary Care and Community Health Centers to pay 100 percent of their mortgage payments each year. There is no formal application for this funding. Instead, the centers communicate directly to members of the legislature about their mortgage

finance needs and are listed specifically (by name and payment amount) in the annual appropriations bill.

The list of payment recipients varies each year as new requests for funding are added while other centers (that have paid off their mortgage) come off the list. Once a center is on the funding list, it is typical that it remains there – and receives 100 percent of the mortgage paid by the State – for the duration of the mortgage (often 20+ years).

Once the Legislature determines each year's recipient list and appropriates the funding to BPH, the Bureau's Division of Primary Care confirms each centers' mortgage amounts and issues grants for the mortgage payments in four quarterly payments. Recipients are not required to submit formal grant applications nor sign any type of grantee agreement.

Findings

For FY13, the Legislature appropriated mortgage payment funding for 24 awards totaling $723,182 (in award amounts ranging from $7,600 to $50,483.)[76] Over the past five years, total appropriations exceeded $3.7million. See the following chart for annual appropriations and the number of facilities supported from fiscal year 2009 to present.

State General Fund Appropriations for Primary Care Center Mortgage Payments FY2009-2013

Budget Year	Annual Appropriation	Number of Facilities Supported
FY2009	$786,918	23
FY2010	$786,918	23
FY2011	$719,072	22
FY2012	$730,272	23
FY2013	$723,182	24
TOTAL	$3,746,362	

Source: WV Bureau for Public Health

There are three concerns associated with the continuation of this payment. First, since there is no grant announcement or publication associated with this subsidy, eligible primary care centers unfamiliar with the appropriation or unaware that they should contact their legislator can be left off of the funding list.

Secondly, with low mortgage refinance rates in recent years, some policymakers have questioned whether centers could have refinanced their properties to produce a cash infusion for operations while the State continues to make its mortgage payments. The Division of Primary Care now maintains a list of each facility's mortgage balance and reports that that this list can be used to monitor any refinance activity.

Thirdly, and most importantly from a public health policy perspective, is the fact that this funding is not tied to any outcome requirements. As described in detail in Section 1, all funding in the health care system should be tied to improved health outcomes in order to ensure the best and most effective use of limited resources.

Finally, in recent years, both the American Recovery and Reinvestment Act of 2009 (ARRA) and the Patient Protection and Affordable Care Act of 2010 have made funds available for primary care infrastructure and capital improvement. BPH reports that several West Virginia centers were able to take advantage of such funding. Based on the availability of these alternative funds, BPH recommended eliminating the Primary Care Centers Mortgage Finance funds in their proposed 7.5 percent budget cuts in 2012.

Recommendations

The Legislature should eliminate state-subsidized Primary Care Center Mortgage Finance payments. If payments are not eliminated completely, lawmakers should consider: 1) closing the list and not allow new projects to be added, or 2) tie payments to improved health outcomes in some area of health concern to the community.

Savings/Revenue Estimate

The State could save over $700,000 annually by eliminating this subsidy. Instead of direct payments, the State should assist local centers in applying for other available federal funds designated for this purpose. The State could also consider reallocating these funds for other primary care or community health needs.

	State	Federal	Total
Year One	$700,000	$0	$700,000
Five Years	$3.5 million	$0	$3.5 million

Issue Statement	West Virginia should create more flexible health funding that can be focused on the state's greatest health priorities.

Background

One of the most-discussed challenges in domestic governance is achieving the proper balance between targeting programs to particular problems/objectives sufficiently to provide accountability, and avoiding a focus too narrow to allow achievement of broader parallel goals. Categorical programs sometimes create silos of funding, personnel, and regulation that prevent recognition of opportunities for synergy and collaborative services for similar and even identical clienteles.

An array of legislative devices has been created over the years at the federal and state levels for breaking down funding and programmatic "silos" and providing for administrative flexibility: provisions allowing for "fungibility" of funds (limited transfers of dollars between specific related programs); waivers of restrictions on funding usages; and block grants that combine discrete funding streams with extensive or complete freedom to allocate dollars as circumstances require.

The need for enhanced flexibility is especially obvious in the arena of health programs, where initiatives often involve prevention and treatment of multiple conditions affecting the same populations. Chronic disease management programs – notably those relating to diabetes, heart disease, stroke, cancer, arthritis, and chronic pulmonary disease – frequently address underlying behaviors (such as smoking) and conditions (especially obesity) that produce multiple diseases. And, unfortunately, many patients must deal with multiple conditions simultaneously. The ability to use funds to confront multiple diseases or common underlying problems can improve not only the efficiency, but the effectiveness, of chronic disease management.

As far back as 1981, Congress recognized the need for funding flexibility for state health programs by creating the Preventive Health and Health Services Block Grant. More recently, Congressional appropriators have begun encouraging the Centers for Disease Control and Prevention to provide more flexible use of funds designed for prevention and treatment of chronic diseases, with their overlapping causes and patient populations. Moreover, the Prevention and Public Health Fund created by the Patient Protection and Affordable Care Act of 2010 (ACA) places a high priority on flexibility in addressing chronic diseases in a synergistic manner through an integrated public health and primary care system – an approach that is directly in conflict with narrow programmatic "silos."

Findings

Like Congress, the West Virginia legislature has over the years created a variety of health programs aimed at improving prevention and treatment of specific health conditions, each with its own funding stream and guidelines. Beyond the inherent shortcomings found in any narrowly-designed programs, these state-level health programs (and appropriations) are typically very small, preventing the kind of economies of scale larger consolidated programs might be able to achieve. Additionally, many of these programs were created at a time when contemporary best practices of disease management had not yet emerged, with their emphasis on identifying common prevention strategies like anti-obesity or nutrition efforts.

In its recent report *Advocating for Chronic Disease Management and Prevention – 2011*, the state's Division of Health Promotion & Chronic Disease describes the challenges of splintered health programs and funding streams:

> *Until recently, strategies to address chronic disease have been shaped by a focus on the specific diseases or conditions addressed within a program, e.g., cardiovascular disease, arthritis, diabetes, and so on. The focus of the Division is now on creating efforts to address chronic disease*

as a whole. However, the programs themselves do not individually have the resources or funding to accomplish a systematic evaluation of all health promotion and chronic disease impacts.[77]

In its report to the legislative Joint Health Committee on December 12, 2012, the Division summed up the problem quite succinctly when describing its lessons learned from recent projects: "Fragmented funding leads to fragmented results."[78]

On a positive note, BPH has taken steps to reorganize its own efforts to address chronic disease. The Division of Health Promotion & Chronic Disease has recently put into place a new organizational structure with functional crosscutting design that has been commended by CDC officials for increasing integration of chronic disease prevention efforts. In its review of the state's Coordinated Chronic Disease Prevention (CCDP) cooperative agreement, the CDC encourages further integration by noting that, "Examining the impact of categorical programs and identifying opportunities for coordination are important first steps in [the] more coordinated process that your agency has undertaken."[79]

In BPH's FY2013 budget, over $7.25 million was appropriated for condition-specific health and education programs. (This amount does not include funds tied directly to preventive health commodities such as vaccines or service delivery/facilities such as clinics). See the following chart for these FY2013 appropriation amounts.

BPH Appropriations for Condition-Specific Programs
FY2013

Budget Year	Appropriation	Amount
FY2013	Current Expenses**	$150,000
	Cancer Registry	$210,184
	ABCA Tobacco Retailer Education Program-Transfer	$200,000
	CARDIAC Project	$475,000
	Healthy Lifestyles	$169,285
	Osteoporosis and Arthritis Prevention	$259,416
	Diabetes Education and Prevention	$105,000
	Tobacco Education Program	$5,684,814
	TOTAL	**$7,253,699**
	**Total appropriation-$4,439,298; includes $150,000 in chronic condition-related funding (Cancer & AIDS/HIV)	

Source: West Virginia Legislature

Many of these individual appropriations are too small for BPH to conduct effective outreach or education efforts. However, if they could be consolidated into a larger, more flexible "Chronic Condition" or "Preventive Health" Fund, a critical mass of resources could be targeted to the state's highest priority health needs. For example, this could mean that rather than producing separate educational materials on heart disease, diabetes, cancer, osteoporosis, and arthritis, BPH could use the funds (more efficiently) to design a cohesive senior health campaign that discusses all of these conditions.

As West Virginia prepares to implement the ACA and use increasingly flexible chronic disease prevention and treatment funds from the federal government, it is an opportune time to consolidate many of the individual, condition-specific state appropriations to align with national efforts.

Recommendations:

In consultation with the Bureau for Public Health, the legislature should review existing state health appropriations with the goal of providing the maximum feasible flexibility in use of funds for overlapping and parallel purposes and populations. Funding "silos" should be eliminated and funds consolidated into a "Chronic Condition" or "Preventive Health" Fund to enhance their effectiveness. This reform process should be conducted in conjunction with a legislative review of steps needed to manage existing and future federal funds, and to implement the ACA.

The legislature should Increase the department's flexibility to transfer funds between budget line items. As lawmakers are considering a fully integrated "Health Fund," steps should be taken to maximize funding flexibility in the present system. Currently, the department has the ability to transfer up to five percent of appropriated funds from one budget line item to another. The legislature should consider increasing this to ten percent.

Savings/Revenue Estimate

By consolidating BPH's condition-specific appropriations into a more comprehensive and flexible fund, the Bureau could certainly recognize savings from the economies of scale that can be realized in larger projects. Additional savings could be found through more efficient administration of the now disparate funding silos (without harm to programs and outcomes).

2.4. Bureau for Children & Families

The Bureau for Children and Families (BCF) is one of the largest bureaus in DHHR with 2,409 FTEs; 93 percent (2,233 positions) are assigned to 55 county field offices under the supervision of 30 “district” supervisors and four regional administrative offices. BCF is organized into three offices: the Office of Operations, the Office of Field Operations, and the Office of Programs.

- **The Office of Operations** includes staff involved in finance, grants and contracts, personnel, procurement, planning and quality improvement, and research and analysis.

- **The Office of Field Operations** is the largest of the three offices within BCF, overseeing the functions of the 55 county field offices, which conduct eligibility reviews for a number of programs including Medicaid, TANF, SNAP, burial assistance, disaster assistance, emergency assistance, refugee resettlement, and transportation assistance. The field offices also investigate child and adult abuse and neglect allegations, work with delinquent youth, provide case managers for TANF clients, conduct home studies for new foster homes, and facilitate adoptions. Each field office also has administrative staff responsible for budgeting, personnel, and procurement.

- Within **the Office of Programs**, the Division of Family Assistance and Division of Children and Adult Services are responsible for developing policy and procedures related to the activities conducted by field office staff. Other functions included licensing and monitoring of residential placement facilities for children and investigating abuse and neglect referrals within those facilities. The Division of Training includes 55 trainers responsible for training field staff based on the policies and procedures developed within the Office of Programs. The Division of Early Care and Education licenses and monitors child care centers and determines eligibility for federal Child Care and Development Funds. The Office of Programs also includes the Head Start State Collaborative.

Issue Statement	DHHR should re-organize the Bureau for Children & Families to improve service delivery, accountability, effectiveness and efficiency.

