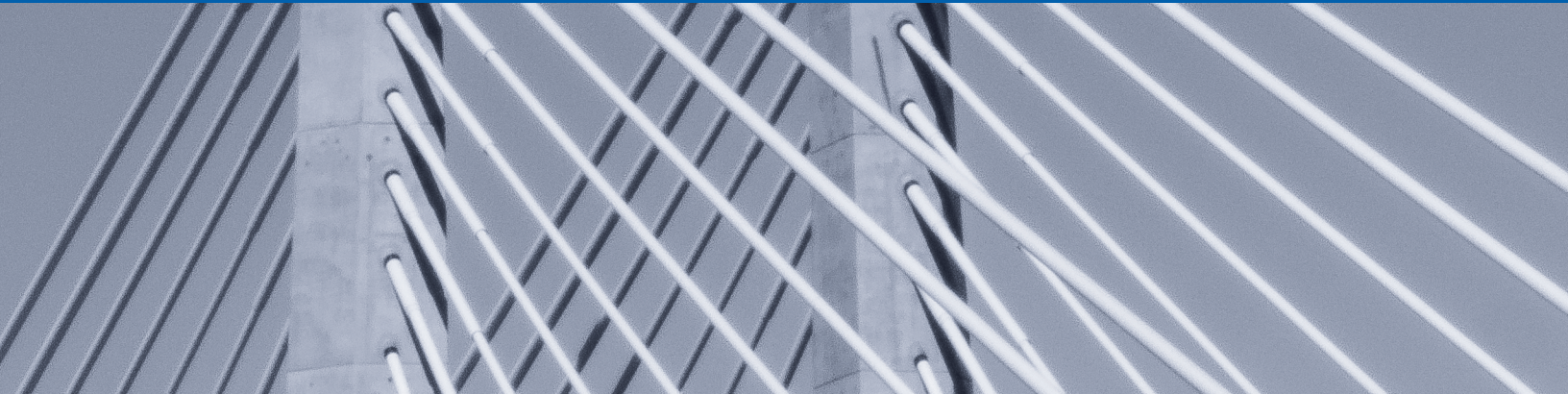


Mid-Point Assessment of Washington's Section 1115 SUD Amendment

ASSESSMENT REPORT

December 11, 2020

CENTER FOR HEALTH SYSTEMS EFFECTIVENESS



Prepared for:

Washington State Health Care Authority



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Executive Summary

Overview

In 2018, Washington obtained an amendment to its Section 1115 waiver allowing the state to obtain federal financial participation for services provided to Medicaid recipients receiving short-term residential treatment for substance use disorder (SUD) in an Institution for Mental Diseases (IMD). Federal funding under the amendment ("SUD waiver") is contingent on the state's progress toward a set of milestones and metrics for care delivery. The Center for Medicare & Medicaid Services also requires Washington to conduct an independent mid-point assessment ("MPA") to examine progress in these areas, identify factors and risks affecting their achievement, and provide recommendations for state actions to support improvement.

Washington's Health Care Authority contracted with the Center for Health Systems Effectiveness at Oregon Health & Science University to complete the MPA, and this report presents its findings. These findings can help guide Washington's efforts and also shed light on how these waivers may affect individuals with opioid use disorder (OUD) and SUD in other states.

Summary of Findings

The state has completed the majority of the actions outlined in the SUD Implementation Plan Protocol for implementing the SUD waiver's six milestones. Actions for milestones 1, 2, 4, and 5 have been completed. The remaining work to complete milestones 3 and 6 involves updating the Washington Administrative Code, a process which the state has begun.

A variety of measures of access and quality for SUD prevention and treatment, assessed using administrative data, showed overall movement in the desired direction and suggested significant progress in expanding access and provider capacity, increasing treatment availability, and improving care coordination.

