WEST VIRGINIA LEGISLATURE

2026 REGULAR SESSION

Committee Substitute

for

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for

Senate Bill 231

BY SENATORS HELTON, ROSE, TAYLOR, RUCKER, DEEDS,

AND BARTLETT

[Reported February 11, 2026, from the Committee on

Finance]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding a new article, designated §9-11-1, §9-11-2, §9-11-3, §9-11-4, §9-11-5, and §9-11-6, relating to value-based payment requirements; providing legislative intent; defining terms; establishing value-based measures; creating timelines for implementation; setting out authority; and making provision inoperable without approval.

Be it enacted by the Legislature of West Virginia:

ARTICLE 11. ADDICTION CARE RECOVERY OUTCOMES.

§9-11-1. Legislative findings and purpose.

The Legislature finds that West Virginia continues to be severely impacted by substance use disorder and overdose deaths. While the state has made substantial investments in treatment, recovery, and prevention, the current addiction care system is fragmented and not aligned to measurable long-term recovery outcomes. The purpose of this article is to reorganize the state's addiction care system into a value-based continuum of care and incentivize coordination, integration, and accountability for recovery success.

§9-11-2. Definitions.

As used in this article:

"Baseline year" means the designated time period during which performance data, including, but not limited to, cost, quality, utilization, and outcome-based performance measures is collected to establish benchmarks.

"Continuum of care" means a coordinated system of services that includes prevention, early intervention, treatment (including withdrawal management and medication-assisted treatment), recovery support, supportive housing, vocational and educational support, and peer services. The continuum shall address the needs of individuals at all stages of substance use disorder and recovery.

"Value-based payment" means a payment model that incentivizes providers for quality and cost-effective care and reduces payments to providers who fail to meet specified metrics,

shifting from paying for volume (fee-for-service) to paying for patient health outcomes and experiences. This payment model shall include performance-based payments tied to specific outcomes identified in this article.

§9-11-3. Establishment of value-based measures.

(a) On or before October 1, 2026, the Bureau for Medical Services, in conjunction with their managed care organizations, shall establish standard billing codes for all substance use disorder services to be used by providers in the continuum of care on or before January 15, 2027.

(b) The Bureau for Medical Services shall collect data from all providers in the continuum of care regarding billing codes and other measures to be collected by providers as set forth in this article for analysis purposes to determine utilization trends, costs, and outcomes by provider.

(c) The Bureau for Medical Services shall analyze the data for utilization and costs trends. After the outcome measures are determined as set forth in this article, the Bureau for Medical Services shall collect and analyze the measures to improve quality in the Medicaid program and determine how to establish value-based payments to incentivize quality substance use disorder outcomes. Any trends indicating overutilization or overbilling shall be referred to the Medicaid Fraud Control Unit.

(d) The Bureau for Medical Services shall submit a report to the Legislative Oversight Commission on Health and Human Resources Accountability on before January 1, 2028, and annually thereafter, regarding substance use disorder utilization trends and costs by provider and provider type. All providers shall be given an anonymized synthetic identifier in the report to allow trends to be followed in multiple years. Once the outcome measures are developed, this report shall further include outcomes by provider and provider type. All providers shall be given an anonymized synthetic identifier in the report to allow trends to be followed in multiple years. The outcome portion of this report shall first be included on July 1, 2028, and be reported annually thereafter. All reports shall contain a comparison of state utilization, cost, and outcomes to the previous fiscal year's data to also include, but not be limited to, the rate for neonatal abstinence

syndrome and statewide adult deaths. This analysis shall also include a comparison of utilization, cost, outcomes, the rate of neonatal abstinence, and adult death rates to a national rate.

(e) On or before July 1, 2026, the Bureau for Medical Services, in consultation with the Bureau for Behavioral Health, relevant state agencies, Marshall University, Joan C. Edwards School of Medicine, West Virginia University School of Medicine Behavioral Health Faculty, individuals in recovery, providers, law enforcement, and other relevant stakeholders, shall develop a set of outcome-based performance measures for each level of care within the addiction treatment and recovery services care continuum.

§9-11-4. Use of value-based measures.

(a) The measures to be utilized under value-based programs shall include, but not be limited to, the following:

(1) Housing stability — which means whether the individual is in stable, safe, and long-term housing;

(2) Sobriety — which means verified abstinence from non-prescribed substances or effective management thorough medication-assisted treatment;

(3) Criminal justice and child welfare avoidance — which means no new arrests, law-enforcement interactions, or Child Protective Services investigations, indicating improvement in the societal burden of their addiction and costs to other governmental agencies;

(4) Self-sufficiency — which means participation in employment, education, training programs, or other activities indicative of long-term recovery and independence, indicating a reduction in dependence on governmental benefits; and

(5) Provider transition plan — which means the development and implementation by a provider of a concrete plan to assist an individual moving between different settings or providers.

(b) These metrics developed pursuant to this article shall be:

(1) Measurable and capable of validation using existing or enhanced state data systems or data input from outside providers;

(2) Inclusive of the delivery of services to address the social determinants of health;

(3) Account for individual complexity and acuity and may include different tiers of performance measures and incentive models based on comorbidity and severity; and

(4) Protective of privacy and consistent with the Health Insurance Portability and Insurance Act and other relevant state and federal regulations.

§9-11-5. Implementation of value-based payment model.

(a) The baseline year will begin on or before July 1, 2027, and continue for a one-year time period during which time performance data, including, but not limited to, cost, quality, utilization, and the outcome-based performance measures, shall be collected and analyzed to establish benchmarks. These benchmarks shall be provided to providers to allow them to improve performance during the baseline year.

(b) On or before July 1, 2028, the Bureau for Medical Services shall require the managed care organizations to provide a value-based payment in conformity with the approved outcome measures and standard billing codes set forth in and developed pursuant to this article.

§9-11-6. Centers for Medicare and Medicaid Authority.

(a) On or before October 1, 2026, the Bureau for Medical Services, to the extent necessary, shall submit a state plan amendment for the appropriate Center for Medicare and Medicaid Services (CMS) authority to implement any payment and coverage changes necessary to effectuate this article. The amendment shall include, but not be limited to:

(1) Development of the value-based payment model, which shall include, but not be limited to, enhanced payments for provider outcomes for meeting or exceeding the outcome measures as set forth in this article and reduces payments to providers who fail to meet outcome measures;

(2) The payment model shall account for a baseline year in which data is collected, communicated to providers to allow notice of performance, and to establish the baseline;

(3) The model shall allow for an annual review of performance measures to permit flexibility and to address quality outcomes;

(4) Provisions for a provider to be de-certified, to have specific code blocked, to be terminated, or otherwise be excluded from the Medicaid program when the provider fails to meet the established outcome measures for three consecutive quarters;

(5) Specific performance measures; and

(6) System-level outcomes that the performance-based model shall produce with common return-on-health-investment measures that can be used to compare the investments in a specific system of care relative to the outcomes.

(b) The provisions of this article shall have no force or effect if CMS does not approve the state plan amendment as required by this section.