Background

Currently the Bureau for Children and Families (BCF) is organized by location rather than function. The 55 DHHR county field offices are responsible for a very wide variety of child and adult services and family assistance programs, and are supervised not only by 30 district supervisors and four regional staffs, but by their own state Office staff and those of various divisions in the Office of Programs.

There are 89 Child Protective Services supervisors and 379 CPS caseworkers (filled positions) in the county field offices. Each county field office is responsible for answering telephone calls regarding claims of child abuse or neglect directly as well as referrals that come in through the statewide hotline. Each field office screens the calls to determine whether the referral requires an investigation and investigates and case manages valid complaints of child abuse and neglect.

Anyone wishing to report known or suspected abuse or neglect of a child or an adult may call the local county Child Protective Services unit or a state-wide toll-free hotline (operated by a vendor contracted with BCF) that is answered 24-hours a day, seven days a week. The vendor provides 11 full-time and 4 part-time hotline staff that are responsible for completing an intake form in the FACTS automated system when a call is received. Reports are reviewed and screened by local county staff. In the case of a call determined to be an emergency, hotline staff make phone contact with the on-call caseworker in the local area.

BCF also has a centralized Institutional Investigative Unit (IIU), staffed by one CPS supervisor and nine CPS workers, that is responsible for investigating reports of abuse and neglect of children in institutions, including: 1) foster care homes for both DHHR and specialized foster care agencies, 2) child care centers and other licensed child care settings, 3) all residential group care treatment facilities in the state where foster children are placed, 4) all Department of Juvenile Services residential settings, and 5) public schools. For out-of-state facilities, the IIU works with investigators where the reported abuse or neglect takes place and monitors actions taken by the local authority.

In FY 2012, BCF received 34,790 referrals of suspected child abuse and neglect (this does not include adult protective services referrals).

Findings

BCF has a highly fragmented and top-heavy administrative structure making it very difficult to develop and implement cohesive, effective and consistent expectations, policies, and training, especially for CPS workers. There is no central chain of command for child welfare services, with responsibilities for distinct program components divided among various offices and divisions within BCF. Local CPS workers are supervised by 30 different community services managers, responsible for a full array of Bureau services, who in turn report to four different regional managers. Policy development and training is implemented by an entirely different chain of command.

As a result, performance, procedures, and response to referrals of claims of abuse and neglect vary significantly among regions and field offices. That has contributed to a questionable record of performance, including the following indicators;

- Very low federal reimbursements for children in foster care (this is addressed in a separate section of this report).
- Ineffective accountability and oversight of state general funds for the Socially Necessary Services (SNS) and special medical card programs (this is also addressed in a separate section of this report).

- High turnover and resulting inexperience of CPS caseworkers.
- Overuse of out-of-state placements for children (this is also addressed in a separate section of this report).
- Significant variances in the handling of referrals for child abuse and neglect.
- Poor communication with judges and the West Virginia court system, which results in judges making decisions from the bench that adversely impact revenue and spending for the state of West Virginia.

Extensive interviews and communication with staff in DHHR and a review of data from DHHR reveal these concerns, which are often attributed to CPS caseworkers having excessive caseloads (a completely unsupported claim which is addressed in a separate section of this report).

By reorganizing BCF around professional responsibilities, DHHR will create cohesive accountability and more consistent outcomes by combining policy, training, and local CPS caseworkers under one office. As shown in the before – and-after organizational charts below, this will be accomplished by:

- Splitting the existing Office of Field Operations into two offices: Office of Children and Adult Services and Office of Family Assistance.

- Eliminating the Office of Programs and moving the five divisions within the Office of Programs into these two new offices.

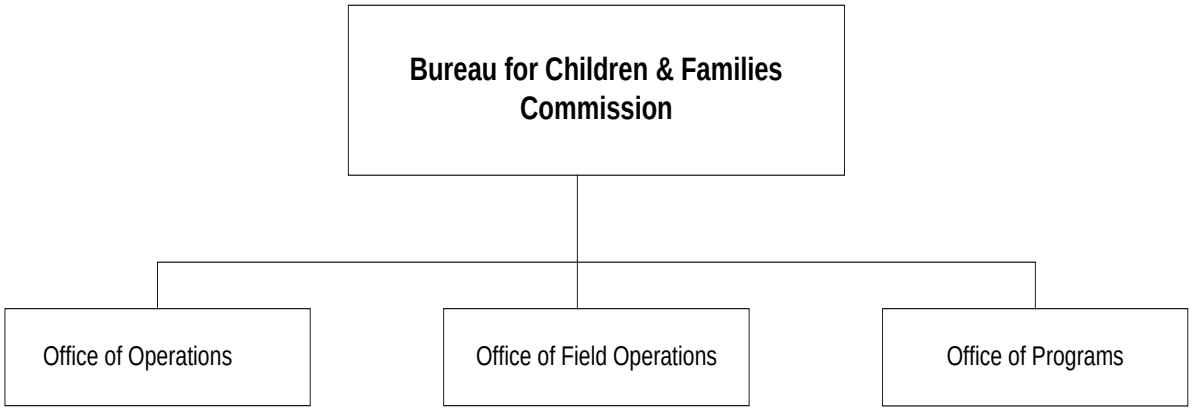
- Move the Division of Children and Adult Services under the new Office of Children and Adult Services.

- Move the Division of Family Services under the new Office of Family Services.

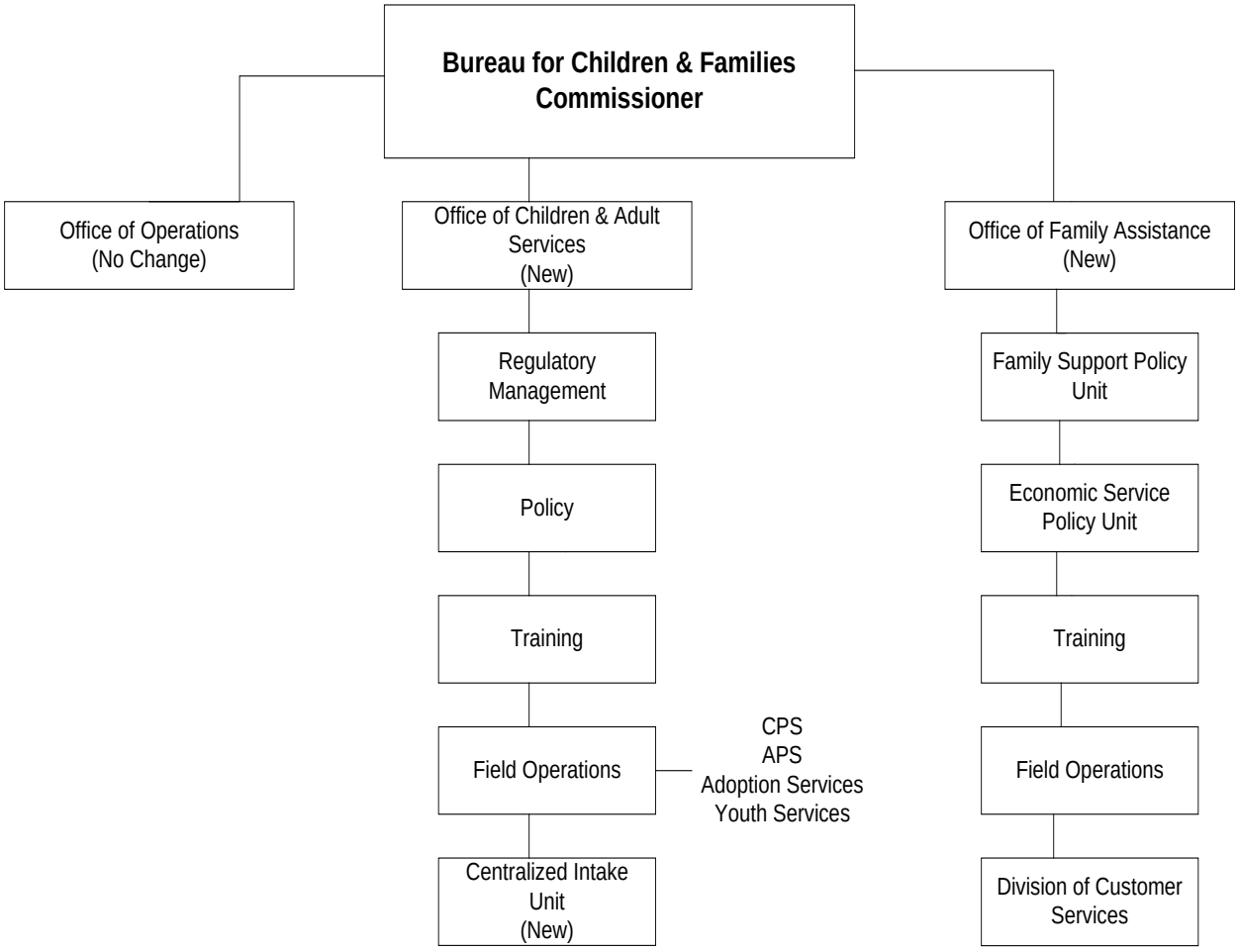
- Divide the Division of Training, which includes 55 training staff already divided into Family Assistance and Children and Adult Services into each of the respective new offices.

- Move Early Care and Education and Headstart State Collaborative to the Office of Family Assistance.

Current BCF Organizational Structure



Proposed BCF Organizational Structure



The current Associate Commissioner for Programs can be assigned to the new Office of Children and Adult Services and the current Associate Commissioner for Field Operations can be assigned to the new Office of Family Assistance. No net increase in staff is necessary, and some positions can be eliminated through attrition: unfilled CPS caseworker positions (discussed below) and the elimination of administrative positions in the field offices (discussed elsewhere in this report).

Staff throughout these new offices will need access to real-time budget and financial information to monitor spending, vacancies, etc, in order to effectively manage state resources.

Recommendation

DHHR should reorganize BCF to create direct reporting relationships for professional staff and create cohesive accountability for outcomes by combining policy, training, and field staff in a single division.

Estimated Savings/Revenue

There would be no direct savings from this reorganization of BCF, but efficiency improvements could allow savings from reductions in administrative and caseworker positions (see separate discussion below) and would allow BCF to increase and maintain increases in federal Title IV-E revenue.

Issue Statement	BCF should implement a centralized intake system for child abuse and neglect referrals.

Background

The state currently has a $509,875 contract with a vendor to answer a toll-free number and enter child and adult abuse and neglect referrals into the state's FACTS system. Some of the concerns with the current arrangement of contracting CPS and APS calls include:

- Hotline staff enter referrals for child abuse and neglect into FACTS; no screening or assessment is done. In an emergency situation, hotline staff contact local, on-call caseworkers by phone or pager, otherwise the referrals are assessed by local CPS caseworkers the next business day.

- Hotline employees are paid less than state CPS caseworkers and many do not have the same licensing requirements; some positions require only a high school education.

- The state cannot distinguish between records created in FACTS by hotline employees and by state employees. While the vendor keeps a log of calls by type, this information is not sufficient to determine the workload statistics of the hotline vendor or any of the individual hotline employees.

- Every referral entered into FACTS by hotline staff must be screened by a state CPS caseworker to assess whether or not the referral warrants an investigation or other follow-up.

- The hotline vendor is required to keep a log of complaints. Logs from FY 2012 show 63 complaints, some of which are complaints by hotline staff and some are complaints about hotline staff. The latter include failure to collect essential information from callers such as a phone number or address and incomplete information entered into the FACTS records.