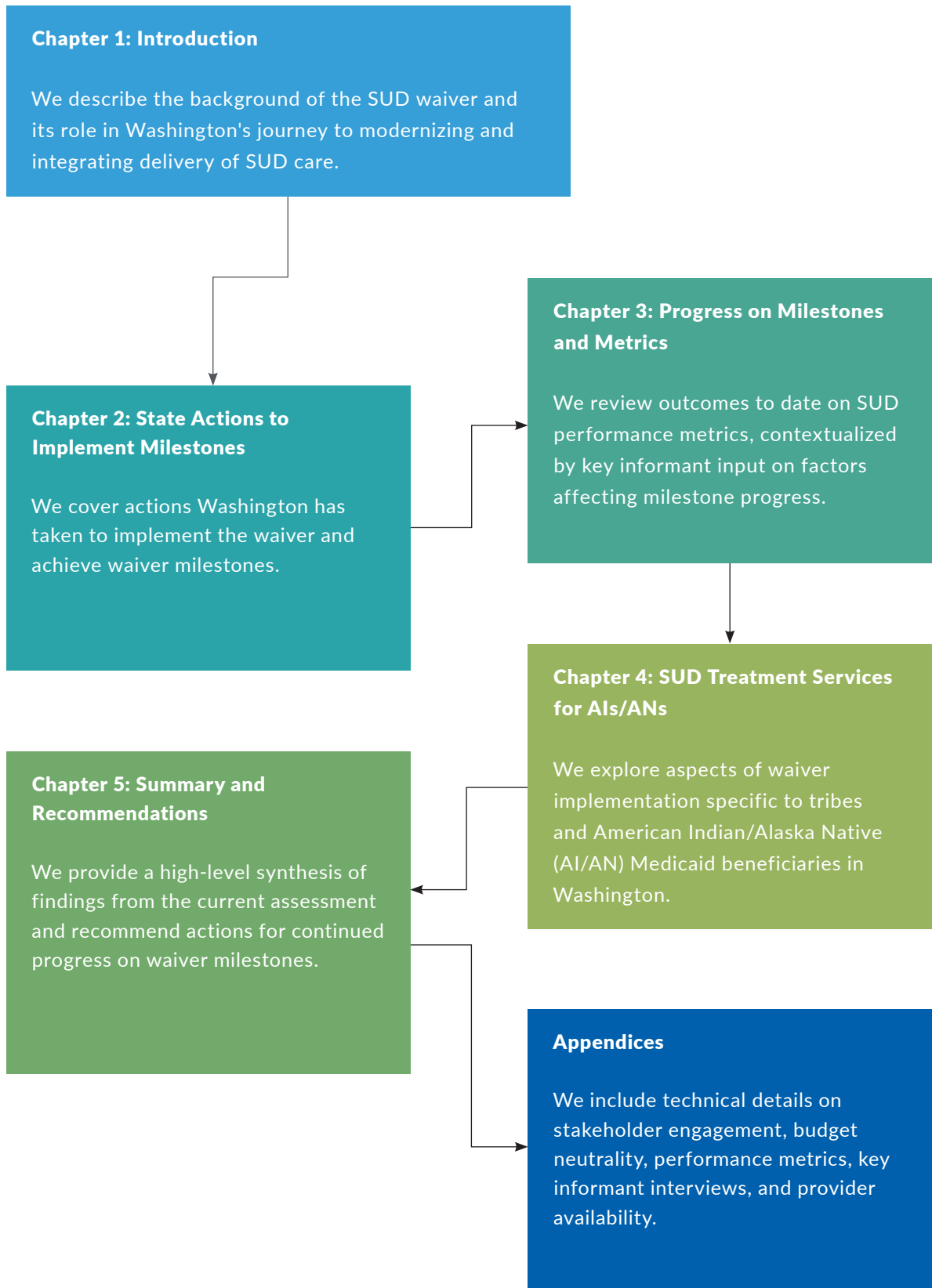
Despite this progress, interviews with stakeholders revealed a number of implementation challenges. Some of these were related to the state's transition to integrated managed care. According to providers, the transition created delays in payment and adversely affected provider financial stability. There continue to be disagreements between payers and providers about the role of residential care in SUD treatment. However, stakeholders also pointed to the financial benefits of the waiver and the greater flexibility it affords in meeting Medicaid beneficiaries' needs for residential treatment.

Recommendations

Based on data and findings from the MPA, we believe the following actions may improve the potential for the state to meet its goals:

- **Engage multiple stakeholders to assess and plan for the future of Washington’s SUD and behavioral health systems.** The state may benefit from a longer-term planning process that would assess current and anticipated gaps in services and address needs in a coordinated way.
- **Develop the state’s evidence base and consensus on the best uses for residential SUD treatment services.** Although the American Society of Addiction Medicine’s (ASAM) criteria for residential placement have been widely adopted, differences in payer and provider interpretation of these criteria suggest that the state may benefit from developing further guidelines on their application and encouraging consensus among providers and managed care organizations about appropriate length of stays in residential settings.
- **Consider the value of expanding the Foundational Community Supports (FCS) program.** Recent SUD-related contracting for FCS – part of Washington’s larger Medicaid Transformation Project (MTP) – could be a mechanism for providing recovery supports such as stable housing, supported employment opportunities, transportation, and peer services.
- **Sustain the advances in telehealth for SUD that were catalyzed by COVID-19.** The state should assess how telehealth for SUD and mental health services can be continued, particularly to improve access in rural areas and increase the ability to provide medications for addiction treatment.
- **Factor in the changing concentration, intensity of use, and delivery of opioids as well as growth in other substances.** Growing mortality from fentanyl and methamphetamines may necessitate a reassessment of how to best respond to the changing landscape of SUD-related outcomes.

Roadmap to the Report



Introduction

Overview

In 2018, Washington obtained an amendment to its Section 1115 waiver designed to help maintain and expand access to substance use disorder (SUD) treatment, with a particular focus on residential and inpatient treatment. Washington sought the SUD waiver amendment in part to respond to the mounting toll of the opioid use disorder (OUD) crisis, which claimed the lives of 694 individuals in the state in 2016.¹ In doing so, it joined 25 other states that applied for and received an SUD waiver between 2015 and 2019.

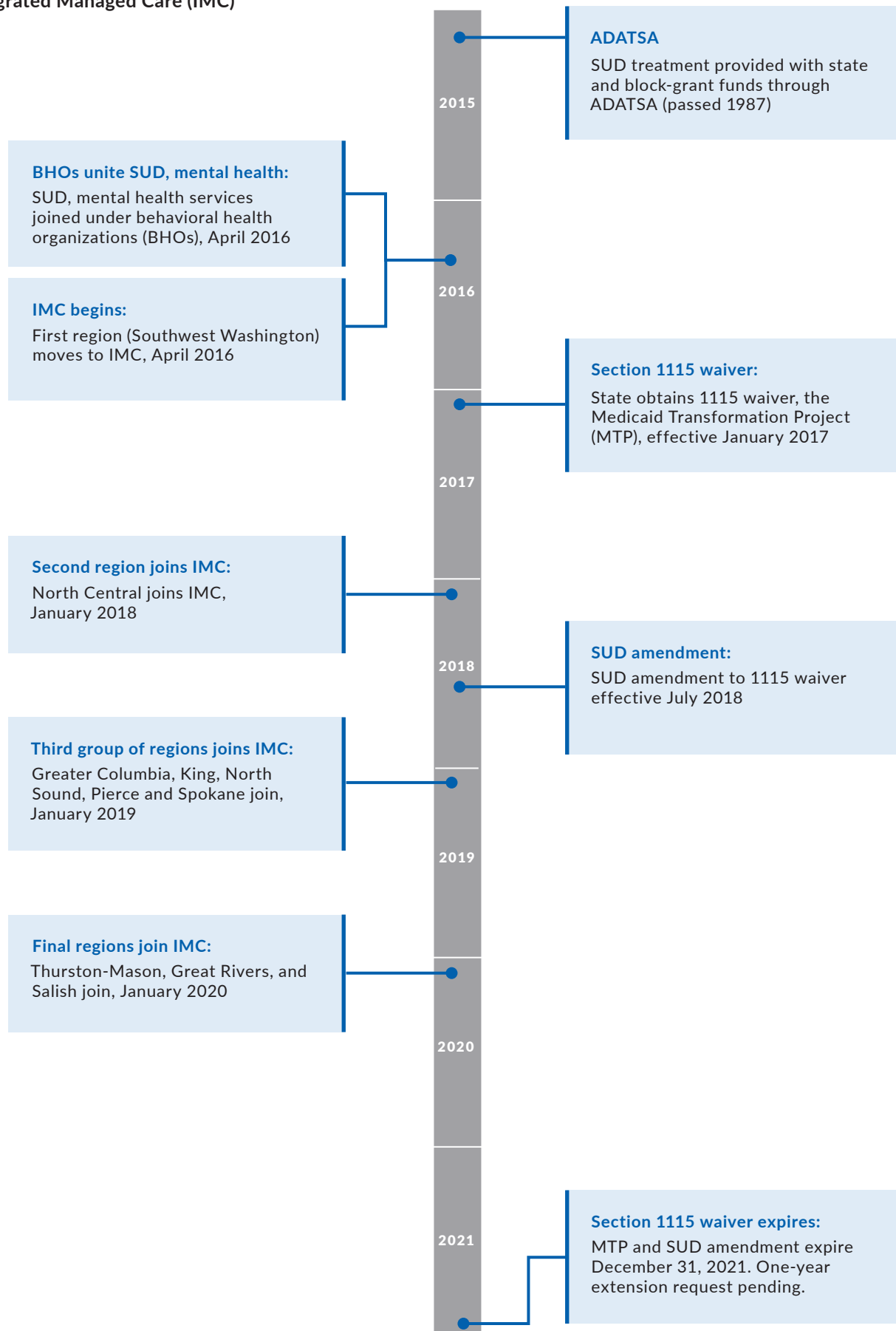
The SUD waiver allows Washington to obtain federal financial participation (FFP) for services provided to Medicaid recipients receiving short-term residential treatment for SUD in an Institution for Mental Diseases (IMD). Expenditure authority covers all Medicaid state plan services, including a continuum of services to treat OUD and other SUDs. Federal funding under the waiver is contingent on the state's progress toward a set of milestones for care delivery.² Progress will be evaluated based on an implementation plan (SUD Implementation Plan Protocol) and a set of performance targets (SUD Monitoring Protocol) agreed upon between the state and the Centers for Medicare & Medicaid Services (CMS).