The hotline vendor has a total of 13.5 FTEs: 6.5 telephone operators for the evening shift, 2.5 for the overnight shift, and 4.5 for the day shift when local field offices are also taking calls. There are currently 38 vacant state CPS caseworker positions, and as will be discussed in a separate section, caseloads for caseworker positions are relatively low. The vendor's assignments can be performed by BCF staff within current resources, providing better-trained, more uniform, and more responsive service.

Each local office currently takes calls for its county. If calls are received in a centralized office, caseworkers will be able to focus on their caseload without having to answer and prioritize referrals. Centralizing intake and assessment will result in more consistency in screening and assessment across the state.

Recommendation

BCF should cancel the vendor contract for child and adult abuse referrals when it expires in June of 2013, and create its own centralized intake system.

Beginning April 1, 2013, the new Office of Children and Adult Services should begin receiving the calls currently answered by the hotline vendor, screening them, and making assignments to caseworkers for investigations and appropriate follow-up.

Savings/Revenue Estimate

Not renewing the statewide hotline contract will result in a savings of $509,875 per year. Additional savings related to CPS services are identified below.

	State	Federal	Total
Year One	$318,672	$191,203	$509,875
Five Years	$1.6 million	$956,000	$2.6 million

Note: The exact federal share is not known at this time. We use 37.5 percent based on the split of state/federal funds for Personnel Services in the department-wide budget.

Issue Statement	BCF should revise staffing and caseload assignments to more efficiently deploy staff around the state.

Background:

In interviews, West Virginia CPS caseworkers and administrators have often complained of excessive caseload burdens exacerbated by high turnover and a relatively large number of unfilled positions. The same factors were also cited as making additional improvements in services and efficiency impracticable.

Findings:

In fact, West Virginia has very low caseloads per caseworker, as compared to the Child Welfare League of America's[80] recommended standards of no more than 12-15 children per caseworker. As shown below, BCF Child Protective Services caseloads are about 13 cases per line staff. Caseload data provided by BCF show caseloads at 10 per caseworker, however those calculations include vacant positions; the table below shows only filled positions.

The information below does not include the following filled positions: 87 CPS Supervisors who may handle high-profile cases or assume a caseload in the absence of a caseworker, 66 CPS Worker Trainees, or 79 Health and Human Services Aids who assist CPS with in-home services and other duties.

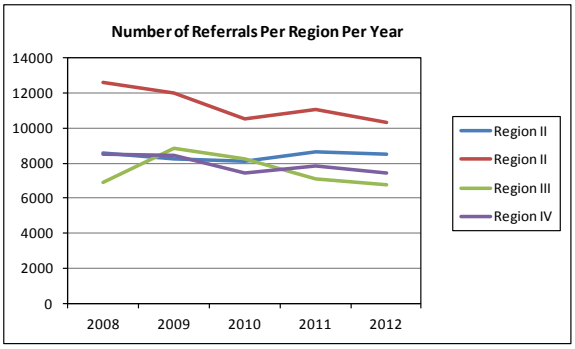
BCF Region	Total Caseload	Number of Filled Staff Positions	Average Caseload	Vacancies	Vacancy Rate
REGION I	1,123	91	12	9	9.00%
REGION II	1,341	98	14	10	9.26%
REGION III	605	51	12	5	8.93%
REGION IV	1,425	94	15	12	11.32%
STATE AVERAGE	**4,494**	**334**	**13**	**36**	**9.73%**

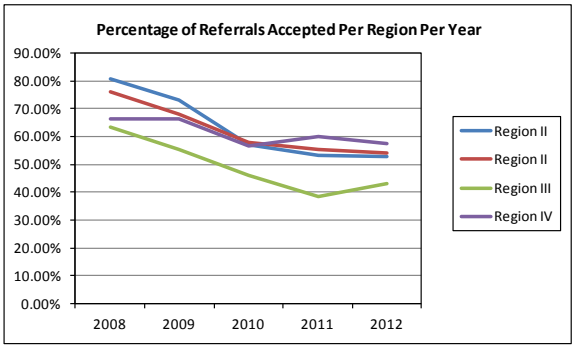
The caseload calculations in the table above consider only filled positions, illustrating that caseloads for CPS caseworkers are well within recommended guidelines, even with considerable vacancies within the department. If all budgeted CPS caseworker positions (adding vacant positions to the filled positions shown above) are considered, caseloads would decrease to an average of about 10 per CPS caseworker. In addition, CPS caseworkers receive assistance from 79 Health and Human Service Aids, which keeps the already low caseloads in West Virginia at very manageable levels. Despite these low caseload volumes, West Virginia has a CPS caseworker turnover rate of 36 percent, comparable to Texas, Arizona, and Florida, where caseloads range from 30 to a high of 50.

Salaries in West Virginia are also cited as problematic, but the average salary for a caseworker in West Virginia is $33,680. While salaries can continue to be reviewed, there are a number of organizational initiatives that can be implemented to improve staff retention.

On a closely related issue, the ratio of caseworker supervisors to caseworkers is relatively low at 1 to 4 in West Virginia, as compared to the Child Welfare League recommended ratio of 1 to 5. CPS supervisors in West Virginia are not assigned a caseload, but may carry a caseload or manage a case due to vacancies or absences within their local field office. Moving two of these positions to the proposed centralized intake unit and bringing the West Virginia ratio up to 1 to 5 would provide a savings to the state equal to the cost of reducing the number of supervisor positions by 16. Two of these positions are currently vacant and the remainder can be eliminated through attrition.

The variance in workload among field offices in the four regions is illustrated in the charts below, which show the number of referrals (claims of child abuse and neglect that must be screened by a caseworker) per region per year and the number that were accepted for investigation after review. The number of referrals accepted for investigation has decreased more steeply from 2008 to 2012 than the number of referrals. Referrals accepted for investigation in 2012 vary widely by county and counties that receive fewer referrals have a wider variation in acceptance rates; acceptance rates vary from a low of 24.56 percent (based on 69 referrals) in Barbour County to a high of 79.29 percent (based on 140 referrals) in Calhoun County. Counties that received more than 1,000 referrals in 2012 had a smaller range of acceptance rates – between 50 percent to 60 percent.





Recommendations

BCF should eliminate 23 of the vacant CPS caseworker positions through attrition.

BCF should eliminate 18 CPS supervisor positions through attrition.

Estimated Savings/Revenue

Eliminating 23 vacant CPS positions at an average annual salary of $33,680 and assuming 42.62 percent in benefits ($48,034 each position total) would result in annual savings of $1.1 million.

Eliminating 16 CPS supervisor positions at an average annual salary of $41,969 and assuming 42.62 percent in benefits ($59,856 each position total) would result in annual savings of $957,700.

Not renewing the statewide hotline contract will result in a savings of $509,875 per year.

	State	Federal	Total
Year One	$1.6 million	$975,00	$2.6 million
Five Years	$8 million	$4.9 million	$12.9 million

Note: The exact federal share is not known at this time. We use 37.5 percent based on the split of state/federal funds for Personnel Services in the department-wide budget.

Issue Statement	BCF should reduce the administrative layers in its field office operations.

Background

BCF County offices are currently managed by the Office of Field Operations (note earlier recommendation for reorganization of BCF to separate field operations into Offices supplying Child and Adult Services and Family Assistance). Aside from dealing with child and adult abuse issues, these county offices help families apply for burial assistance, disaster assistance, emergency assistance, Medicaid, refugee resettlement, school clothing allowance, supplemental nutrition assistance, transportation assistance, West Virginia Healthy Families Initiative, and WV Works (TANF).

Most of the staff in BCF (93 percent, or 2,233 positions) are assigned to the Office of Field Operations, which oversees the 55 county field offices and four regional administrative offices throughout the state.

Findings

While each of the 55 counties in West Virginia has a field office, some of the field offices are combined administratively into "districts" of 2, 3, or 4 counties supervised by one community service manager. There are currently 30 districts. Other than sharing the Community Service Manager, each county office retains individual responsibility for accounting, purchasing, operations, human resource, and other administrative functions. There are also instances where county offices are staffed by only one or two workers.

- One county office has only two Economic Service Workers who determine eligibility for a number of programs and two office assistants.

- Another county office has only two Economic Service Workers and one office assistant.

There are 245 administrative positions (including accounting, administrative, and office assistant positions) in the regional field offices, 15 administrative positions in the four regional directors' offices, and 41 administrative positions in the central Bureau for Children and Families office. The chart below shows the distribution of positions within the Bureau.

The administrative FTEs are in addition to 83 budgeted Health and Human Resources Aid positions, nearly three per district, that were created to provide support to CPS caseworkers; these positions may also support other professional staff within the field offices, but are not included in the administrative positions shown in the table below.

BCF Division	Total Positions	Total Administrative Positions	Ratio of Administrative to Total Positions
Bureau/Central Offices	176	41	23%
Region 1 Director's Office	12	3	25%
Region 1 Field Offices	541	64	12%
Region 2 Director's Office	15	5	33%
Region 2 Field Offices	695	73	11%
Region 3 Director's Office	11	4	36%
Region 3 Field Offices	385	46	12%
Region 4 Director's Office	12	3	25%
Region 4 Field Offices	562	62	11%
Total	**2,409**	**301**	**12%**

The highly de-centralized organization of BCF results in a host of avoidable problems. The complexity, duplication and time-consuming efforts needed to process personnel actions is particularly troubling in an organization that reports high staff vacancy and turnover rates. Each county office is responsible for initiating each WV11 personnel action form. Approximately 4,000 forms are processed yearly; Region 2 has the largest number -- processing 1,200 of these forms each year. Forms are prepared manually by field office administrative staff, sent to the regional office for review and entry into the electronic personnel action system, and tracked through multiple reviews and approvals up through the department.

Because the reorganization of BCF recommended above will reduce the span of control of the community service managers (CSMs) who manage the 30 local district offices, there may be opportunities to further consolidate individual county offices into districts and reduce the number of CSMs.

Recommendations

BCF should reduce the layers of administrative positions within the Office of Field Operations. This can be accomplished by:

- Consolidating back office functions to streamline handling and reduce delays in processing of administrative documents and payments and allow specialization among regional staff.

- Eliminating two administrative positions in each of the 30 district offices to reduce administrative personnel by 60 FTEs, bringing the number of administrative positions from eight per district to six per district.

- Reorganizing administrative responsibilities so that regional office staff specialize in different administrative functions – human resources, purchasing, financial management, etc. DHHR can continue to support remote processing through its current information technology capabilities.

- Establishing a direct reporting relationship between administrative staff in field offices to regional staff by function.

- Organizing administrative field office staff by function to support multiple field offices where possible. There are instances where one county field office could provide human resource or purchasing or financial support to multiple field offices. Having these staff report directly to regional staff could establish clear lines of authority and responsibility.

- Reducing the number of administrative positions in the field offices by 60 positions. Of these, 17 are currently vacant and the remainder can be eliminated through attrition. Vacant positions are used to fund overtime, but there is sufficient staff to perform necessary functions.

Estimated Savings/Revenue

Reducing 60 administrative positions (through attrition) would save approximately $1.9 million per year. Field administrative FTEs make an average of $22,658 in salary; assuming 42.62 percent in benefits annually ($32,315 per position total) would provide $1.9 million in annual savings and result in 5-year savings of $9.7 million.