In addition, CMS requires Washington to conduct an independent mid-point assessment ("MPA") of the SUD waiver to further examine progress on milestones and performance targets, including factors affecting their achievement and the risk of not meeting them. Washington's Health Care Authority (HCA) contracted with the Center for Health Systems Effectiveness (CHSE) at Oregon Health & Science University (OHSU) to complete the MPA. This report presents its findings. These findings can help guide Washington's efforts and also shed light on how these waivers may affect individuals with OUD and SUD in other states.

Washington's SUD Delivery System: Transitioning to Integrated Managed Care

Implementation of Washington's SUD waiver occurred against the backdrop of a larger, years-long transition from a locally contracted, disciplinarily siloed SUD delivery system to a statewide, integrated managed care model. Exhibit 1.1 provides an abbreviated timeline for these changes, described further below.

Exhibit 1.1: Washington's Transition to Integrated Managed Care (IMC)



ADATSA

Like most states, Washington had a history of providing SUD treatment separate from delivery of physical and mental health care. Prior to the Affordable Care Act (ACA) (effective January 1, 2014), outpatient SUD services for Medicaid-eligible residents generally were delivered via county-level contracts separate from physical and mental health care. Adult residential treatment was delivered through providers contracted directly with the state, funded via a mix of state and federal block grant dollars. The state's Alcohol and Drug Addiction Treatment and Support Act (ADATSA), passed in 1987, provided assessments, chemical dependency treatment, and financial support for individuals disabled from employment due to an alcohol or other drug use disorder.³ Residential providers were generally paid for the duration of care, unless the client left against medical advice, and there were no prior authorization requirements or other provisions for utilization management.

Behavioral Health Organizations

In 2014, as ACA implementation and Washington's Medicaid expansion approached, the Washington legislature passed Senate Bill 6312, directing the state to gradually transition the Medicaid system to integrated behavioral and physical health care ("Integrated Managed Care," or IMC) by 2020.