	State	Federal	Total
Year One	$1.2 million	$712,500	$1.9 million
Five Years	$6 million	$3.6 million	$9.6 million

Note: The exact federal share is not known at this time. We use 37.5 percent based on the split of state/federal funds for Personnel Services in the department-wide budget.

Issue Statement	The work group established by DHHR to design and implement plans to increase the IV-E penetration rate should report directly to the Secretary of DHHR and be tasked with taking immediate steps to increase claiming of federal funds.

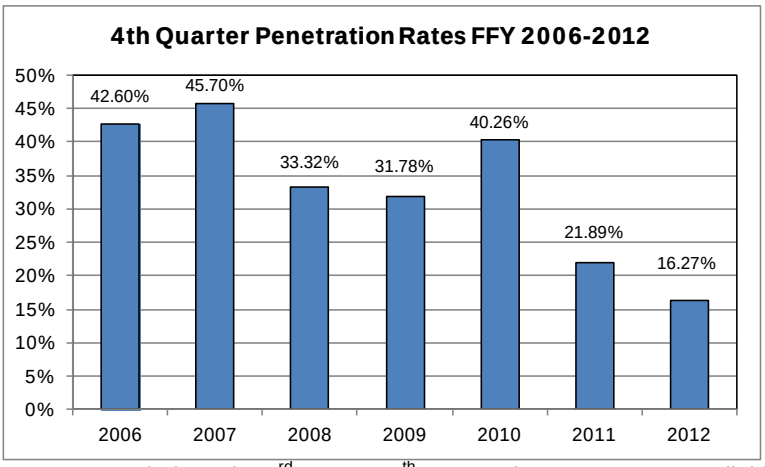
Background

States are able to claim federal Title IV-E funding for eligible children in foster care who are in qualified foster care placements. The federal matching rate ranges from 50 to 83 percent depending on a formula that considers the state's per capita income. The FFY 2012 rate in West Virginia is 72.62 percent.

The percentage of foster care children within a state who are determined eligible for Title IV-E funds is considered the "penetration rate." In 2010, the national average for the percentage of children in foster care who are eligible for Title IV-E funds was 49 percent.

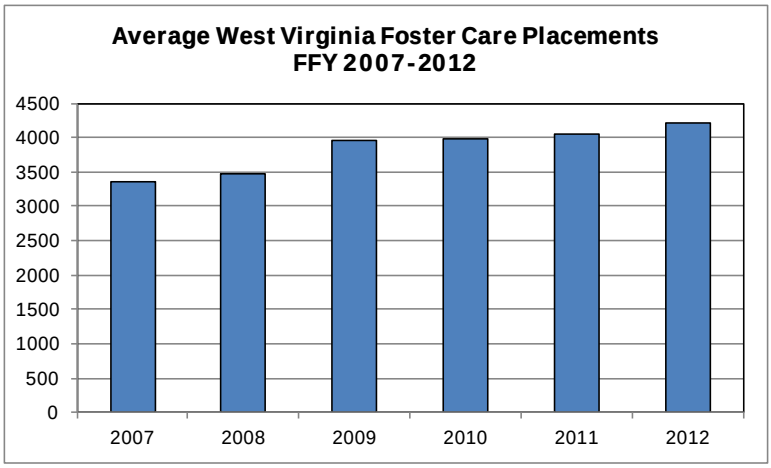
Findings

West Virginia currently has a penetration rate of 16.27 percent; down from just over 40 percent in 2010. As shown below, the rate has fluctuated over the last seven years, however has dramatically declined in the last two.



Note: 2012 rate is from the 3rd quarter; 4th quarter data was not yet available.

The percentage of children determined eligible for Title IV-E has decreased significantly as the number of children placed in foster care has increased over the last six years.



To assist the state in assessing the causes for this decline, the Annie E. Casey Foundation reviewed DHHR's current process for claiming and submitted a report in April 2012 that contains 44 recommendations that should be implemented to increase federal Title IVE claiming. Many of the recommendations are focused on policy changes within BCF and some require changes to FACTS, the automated system for tracking children in foster care. In some cases, state policy is more restrictive than federal policy. For example, West Virginia requires foster families to complete 20 hours of training before becoming licensed, which is not mandated at the federal level. Federal requirements focus on safety, such as conducting background checks, to ensure that children are placed in safe and secure homes.

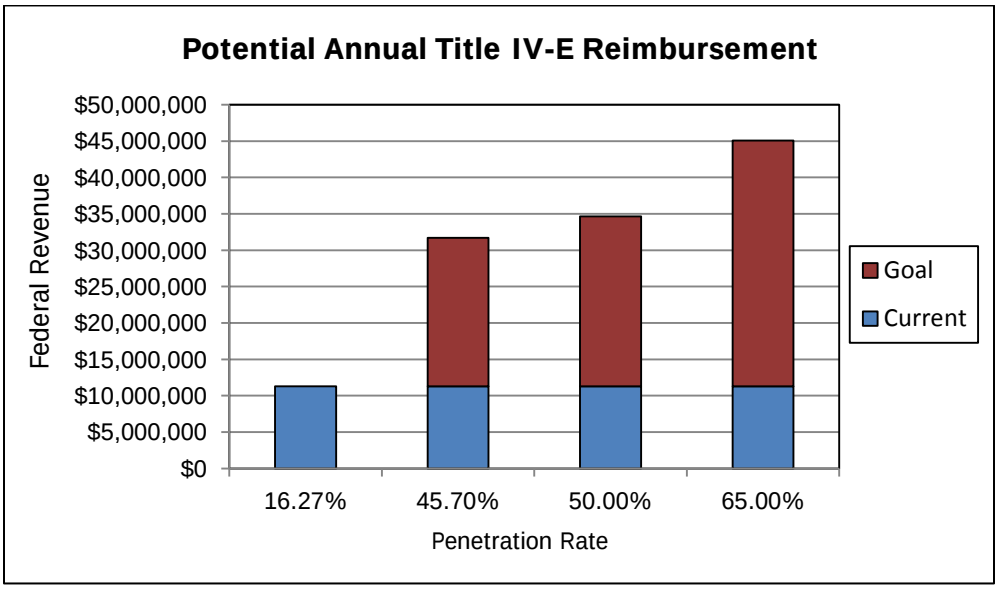
West Virginia also has a practice of verifying parent income for the purposes of eligibility; which is not required by federal policy. Some states use a declaration form that the court requires parents to sign as a sufficient indicator for determining eligibility. Other recommendations in the Casey report are related to cost allocations, calculations, and the language in court orders.

The Casey assessment also found that a considerable amount of information is available from the FACTS system to guide policy and management decision-making related to Title IV-E eligibility. This information, however, is not regularly reported or reviewed.

DHHR and BCF are aware of the decrease in federal match claims and recently formed a work group to address foster care issues. The work group should be aggressive in addressing each of the recommendations in the Casey report, and should disregard specious complaints that Child Protective Services (CPS) workers have excessive caseloads and cannot devote sufficient time to complete the paperwork requirements that may be necessary to increase federal claiming.

Recommendations

DHHR should establish the goal of the work group to Increase Title IV-E penetration rate to at least 50 percent (with continued target of 65 percent).



Estimated Savings/Revenue

West Virginia is currently spending approximately $95 million annually for maintenance costs for the 4,191 children in foster care at an average rate of $62.42 per day. With the current penetration rate of 16.27 percent, West Virginia receives $11million in federal reimbursements from Title IV-E. If the penetration rate were 45.7 percent (which it was in Quarter 4 of 2007, the highest rate since 2006), federal reimbursements would increase by $20 million and if it were 50 percent, West Virginia would receive an additional $23 million annually.

If the penetration rate could be raised to the national target of 65 percent, the increase in federal reimbursement would be $34 million annually.

	State	Federal	Total
Year One	$23.4 million	$23.4 million	$85 million
Five Years	$117 million	$117 million	$425 million

Issue Statement	BCF should increase oversight and improve accountability in the Social Necessary Services (SNS) program to ensure that services are essential and provided in the most cost-effective manner as measured by reasonable levels of spending per family and provider.

Background

The Bureau for Children and Families provides support to biological families whose children are at risk of being removed or have been removed from the home. In addition, services are provided to children in foster care, to foster care families, and to adoptive families. Services include parenting education, adult life skills, supervised visitation, in-home services, reunification services, drug-testing, and transportation reimbursement to providers and families to facilitate the delivery of services.

This program, known as Socially Necessary Services (SNS), provides services to families either directly by BCF CPS caseworkers or through contracts with providers throughout the state. These contracted services are funded by a combination of state general revenue funds and federal funds through the Title IV-E and Title IV-B programs.

As noted earlier, federal Title IV-E funds are available to states to support children in foster care. Federal Title IV-B funds are provided to states for programs directed toward the goal of keeping families together. They include preventive intervention so that, if possible, children will not have to be removed from their homes. If this is not possible, children are placed in foster care and reunification services are available to encourage the return of children to their families. Services are available to children and their families without regard to income. Each state receives a base amount of $70,000 and additional funds are distributed in proportion to the state's population of children under age 21 multiplied by the state's average per capita income. The West Virginia federal matching rate for Title IV-B is 73.89 percent.

As part of the administration of the SNS program, BCF enrolls providers in a process similar to that used for Medicaid. Enrollment is processed by BCF, entered into the FACTS system, and APS, the vendor that provides utilization management and prior authorization services for Medicaid as well as other state programs, is notified that the provider is enrolled. BCF maintains a Utilization Manual that lists the types of services that may be provided through SNS and what the state will reimburse for those services. There are currently about 1,800 providers enrolled in the SNS program throughout the state.

In addition to the SNS program, West Virginia has a special medical card process to pay for medical services for relevant families who are not eligible for Medicaid. These services are authorized by CPS caseworkers in BCF, with the payments reviewed by APS, and paid by BMS.

West Virginia has requested technical assistance from the National Resource Center for Youth Development (NRCYD) and the National Resource Center for In Home Services to assess the status of in-home services provided throughout the state and to identify areas of success and improvement. BCF staff met with these organizations in December 2012 and will continue to work with them in 2013. This workgroup is focused on determining whether in-home services provided to families are meeting the intended goals. Some of the challenges identified include confusion about eligibility for services and lack of consistency in service provision across the state.

Findings

The state general fund pays about 75 percent of the $16 million average SNS expenditures each year. Total funding and the state general revenue portion have remained about the same since 2008. In FY 2012, SNS expenditures were $16.9 million and the services provided were:

- Parenting skills and adult life skills training: $6.4 million.
- Transportation: $4.2 million.
- Supervised visitation: $2.1 million
- Reunification support, respite services, safety services, and other services: $4.2 million

About 25 percent of SNS expenditures are for transportation, paid to families directly as well as to service providers. In addition to the fee charged for the unit of service, providers may also invoice for mileage reimbursement and travel time to and from service locations. This practice was instituted as a way to increase payments to providers who argued that service payment amounts were too low. Rates for SNS services are established in the SNS Utilization Manual. A BCF workgroup is currently working on recommendations for changes to the rates; the issue of payments to providers for mileage reimbursement and travel time should be included in the deliberations.