As an interim step to full integration, the state brought SUD and mental health services together under regional Behavioral Health Organizations (BHOs), made up of counties or consortiums of counties, in April 2016. BHOs entered into Prepaid Inpatient Health Plan (PIHP) contracts with the state and subcontracted with SUD and mental health providers for the stipulated behavioral health services.

Managed Care Organizations

Washington's final step in system integration was to bring behavioral health services under the same managed-care roof with physical health services. This integration began in April 2016 and rolled out regionally. The last region to move to IMC made the shift in January 2020, 18 months after the SUD waiver came into effect.⁴ The vast majority of SUD treatment providers serving Medicaid beneficiaries now provide those services through contracts with statewide managed care organizations (MCOs). As we will examine through key informant interviews in Chapter 3, this final stage of integrated contracting was both an instrument for implementing the SUD waiver and a source of unanticipated challenges for residential SUD providers.

State Agency Governance Changes

The IMC transition was mirrored by a series of organizational changes among state agencies responsible for administration and management of behavioral health benefits. On July 1, 2018, Washington's Department of Social and Health Services' (DSHS) Division of Behavioral Health and Rehabilitation (DBHR), the agency overseeing behavioral health rule-making and provider licensing, was dissolved. Responsibility for licensing and certification of behavioral health providers was transferred to the Department of Health (DOH), while staffing and behavioral health rule-making responsibilities were transferred to HCA and DOH. These changes were intended to facilitate delivery system integration and reduce administrative costs.

Federal Funding for SUD IMD Services

In moving residential SUD services under the Medicaid umbrella, Washington's larger residential SUD providers became subject to the federal exclusion for IMDs. Residential treatment services provided in IMDs are generally excluded from the Medicaid statute of services. See Box 1.1 for details.

Box 1.1: The IMD Exclusion

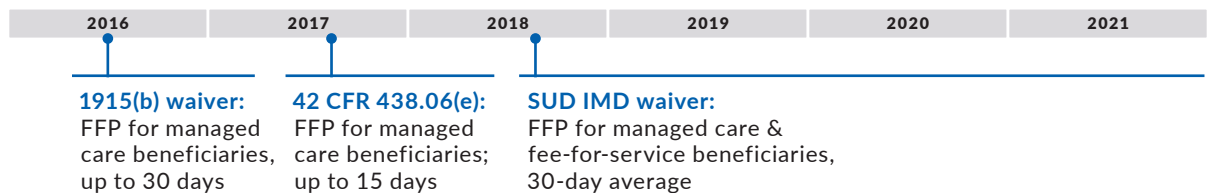
An IMD is defined as “a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.” (Social Security Act §1905(i)) IMDs are generally licensed or accredited facilities that specialize in providing psychiatric, psychological, and/or SUD treatment services.

In force since Medicaid's inception in 1965, the IMD exclusion prohibits state Medicaid programs from obtaining FFP to pay for IMD services. The policy was intended to support a shift from institutionalized care to community-based treatment for mental illness, while establishing states as the primary payer for inpatient mental health services. The exclusion applies to services provided to Medicaid beneficiaries between the ages of 21 and 64, but does not preclude states from receiving federal Medicaid funding for services provided in facilities that do not meet the definition of an IMD, such as facilities with 16 or fewer beds. In 2016, CMS amended the rules for Medicaid managed care such that states' capitation payments to managed care entities for enrollees admitted to an IMD qualified for full federal matching as long as the IMD length of stay did not exceed 15 days in a calendar month.

Between April 2016 and July 2017, Washington State was nevertheless able to obtain FFP for SUD services for managed care beneficiaries in treatment facilities with more than 16 beds. This authority was included in the state's 1915(b) waiver and applied to SUD and mental health services provided to BHO PIHP enrollees “in lieu of” equivalent services in non-IMD settings. It covered residential stays of 30 days or less.