There is some indication that services provided through SNS may overlap and duplicate the services provided to families through Title IV-E. SNS services can be arranged by field staff or may be court-ordered. While some court-ordered services may not be required from a professional social worker assessment, the services must still be provided. More importantly, however, CPS workers and supervisors can order these services without regard to cost. Staff and supervisors have no access to utilization data and costs to determine if or when spending is exceeding budget levels.

BCF has a contract with APS for nearly $350,000 to monitor and review the services provided through the SNS program. APS reviews providers every two years unless there is a complaint about a provider. APS investigation reports are reviewed by BCF staff on a monthly basis, however. As the final decision-makers, field staff can permit low-performing providers to continue to provide services with no consequences.

West Virginia employs 574 CPS caseworkers, supervisors, trainees, and health and human resources aides who provide services to these families at a cost of $18.7 million

annually. If vacant positions are considered, there are 627 child welfare workers, which cost $20.4 million annually.

West Virginia spends $1.97 million annually on the special medical card program, which is funded entirely through the state general fund, and program provides medical and behavioral health services to the biological families of children in foster care that aide in reunification efforts. Medical services may also be authorized for foster parents. CPS caseworkers may only authorize services from a specific menu of services and the authorization is approved by their supervisor. The costs of these services are based on comparable Medicaid rates. The issues related to accountability for SNS services are also applicable to this program and include concern that BCF field staff authorizes services without regard to cost and BMS pays for the expenditures.

Including staff resources, SNS expenditures, special medical card expenditures, and the contract with APS to monitor the SNS program, BCF is spending almost $40 million annually on in-home and supportive services to biological, foster, and adoptive families. This is approximately $9,905 for the biological, foster, and adoptive families of each of the approximately 4,000 children in foster care in West Virginia. Oversight and accountability of those funds is not sufficient to ensure that the services are essential, that they are provided in the most cost-effectiveness manner, and that costs per family and payments per provider are reasonable and similar across the state. Caseloads in CPS are relatively low, giving BCF the capacity to provide some of these services directly rather than through contracted providers.

Existing policies and procedures for the use and authorization of SNS and special medical card expenditures are outdated and insufficient for providing guidance to caseworkers.

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Recommendation

BCF should assign the authority for monitoring and overseeing SNS and special medical card expenditures to the new BCF Office of Family Assistance.

DHHR should determine the cost per family of providing support services and look at variations in expenditures among regions and district offices to establish priorities and targets for spending.

DHHR should develop clear and comprehensive policies and procedures for the authorization and review of SNS and special medical card expenditures.

DHHR should review the process for approval of SNS providers and determine participation in the program based on department policy, not individual CPS caseworkers.

DHHR should ensure that program managers and employees in the field are accountable for the expenditures for these services, through real-time

budget and financial information. Budget limits should be established for each region and/or district office.

The menu of services and reimbursements to SNS providers should be reviewed and updated.

Estimated Savings/Revenue

It is unclear from existing data whether or not the expenditures for SNS and the special medical card expenditures are appropriate or cost effective. It is reasonable to expect that savings in the program can be achieved through improved oversight and management of the program. Additionally, DHHR must ensure that all federal funds are being claimed.

If these improvements can save 10 percent of current expenditures, the state would save $3.3 million

	State	Federal	Total
Year One	$4 million		$4 million
Five Years	$20 million		$20 million

Issue Statement	The Bureau for Children and Families should reduce out-of-state placements of children and build the capacity for the services required within the state.

Background

In West Virginia, more than 1,300 children each year are placed in out-of-state care because appropriate placements or facilities are not available in-state. The cost to the state was just under $27 million in FY 2012. The most common temporary placements for children out-of-state are group residential care, long-term psychiatric care, and temporary foster family placements.

A Commission to Study Residential Placement of Children is in place, originally created by an act of the 2005 West Virginia Legislature (HB 2334) designed to achieve systematic reform for youth at risk of out-of-home residential placement, and to establish an integrated system of care for these youth and their families. In 2010, the Legislature passed SB 636 to reconstitute the Commission This bill includes responsibility for addressing any other issues related to foster care placement and requires a reduction in out-of-state placements.

Findings

Since 2010, an average of 1,364 children are placed in out-of-state care annually as shown in the table below.

Number of Children in Out-of-State Placements at Some Point During the Fiscal Year

Provider Type	FY 2010	FY 2011	FY 2012
Department Adoptive Home	658	677	696
Group Residential Care	478	411	388
Psychiatric Facility (Long Term)	131	130	126
Temporary Foster Family Care	92	72	85
Therapeutic Foster Care	29	33	28
Kinship/Relative	16	10	8
Psychiatric Hospital (Short Term)	3	0	3
Medical Hospital	2	2	2
Transitional Living Client	2	4	2
Interstate Compact for the Placement of Children (ICPC)	0	1	1
School For Children with Special Needs	1	0	0
Grand Total	**1,412**	**1,340**	**1,339**

With the exception of adoptive homes, the placements shown in the table above are intended to be temporary placements for children. When children are placed outside the state, distance can make it difficult for families to maintain contact with their children.

Each year, West Virginia spends approximately $27 million on out-of-state placements as shown in the table below.

Payments for Out-of-State Placements for Children

Provider Type	FY 2010	FY 2011	FY 2012
Department Adoptive Home	$3,991,263	$4,274,934	$4,473,350
Group Residential Care	$20,420,631	$18,525,942	$18,337,959
Psychiatric Facility (Long Term)	$1,840,798	$1,968,129	$2,728,955
Temporary Foster Family Care	$340,225	$259,307	$298,547
Therapeutic Foster Care	$727,754	$844,458	$665,785
Kinship/Relative	$6,901	$5,789	$7,893
Psychiatric Hospital (Short Term)	$9,633	n/a	$736
Medical Hospital	$54,686	$244,395	$208,831
Transitional Living Client	$5,544	$18,525	$8,200
ICPC	n/a	$4,770	$4,471
School For Children with Special Needs	$4,486	n/a	n/a
Total	**$27,401,919**	**$26,146,248**	**$26,734,726**

On January 4, 2012, state automated records indicated that there were 116 residential placements beds available in West Virginia, a combination of levels I, II, III, emergency shelter and psychiatric beds. The reasons for the number of out-of-state placements is complex and includes the following:

- The available beds in West Virginia may not meet the needs of the child being placed.
- Some parts of West Virginia border neighboring states, and a “community” placement may actually be just across the border.
- Courts may order placements in specific facilities.
- Caseworkers may not be knowledgeable about in-state placements that are available.
- Large out-of-state facilities aggressively market their services and small, independent facilities in West Virginia have a hard time competing

There is a voluntary review process for considering whether an out-of-state placement is necessary. This is funded as part of five System of Care general fund contracts totaling $519,000

The System of Care grant funds a reviewer in each of the four regions, plus two statewide program coordinators. While the review process is available to caseworkers, the review is non-mandatory and the results of the review are non-binding. These contracts were put in place in FY 2008 and have not reduced the number of out-of-state placements.

One of the issues with out-of-state placements is reviewing and monitoring providers. BCF has a licensing and monitoring staff for in-state facilities. In 2010, this staff began on-site visits to out-of-state providers to ensure that they were meeting West Virginia standards. Monitoring staff conduct five out-of-state reviews each fiscal year. Reviews

have resulted in recommendations against placing children in particular out-of-state facilities, but there is no formal process for preventing placements. In one case a specific facility circumvented a recommendation against placements by changing its name and marketing its services to BCF staff.

In another case, an out-of-state facility was found to be providing only Level 2 care when the state was paying for Level 4 care. No changes have yet been made to reduce the payments to the facility based on the finding.

A Commission composed of BCF staff, judges, education representatives, parent advocates, and providers meets quarterly. Recent actions by the Commission have included automating the referral process and initiating the out-of-state facility reviews. The 2010 legislation creating the Commission required the reduction of out-of-state placements by 10 percent in the first two years and 50 percent by the third year; these goals have not been met.

Recommendations

DHHR should implement a formal process for reviewing each out-of-state placement before the placement occurs and at regular intervals after placement.

DHHR should educate caseworkers about options for in-state placement, and take action to prevent placements and payments to out-of-state providers when issues are identified. Data currently is available to identify areas where more out-of-state placements are occurring and this should be used to hold staff making decisions in those areas accountable for reducing these placements.

BCF should not renew the $519,000 in contracts with outside providers for the System of Care program when it expires at the end of FY 2013 and task the new Office of Children and Adults Services in BCF with this responsibility.

Estimated Savings/Revenue

While this recommendation will not reduce the number of children in need of services, the funds expended by the state will remain within West Virginia and provide economic benefits to the state, and in-state placements are estimated to be about 30 percent less costly than similar out-of-state levels of care. This recommendation will also facilitate family communication and reunification by providing placements for children closer to their families.

Not renewing the contract for the System of Care will result in a savings of $519,000 to the state general fund.

	State	Federal	Total
Year One	$5.3 million	$3.2	$8.5 million
Five Years	$26.5 million	$16 million	$42.5 million

Note: The exact federal share is not known at this time. We use 37.5 percent based on the split of state/federal funds for Personnel Services in the department-wide budget.

The sum total of these recommendations for BCF will have a significant impact on the operations of the bureau and provide considerable opportunity for savings and improved services. In order to ensure plans move forward, we recommend that the department establish special reporting requirements during a one-year transition period to track progress in each of the following areas:

- Reducing staff turnover.
- Filling vacancies more quickly.
- Increasing Title IVE revenue.
- Reducing out-of-state placements.
- Implementing centralized intake.
- Developing an appropriate budget and policies for the SNS and special medical card program.
- Improving relationships with judges and providing on-going education and information to the court system on the cost impact of decisions made by judges.

With low caseload volumes, West Virginia is in a unique position to take advantage of the opportunity to improve revenue, efficiencies, accountability, and oversight of child welfare functions without additional resources. The recommendations for BCF will allow better deployment of resources in the field and ensure that caseloads remain even throughout the state.

2.5. Bureau for Behavioral Health & Health Facilities

The Bureau for Behavioral Health and Health Facilities (BHHF) administers West Virginia's community-based mental health, substance abuse, developmental and intellectual disabilities services. In addition, it runs the state's four long term care facilities, a community hospital that has a long term care unit, and two acute care facilities for individuals diagnosed with severe mental health and/or substance abuse disorders.

West Virginia's publicly funded community-based behavioral health system is composed of thirteen regional Comprehensive Behavioral Health Centers (CBHCs) which serve the state's 55 counties. BHHF is responsible for services funded through the state's General Revenue Fund and the federal Substance Abuse and Mental Health Services Administration (for individuals who are not eligible for Medicaid-funded services). In Fiscal Year 2012 BHHF had a total budget of almost $288 million and 1,868 FTEs, 30 percent of the total DHHR staff.

FY 2012 BHHF Budget and FTEs

	Budget	FTEs
Central Office/Community Programs	$157,626,465	86 (Central Office only)
State Facilities (7)	$128,744,138	1,782
Total	**$285,744,138**	**1,868**

The seven state facilities which are the responsibility of BHHF are located around the state, and account for 95.6 percent of BHHF staff and 45 percent of its total budget. The remaining BHHF budget includes staffing and operations of Central Office functions and funding of community-based programs.

Issue Statement	West Virginia should increase opportunities to more effectively integrate behavioral health care and primary care.

Background

Evidence shows that health outcomes improve when behavioral health care is more effectively integrated with primary care. Behavioral health conditions, such as depression and anxiety, can negatively impact an individual's ability to cope with chronic conditions like diabetes or heart disease. Conversely, physical illnesses and conditions can lead to or exacerbate mental health conditions; an adverse health event is associated with a three-fold increase in the likelihood of an individual visiting a provider or being prescribed medication for a mental illness.[81] Research shows that when both behavioral health and physical health needs are met, health outcomes improve and costs are reduced.[82,83]

There are different ways to integrate primary care and behavioral health. Integration can be at the **financial** level, by consolidating payments for behavioral and primary care services occurring on the same visit; on the **structural** level, by co-locating services or providing them under the same umbrella of an organization; and on the **clinical** level, integrating services for a patient at the actual point of care.[84]

The ultimate goal of primary care and behavioral health integration should be clinical integration the consumer can actually experience; this typically needs to be supported by financial and structural mechanisms.[85]

At the clinical level, there are existing tools and models for health care providers wishing to improve integration of primary care and behavioral health, and it is important to maximize opportunities for prevention and treatment to take place regardless of setting. For example, more primary care providers are integrating behavioral health care services into their practices,[86] and conversely, behavioral health care providers are integrating more primary care services into their practices.[87] These models make it easier for individuals to get the care they need regardless of the type of setting they seek out first – reducing duplication, wasted time, and wasted effort on the part of patients, families, and providers.

Findings

The distribution of West Virginia's population through rural and mountainous areas, with many residents in remote locations, presents challenges in providing access to health, behavioral health and social services. The integration of behavioral health care with primary care not only can improve outcomes for individuals, but also presents an opportunity to reach more people through the use of one location for both services. Educating physicians and other primary care providers in identifying potential behavioral health needs, and having behavioral health professionals accessible on site, can reduce the need for later crisis intervention, improve health outcomes for those with chronic conditions, and can ultimately help reduce the number of admissions to more restrictive and costly care settings for those with severe conditions.

Federal funding opportunities for integration of primary care and behavioral health currently exist through the federal Substance Abuse and Mental Health Services Administration. West Virginia is already taking a step towards improved integration through its State Plan Amendment (SPA) for health homes focusing on individuals with bipolar disorder who are at risk for Hepatitis C (in a limited number of counties). These two conditions were found to be co-occurring at high rates and were among the most expensive conditions. The Bureau for Behavioral Health and Health Facilities also has pilot-tested a core set of performance measures for substance abuse treatment and prevention for use in publicly-funded and commercially-insured systems of care.

Despite these initial steps, significant barriers exist to successful integration. West Virginia remains among a minority of states that does not currently pay for behavioral health services occurring on the same day as a primary care visit.[88] In addition, West Virginia behavioral health providers report challenges obtaining the necessary certificates of need to provide primary care services at their locations.

One of the more recent debates in West Virginia has centered on the question of using managed care arrangements rather than fees for service to deliver behavioral health care under Medicaid. While this approach can improve integrated financing for behavioral health and primary care services, providers have raised concerns that it would boost administrative costs while reducing their own fees, without necessarily increasing opportunities for integration at the point of care. Simply enrolling people in managed care rather than fee-for-service, without appropriate quality measures, safeguards, and oversight, will not necessarily accomplish the goal of care integration; nor will allowing the current fee-for-service system to continue without appropriate measures and financing mechanisms achieve the intended outcomes of integration.

Recommendations

DHHR should make the interaction of the new Clinical and Payor Advisory Groups a priority to gather data and plan initiatives.

In 2011, the West Virginia Health Improvement Institute published a report outlining recommendations from a multi-stakeholder working group on integration of primary care and behavioral health.[89] However, much remains to be accomplished to implement the recommendations and achieve the goals outlined in the report. Given the enormous need for better integration of primary care and behavioral health that actually reaches patients, there is a strong need for transparent, goal-oriented dialogue in West Virginia involving patients, providers, and payers to identify the best financing mechanisms for improving care integration for patients. This continued dialogue should be accomplished through the interaction of new Clinical and Payor advisory councils, and supported by transparent, robust data and open stakeholder engagement with the goal of improving health outcomes.

Moreover, to improve the quality of care for patients needing both physical health and behavioral health services, West Virginia should:

- Continue to aggressively pursue the Medicaid State Plan Amendment for integration of care for individuals with bipolar disorder and hepatitis C.

- Remove barriers to co-locating primary care and behavioral health services at either primary care or behavioral health locations. In particular, West Virginia payers beginning with Medicaid should review their payment policies to ensure that financial integration of primary care and behavioral health is maximized and that individuals can access appropriate behavioral health and primary care services on the same visit, if necessary.

- Maximize the use of telemedicine for behavioral health treatment in primary care settings. Telemedicine can be a powerful tool for

connecting individuals to appropriate behavioral health care – especially in rural states like West Virginia. The West Virginia Telehealth Alliance currently is working to expand broadband connectivity throughout the state through a $9.7 million Federal Communications Commission grant, and has solicited input from health care stakeholders on the best uses of telemedicine. This is an important opportunity to maximize the use of telemedicine technology for the benefit of West Virginians with both primary care and behavioral health needs.[90]

Estimated Savings/Revenue

These recommendations will save money, however savings are not specifically identified since funds should be used reinvested in the system to support evidence-based programs for improved care.

Issue Statement	The Department should develop and implement a strategy and timeline for modifying, and eventually ending, court oversight of behavioral health services under the Hartley litigation.

Background

For over 30 years the E.H. v Matin litigation, popularly known as "Hartley", has prescribed spending in BHHF and continues to impose ongoing oversight and considerable control over key aspects of the state's behavioral health system by the West Virginia circuit court. The most recent Agreement between the plaintiffs and the Department was approved by the court in 2009. In addition to governing conditions and services in the state psychiatric hospitals, the Agreement was intended to improve access to and availability of behavioral health services in the community in order to prevent and reduce admissions to psychiatric facilities. Unlike many similar court orders or agreements of this type, the 2009 Agreement detailed the number and type of new community-based facilities to be developed, as well as staffing levels and salaries. As a result, the Department currently is committed to expenditures of over $20 million a year in dedicated state funds to develop and maintain improvements to the community-based service system.

Findings

While the intent of the Agreement was to reduce psychiatric hospital admissions and lengths of stay by improving and expanding the system of community-based treatment, this has not been the result. With few exceptions (primarily related to changes in salaries), the bureau has been able to satisfy the court that the requirements of the Agreement have been met. But psychiatric facility admissions have not declined over

that time, despite significant expenditures for expanded crisis intervention and residential services in the community.

An evidentiary hearing to determine the state's compliance with terms of the 2009 Agreement was held in December, 2011. Following the hearings, the Department submitted to the court recommended findings of fact concerning its compliance, which subsequently were accepted by the court.

Ongoing additional expenditures of more than $20 million a year specified and monitored by the Hartley court warrants an examination of why the strategies agreed upon in 2009 failed to reduce institutional admissions. Experts and practitioners in the field of behavioral health and substance abuse treatment, like those in other human services fields, continually examine and assess the most effective approaches to care and treatment. By contrast, courts generally are not equipped to determine and to continually evaluate the most effective treatment approaches, or to direct the use of resources for the best results. Consequently, prescriptive court orders or agreements, as in Hartley, restrict the ability of clinical and program professionals to use the most current best practice approaches, and to direct limited resources to those approaches shown to produce desired results.

The Department's recent track record – as evidenced by the findings of fact accepted by the court – shows a commitment to comply with the requirements of the Agreement. Yet the court has established no benchmarks for bringing its oversight to an end. The Bureau for Behavioral Health and Health Facilities needs the flexibility to determine not only why the strategies and expenditures under Hartley have failed to result in reduced hospital admissions, but to redirect funding to proven programs and strategies. The argument for flexibility – and for improved accountability – is not for the purpose of reducing spending on community-based treatment services. The administration has made a clear commitment to community-based services, and to employing effective strategies for lowering the growing human and financial costs of a steadily increasing prison and jail population, increased court-ordered commitments to psychiatric hospitals, and a chemical dependence and substance abuse epidemic. It is essential that the use of funding to address these challenges be invested in services that are shown to produce positive results.

Recommendations

BHHF should conduct an assessment of the specific programs, services and residential facilities developed in the past three years under the provisions of the Hartley Agreement and determine why they have not had the desired results of reducing hospital admissions.

The Department and legal counsel should inform the court that this assessment and analysis will be undertaken and provide a target date for completion.

The assessment should include:

- Communication with and input from stakeholders,

- A timeline for completion,
- A plan for use of findings to improve the service system.

The Governor's Council on Substance Abuse, the Strategic Plan for Substance Abuse Prevention and Treatment and the Department's imminent completion of a statewide strategic plan for behavioral health, can and should provide BHHF an opportunity to coordinate these efforts and fold the assessment of the court-ordered program expansion into their planning and implementation efforts.

Once the assessment is completed, the results should be used to formulate a request to the court for flexibility in the use of current evidence-based treatment approaches and the redirection of resources accordingly.

The Bureau also should develop and implement a detailed strategy for subsequent assessment of any program changes and redirected funding and provide the court with its findings.

BHHF and legal counsel should determine, based on the outcome of the above actions, when to petition the court for delineation of requirements and related timelines to be met in order to end the litigation.

Savings/Revenue Estimate

These recommendations will not result in less spending on community-based behavioral health services but will provide for more targeted spending on evidence-based interventions that will meet the goal of the court, BHHF and the broader behavioral health community.

Issue Statement	The work of the *Governor's Advisory Council on Substance Abuse* should be linked closely to the West Virginia *Justice Reinvestment* initiative to address needed improvements in providing community-based treatment programs.

Background

A significant number of those who populate jails and prisons around the country have a history of substance abuse and/or serious mental illness[91]. Recent nationwide studies confirm that substance abuse and mental illness are significant contributors to incarceration rates and recidivism in state and local corrections facilities[92]. Despite a steady decline in the nation's crime rate since the early 1990s, (presently at its lowest level since 1968)[93] spending on prison expansion has continued, and incarceration rates have increased, with over 1 in 100 American adults behind bars.[94] Three quarters of those released from prison have a history of substance abuse, and roughly 53 percent

meet acceptable clinical criteria for drug abuse or dependence. Over 70 percent of those with a serious mental illness are diagnosed with a substance abuse disorder [95] Studies of recidivism rates confirm that sufficient supervision and treatment upon release is essential to successful "reentry" and reduced recidivism rates, and consequently on costs to state and local criminal justice systems.

Findings

National estimates of the prevalence of behavioral health disorders in the corrections population show the following:[96]

	State Prisons	Probation & Parole	Jails
Serious Mental Illness	7%	4-5%	5%
Substance Abuse	44%	32-36%	56%
Co-occurring Mental Illness & Substance Abuse	9%	3-4%	12%

In 2011, West Virginia prisons housed roughly 6,800 inmates. In addition, over 1,700 individuals sentenced to the custody of the Division of Corrections are in regional jails. Prison commitments are rising, up 9 percent from 2007 to 2011. Over 2,800 individuals incarcerated under the supervision of the Division of Corrections were released to their communities in 2011, up from 2,406 in 2007.[97] Of these, it is projected that 30 percent will return to prison within three years, up from 20 percent in 2001.[98] Contributing to this recidivism are multiple factors, including unemployment, inadequate access to housing, continued substance abuse, probation violations, unmet behavioral health needs and lack of a natural support system.

In June of 2012, Governor Tomblin and other state leaders announced a major initiative aimed at reducing prison admissions, recidivism and spending. This effort was a result of a collaborative bi-partisan effort that included the executive, legislative and judicial branches of state government. A request was made to the Council of State Governments (CSG) Justice Center for technical assistance in using a national model recently undertaken by 16 other states. This model, *Justice Reinvestment*, was developed by the CSG Justice Center as an approach for states to address rising human and financial costs of incarceration and recidivism in a radically different way, using objective data, best practice, and broad-based stakeholder involvement.

In partnership with the Pew Center on the States and the Bureau of Justice Assistance of the U.S. Department of Justice, and working with state officials, the initiative staff has collected a significant amount of relevant data, conducted research and analysis and prepared preliminary recommendations and projected cost savings for improvements to West Virginia's system.

The most recent *Justice Reinvestment* interagency work group report recognized the work and value of the *Governor's Advisory Council on Substance Abuse*. Appointed by the Governor as part of Executive Order 5-11, this group consists of representatives of many of the same governmental entities as the *Justice Reinvestment Initiative*, and works closely with DHHR and BHHF to assess progress in implementing the state's Strategic Plan for Substance Abuse Prevention and Treatment.

The statistics cited above – and those presented recently to the *Justice Reinvestment* work group – are stark indicators that substance abuse is a significant contributor to West Virginia's increased incarceration rates and a steady recidivism rate of approximately 30 percent. As the *Governor's Council on Substance Abuse* oversees the State's implementation of the strategic plan and subsequent assessment of its effectiveness, it is essential that its work is closely integrated with the *Justice Reinvestment* initiative.

As noted earlier in this report, DHHR has missed some important opportunities and may be limiting its effectiveness as a result of overlapping efforts among bureaus and the Secretary's Office, lack of effective coordination across bureaus in addressing key health and social services needs of West Virginia's population, and potentially redundant advisory groups that may be addressing the same issues. While the *Justice Reinvestment* initiative primarily recommends reforms to state and local criminal justice systems, it provides clear evidence of the need to involve DHHR/BHHF in implementing recommended policy changes and targeting of resources to reduce the contributions of substance abuse to incarceration rates. The emphasis on using proven risk assessment tools is an opportunity for BHHF and its network of Community Behavioral Health Centers to be more involved with Corrections in providing treatment intervention before incarceration and at the point of release.

As West Virginia moves forward in using the proven strategies employed through *Justice Reinvestment*, similar research and models should be employed to address challenges in the juvenile justice system. Adult corrections trends and innovations have been studied for decades, and replication models have been developed and implemented across the country with positive results. Only in recent years, however, has research into distinct factors affecting juvenile crime and its prevention started to produce findings and descriptions of successful evidence-based approaches. These findings imply that investment and reinvestment in successful models of prevention and treatment of the causes of juvenile crime, not only improve the lives of at-risk juveniles and their families, but also improve public safety and produce significant savings in both juvenile and adult corrections spending. One study found that "The benefits per $1 invested range from $1 – $25, depending on the program"[99]

Research shows that "the number of adolescents with undiagnosed mental health disorders committed to the juvenile justice system has exploded." It is estimated that between 50 percent and 75 percent of youth in the corrections system have diagnosable mental health disorders.[100] Many of these youth have co-occurring chemical dependency or a history of substance abuse.[101]

West Virginia spends approximately $47.1 million a year on juvenile justice programs, both in community programs and maintenance of facilities around the state. Presently there are nine youth detention facilities that have an average daily population of 144. In addition, there are two correctional facilities and one sex-offender treatment program that have a combined average daily population of 171. With an average daily cost of $408, as compared to $265 for adult corrections, juvenile justice is an area ripe for examination of "reinvestment" opportunities and evidence-based approaches.

Crime, mental illness and drug dependency among West Virginia's youth affect – and will continue to affect – public safety, education, physical and mental health and employment opportunities. An approach similar to that taken recently by the *Justice Reinvestment i*nitiative for adult corrections should be employed.

Recommendations

The Governor should request formally that the Department of Military Affairs and Public Safety and the Department of Health and Human Resources – along with the Governor's Advisory Council on Substance Abuse and the *Justice Reinvestment* Work Group – jointly determine the most effective means of coordinating and collaborating in their respective efforts, and report how this will be achieved. Coordination should include:

- Sharing and use of relevant data.
- Joint discussions on the integration of policy and statutory recommendations.
- Identification of areas in which there currently are, or potentially could be, overlapping or closely related efforts and use of staff resources.
- Description in reports to the Governor of collaborative efforts, ongoing communication and information sharing.
- Development of outcome-based approaches to substance abuse treatment that reflect the findings of the Reinvestment Work Group and the Governor's Advisory Council on Substance Abuse especially related to those at highest risk of incarceration or re-incarceration.

The Bureau of Behavioral Health and Health Facilities should play a key role with the Division of Corrections in the use of risk assessment tools for determining substance abuse treatment needs.

The Governor should appoint a work group, similar that guiding the *Justice Reinvestment Initiative*, composed of key stakeholders and practitioners, DHHR and BHHF, and representatives from the Division of Juvenile Justice in the Department of Military Affairs and Public Safety. The group should be charged with developing evidence-based initiatives targeted at mental health and substance abuse issues of juveniles in the corrections system. The Governor should also charge the work group to report within a specified time line on the recommendations made and implementation progress.

Savings/Revenue Estimate

The *Justice Reinvestment* initiative will include identification of policy options for consideration and action. Those options may result in proposed legislation which would allow for implementation of changes that would improve results and lower costs. In other states that have enacted legislation as a result of the Justice Reinvestment process, projected savings over several years have been significant. Ohio is expected to avoid spending $500 million by 2015 by slowing the growth in the prison population.[102] North Carolina is expected to save/avoid costs of $290 million over six years. [103]

Similar types of savings and potential for reinvestment of funds in the juvenile justice system are possible.

3. CONCLUSION

This report summarizes the results of an extensive review of West Virginia's health care challenges and opportunities, with a specific focus on the Department of Health and Human Resources and the Medicaid program. In conducting this review, **Public Works** reviewed key documents, interviewed multiple stakeholders, and identified best practices occurring in West Virginia and other states. Our findings indicate that West Virginia's health care system is fraught with systemic challenges involving rising health care costs, poor health outcomes, and lack of access to appropriate care. However, West Virginia's Department of Health and Human Resources and other health care agencies, rather than working together to mitigate these problems, are beset by fragmentation, an insufficient workforce, and the lack of an overarching strategic vision and a sustained mechanism for accountability.

This report outlines a new strategic vision for West Virginia's health care system centered around the three, interrelated goals of Better Health, Better Care, and Lower Costs, and suggests concrete steps the state can take within this vision to address high-cost, but preventable, health care conditions, including poor maternal and child health outcomes, heart attack and stroke, and preventable falls and hospitalizations among seniors. The report recommends that solutions to these challenges harness the expertise of West Virginia's health care professionals, along with the purchasing power of payers and the health expertise of the public health community.

The report then outlines specific steps that the Department of Health and Human Resources can take to improve the efficiency of its internal operations – both by saving taxpayer dollars and improving the department's ability to move West Virginia towards establishing an efficient and effective health care system, including maximizing federal funding opportunities. The report identifies 78 recommendations with potential General Fund savings or new revenue of $56.7 million.

While daunting, West Virginia's health care challenges are not insurmountable. Indeed, our review found that many individuals both inside and outside of state government are eager to make improvements, but feel they lack the tools and resources to make these improvements. By working towards a common strategic vision centered around better health, better care, and lower costs, and utilizing its resources and efforts accordingly, West Virginia can make great strides towards an effective, efficient, and sustainable health and human services system.

[1] C. Schoen, J. Lippa, S. Collins, and D. Radley, State Trends in Premiums and Deductibles, 2003–2011: Eroding Protection and Rising Costs Underscore Need for Action, The Commonwealth Fund, December 2012. Available at: http://www.commonwealthfund.org/Publications/Issue-Briefs/2012/Dec/State-Trends-in-Premiums-and-Deductibles.aspx
[2] Kaiser Family Foundation, West Virginia: Average Annual Growth in Medicaid Spending, FY1990 - FY2010. http://www.statehealthfacts.org/profileind.jsp?ind=181&cat=4&rgn=50
[3] Kaiser Commission on Medicaid and the Uninsured, May 2012. Enrollment-Driven Expenditure Growth: Medicaid Spending during the Economic Downturn, FFY2007-2010. Available at: http://www.kff.org/medicaid/upload/8309.pdf
[4] http://www.americashealthrankings.org/WV/PH_Spending/2012
[5] http://www.statehealthfacts.org/profileind.jsp?cat=8&sub=166&rgn=50
[6] America's Health Rankings, 2012, available at http://www.americashealthrankings.org/WV/2012
[7] Trust for America's Health, Investments in Disease Prevention Yield Significant Savings, Stronger Communities. July 2008. Available at http://healthyamericans.org/reports/prevention08/
[8] http://legiscan.com/LA/bill/SCR111/2012
[9] http://www.hca.wv.gov/policyandplanning/Pages/EDQC.aspx
[10] Pittsburgh Regional Healthcare Initiative, Success Stories, http://www.prhi.org/success-stories
[11] http://www.ncsl.org/issues-research/health/medicaid-payment-reform.aspx#.UMj7pX3IUR0.mailto
[12] Centers for Medicare and Medicaid Services, Partnership for Patients, http://partnershipforpatients.cms.gov/about-the-partnership/aboutthepartnershipforpatients.html
[13] Centers for Medicare and Medicaid Services, Partnership for Patients, http://partnershippledge.healthcare.gov/
[14] Centers for Medicare and Medicaid Services, Innovation Center, Innovation Models, http://innovation.cms.gov/initiatives/index.html#_Expand
[15] Agency for Healthcare Research and Quality, 2012 Annual Progress Report to Congress: National Strategy for Quality Improvement in Health Care. Available at: http://www.ahrq.gov/workingforquality/nqs/nqs2012annlrpt.htm
[16] Center for Medicare and Medicaid Services, Innovation Center, State-by-State initiatives, http://innovation.cms.gov/initiatives/map/index.html?statePass=WV
[17] http://www.washingtonpost.com/blogs/wonkblog/wp/2012/09/07/we-spend-750-billion-on-unnecessary-health-care-two-charts-explain-why/
[18] Better Health Greater Cleveland – Better Care, Better Health, Lower Cost. Winter 2013. http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf404020
[19] http://www.paymentinitiative.org/aboutUs/Pages/default.aspx
[20] http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx
[21] WV Vital Statistics 2008
[22] Strong Start for Mothers and Newborns, Center for Medicare and Medicaid Innovations, http://innovation.cms.gov/initiatives/strong-start/index.html
[23] http://www.cdc.gov/breastfeeding/pdf/2011breastfeedingreportcard.pdf
[24] http://www.babyfriendlyusa.org/find-facilities
[25] New England Journal of Medicine, http://www.nejm.org/doi/full/10.1056/NEJMp1102796
[26] Campaign for Tobacco-Free Kids, Comprehensive Statewide Tobacco Prevention Programs Save Money, http://www.tobaccofreekids.org/research/factsheets/pdf/0168.pdf
[27] Campaign for Tobacco-Free Kids, Comprehensive Statewide Tobacco Prevention Programs Save Money, http://www.tobaccofreekids.org/research/factsheets/pdf/0168.pdf
[28] Centers for Disease Control and Prevention, West Virginia Burden of Chronic Diseases, 2008. http://www.cdc.gov/chronicdisease/states/pdf/west_virginia.pdf

[29] Centers for Disease Control and Prevention, West Virginia Burden of Chronic Diseases, 2008. http://www.cdc.gov/chronicdisease/states/pdf/west_virginia.pdf
[30] Million Hearts campaign website, http://millionhearts.hhs.gov/be_one_mh.html
[31] Centers for Disease Control and Prevention, Addressing the Nation's Leading Killers: At A Glance 2011. http://www.cdc.gov/chronicdisease/resources/publications/AAG/dhdsp.htm
[32] Trogdon, JG, EA Finkelstein, IA Nwaise, FK Tangka, and D Orenstein. "The Economic Burden of Chronic Cardiovascular Disease for Major Insurers." *Health Promotion Practice. 8.3 (2007); 234-242.*
[33] Centers for Disease Control and Prevention, Addressing the Nation's Leading Killers: At A Glance 2011. http://www.cdc.gov/chronicdisease/resources/publications/AAG/dhdsp.htm
[34] America's Health Rankings 2012, http://www.americashealthrankings.org/WV/2012
[35] U.S. Census Bureau, http://www.agingstats.gov/Main_Site/Data/2012_Documents/Population.aspx
[36] Medicaid and CHIP Payment Advisory Commission, MACPAC, June 2012 report.
[37] Medicaid and CHIP Payment Advisory Commission, MACPAC, June 2012 report.
[38] Medicare Payment Advisory Commission (MedPAC), 2010.
[39] Centers for Medicare and Medicaid Innovation, http://innovation.cms.gov/initiatives/rahnfr/
[40] Medicare Payment Advisory Commission, March 2012
[41] Centers for Disease Control and Prevention, http://www.cdc.gov/HomeandRecreationalSafety/pdf/steadi/falls_are_a_major_threat.pdf
[42] Centers for Disease Control and Prevention, STEADI toolkit, http://www.cdc.gov/homeandrecreationalsafety/Falls/steadi/about.html
[43] Medicaid and CHIP Payment Advisory Commission, MACPAC, June 2012 report.
[44] Medicaid and CHIP Payment Advisory Commission, MACPAC, June 2012 report.
[45] National Council on Aging, http://www.ncoa.org/improve-health/center-for-healthy-aging/falls-prevention/falls-free-initiative.html
[46] Medicaid Supplemental Payments: Where do they fit in payment reform? Center for Health Care Strategies, August 2011. http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261283
[47] Medicaid Supplemental Payments: Where do they fit in payment reform? Center for Health Care Strategies, August 2011. http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261283
[48] http://www.bls.gov/jlt/
[49] http://www.webpronews.com/employee-retention-what-employee-turnover-really-costs-your-company-2006-07
[50] Ibid
[51] Maryland Governor's Grant Office website, available at: http://grants.maryland.gov/Pages/AboutUs.aspx.
[52] http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/index.html?redirect=/deficitreductionact/021_repcongress.asp
[53] http://www.namfcu.net/publications/annual-state-surveys/Statistics percent202012 percent20-percent20expanded.pdf
[54] http://sphhs.gwu.edu/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_377A5480-5056-9D20-3DF264AA41CFBDEC.pdf
[55] https://oig.hhs.gov/oas/reports/region2/20901024.pdf
[56] https://oig.hhs.gov/oas/reports/region6/60800096.pdf
[57] http://www.kaiserhealthnews.org/daily-reports/2001/may/29/dr00004837.aspx
[58] The National Consortium on the Coordination of Human Services Transportation, Medicaid Non-Emergency Transportation: Three Case Studies.
[59] Ibid.

[60] Ibid.
[61] WV Bureau for Public Health website, available at: http://www.dhhr.wv.gov/bph/Pages/default.aspx.
[62] West Virginia Legislature, Senate Bill 160, passed March 16, 2012, available at: http://www.legis.state.wv.us/Bill_Status/bills_text.cfm?billdoc=sb160 percent20sub1 percent20enr.htm&yr=2012&sesstype=RS&i=160.
[63] Alliance for Health Reform, "Public Health Prevention Efforts: Saving Lives, Saving Money?" October 2012, page 3, available at: http://allhealth.org/publications/Public_health/Public_Health_Prevention_Efforts_Issue_Brief_115.pdf.
[64] Care Share Health Alliance website, available at: https://www.caresharehealth.org/healthy-carolinians.
[65] Community Prevention Services Taskforce findings, October 3, 2011, available at: http://www.thecommunityguide.org/about/findings.html
[66] Wright, Jessica G., Director, Health Promotion & Chronic Disease, "West Virginia's Challenge Addressing Obesity and Related Chronic Diseases," Report to WV Legislative Health Committee, December 12, 2012, page 1.
[67] Kaiser Family Foundation, "Percent of Adults Who are Overweight or Obese, 2011," available at: http://www.statehealthfacts.org/comparetable.jsp?ind=89&cat=2&sub=26&yr=200&typ=2&sort=a.
[68] Kaiser Family Foundation, "Percent of Adults Who Smoke, 2011," available at: http://www.statehealthfacts.org/comparetable.jsp?ind=80&cat=2&sub=24&yr=200&typ=2&sort=a.
[69] Kaiser Family Foundation, "Percent of Adults Who Have Ever Been Told by a Doctor that They Have Diabetes, 2011," available at: http://www.statehealthfacts.org/comparetable.jsp?ind=70&cat=2&sub=22&yr=200&typ=2.
[70] Wright, Jessica G., Director, Health Promotion & Chronic Disease, "West Virginia's Challenge Addressing Obesity and Related Chronic Diseases," Report to WV Legislative Health Committee, December 12, 2012, pages 1-2.
[71] Joe Barker, Director, West Virginia Bureau for Public Health, Office of Community Health Systems and Health Promotion.
[72] Henry J. Kaiser Family Foundation, ACA Federal Funds Tracker, available at: http://healthreform.kff.org/federal-funds-tracker.aspx#.
[73] See: WV Code §§16-5B-4, 16-5C-6(e), 16-5D-6(i), 16-5N-6.
[74] See: WV Code §20-2-42.
[75] Bureau for Public Health, Monthly and YTD Revenue Balances - By Fund, Org, Source, FY 2012, January 23, 2013.
[76] Senate Bill 160, March 16, 2012, pages 48-50, available at: http://www.legis.state.wv.us/Bill_Text_HTML/2012_SESSIONS/RS/pdf_bills/sb160 percent20sub1 percent20enr percent20PRINTED.pdf
[77] Bureau for Public Health, Office of Community Health Systems and Health Promotions, Division of Health Promotion & Chronic Disease, "Advocating for Chronic Disease Management and Prevention – 2011," May 2011, page 13, available at: http://www.wvdhhr.org/bph/hsc/pubs/other/ChronicDiseaseManAndPrev2011/Advocating_for_Chronic_Disease_Management_and_Prevention_2011.pdf.
[78] Wright, Jessica G., Director, West Virginia Division of Health Promotion & Chronic Disease, "West Virginia's Challenge Addressing Obesity and Related Chronic Diseases," Report to WV Legislative Health Committee, December 12, 2012, page 2.
[79] *CDC Division of Population Health, Letter from Susie McCarthy, MPH, Health Education Specialist/Project Officer, 2012.*
[80] http://www.cwla.org/newsevents/news030304cwlacaseload.htm. The Child Welfare League recommends 12 to 15 children per social worker.

[81] Yoon et al. The role of adverse physical health events in the utilization of mental health services. Health Services Research. February 2013. http://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2012.01442.x/abstract
[82] Substance Abuse and Mental Health Services Administration, http://www.integration.samhsa.gov/research
[83] Butler M, Kane RL, McAlpine D, Kathol, RG, Fu SS, Hagedorn H, Wilt TJ. Integration of Mental Health/Substance Abuse and Primary Care No. 173 (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-02-0009.) AHRQ Publication No. 09-E003. Rockville, MD. Agency for Healthcare Research and Quality. October 2008.
[84] National Council on Community and Behavioral Healthcare, Behavioral Health/Primary Care Integration: Environmental Assessment Tool, State Level Policy and Financing. Spring 2004. http://www.thenationalcouncil.org/galleries/business-practice percent20files/PC-BH percent20Environment-State percent20Policy.pdf
[85] National Council on Community and Behavioral Healthcare, Behavioral Health/Primary Care Integration: Environmental Assessment Tool, State Level Policy and Financing. Spring 2004. http://www.thenationalcouncil.org/galleries/business-practice percent20files/PC-BH percent20Environment-State percent20Policy.pdf
[86] SAMSHA, Behavioral Health in Primary Care, http://www.integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care
[87] SAMSHA, Primary Care in Behavioral Health, http://www.integration.samhsa.gov/integrated-care-models/primary-care-in-behavioral-health
[88]Substance Abuse and Mental Health Services Administration, http://www.integration.samhsa.gov/financing/Paying_for_BH_visits_on_same_day_as_medical_visit.pdf
[89] WV Health Improvement Institute, Behavioral Health Work Group on Integration of Primary Care and Behavioral Health, August 2011. http://www.wvhealthimprovement.org/Portals/0/documents/Final percent20Report percent20August percent202011.pdf
[90] WV Telehealth Alliance, http://www.wvtelehealth.org/Projects/BroadbandProjects/tabid/103/Default.aspx
[91] Osher, F., D. A. D'Amora, M. Plotkin, N. Jarrett, A. Eggleston, *Adults with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery,* (2012)
[92] Pew Center on the States, *State of Recidivism: The Revolving Door of America's Prisons* (April, 2011)
[93] Ibid
[94] Carson, E.A. & W.J. Sabol. *Prisoners in 2011*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2012. National Rentry Resource Center, Council of State Governments Justice Center. Available at bjs.gov/content/pub/pdf.
[95] Ibid
[96] Council of State Governments, Justice Center, [96] Osher, F., D. A. D'Amora, M. Plotkin, N. Jarrett, A. Eggleston, *Adults with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery,* (2012)
[97] West Virginia Department of Military Affairs and Public Safety, 2010-2011 Annual Report
[98] West Virginia Department of Military Affairs and Public Safety, Division of Corrections, Recidivism Reports.
[99] "Cost-Benefit Analysis of Juvenile Justice Programs-A Guide Book for State Legislators". National Council of State Legislatures. Available at ncsl.org/documents/cj/jjguidebook-costbenefit
[100] "Meeting the Mental Health Needs of Youth in Juvenile Justice", International Society of Psychiatric-Mental Health Nurses. Available at ispn.org/docs/juvenile justice.

[101] U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, Conference on Mental Health Issues and Juvenile Justice, April, 2012. Available at juvenilenet.org/jjtap/mentalhealth/index.
[102] Council of State Governments Justice Center. Available at justicereinvestment.org/resources/ohio and north carolina update.
[103] Ibid