Federal funding for IMD services under the 1915(b) waiver was restricted in July 2017 with implementation of CMS' 2016 managed care rule change, which prohibited the use of federal funds for IMD stays longer than 15 days per month. The reduction in federal funding meant that Washington needed to use state dollars to pay for IMD treatment stays longer than 15 days in a calendar month. The state's legislature allocated \$26 million for this purpose in 2017. These changes may have restricted the supply of residential treatment beds in the state while also reducing the state's ability to fund other SUD-related services. Exhibit 1.2 below summarizes the extent of federal funding for Washington Medicaid beneficiaries' SUD services in IMDs since 2016.

Exhibit 1.2: Federal Financial Participation for SUD Services in IMDs, 2016-2021



In November 2017, CMS issued new guidance for states about using Section 1115 demonstrations to increase Medicaid beneficiaries' access to high-quality, evidence-based treatment services for OUD and other SUDs. Such demonstrations offered a flexible way for states to implement best practices for addressing the opioid crisis while taking into account factors specific to their populations.⁵

Following this guidance, in March 2018, Washington's HCA applied for an amendment to its Section 1115 waiver, the Medicaid Transformation Project (MTP), which had been effective since January 2017. See Box 1.2 below for an overview of MTP.

Box 1.2 Washington's MTP

MTP is Washington's five-year agreement with CMS, under a Section 1115 Medicaid demonstration waiver, to improve the quality of care delivered to people enrolled in Medicaid while testing innovative approaches to improve and transform Washington's health and wellness systems. The waiver spans the 2017-2021 period. At the time of this report, HCA was in negotiations with CMS regarding a potential one-year extension of the waiver, and a final determination had not yet been made.

MTP consists of multiple initiatives, two of which have particular relevance for SUD treatment delivery:

Initiative 1: *The Delivery System Reform Incentive Payment (DSRIP) Program established nine regional Accountable Communities of Health (ACHs) to collaborate with health and social services organization partners on locally led health improvement projects under several domains. Within Domain 3 is Project 3A, "Addressing the Opioid Use Public Health Crisis," required for all ACHs. This project is intended to work toward the state's goals of reducing opioid-related illnesses and deaths, as set forth in Governor Jay Inslee's Executive Order 16-09. It requires ACHs and partners to implement programs aimed at preventing opioid use and misuse, linking people with OUD to treatment, intervening in opioid overdoses to prevent death, and helping people with recovery and long-term stabilization.*

Initiative 3: *This initiative establishes Foundational Community Supports (FCS), a range of new services helping vulnerable Medicaid beneficiaries – including potentially those with behavioral health issues and SUD – maintain housing and employment. FCS are discussed at more length in Chapter 3 under Milestone 6: Care Coordination.*

A detailed description of MTP and its initiatives can be found in the MTP Evaluation Baseline Report. See <https://www.hca.wa.gov/assets/program/iee-full-baseline-report.pdf>

The state noted in its application that under the 1915(b) waiver authority, FFP for services in IMD facilities had proven to be a "cost-effective approach to ensuring network sufficiency for those in need of inpatient and residential services."⁶ HCA further expected that approval of the waiver amendment request would improve access to the full continuum of SUD treatment services and prompt existing residential SUD facilities to expand their bed capacity to more than 16 beds.

The SUD Amendment

The SUD amendment ("SUD waiver") went into effect on July 17, 2018, and applies through December 31, 2021 with an extension expected through December 31, 2022. The waiver's expenditure authority covers SUD treatment services provided under Washington's Medicaid state plan to individuals in an IMD, including outpatient services, intensive outpatient services, residential treatment, medically supervised withdrawal management, and medications for opioid use disorder (MOUD). The state would aim to achieve a statewide average length of stay of 30 days for SUD treatment in residential settings, subject to monitoring through a set of performance measures.⁷ Washington must also comply with budget neutrality requirements.

Expenditure authority under the SUD waiver applies to all Medicaid beneficiaries who receive inpatient SUD services in an IMD that would otherwise be subject to the 15-day IMD rule. While there are existing exemptions to the IMD exclusion for the <21 and 65+ age ranges, these are subject to facility-type restrictions that Washington's SUD IMDs do not meet. Therefore, this amendment also enables IMD facilities in Washington to receive FFP for previously ineligible individuals younger than 21 and older than 65. Additionally, the waiver applies to services provided to Washington residents enrolled in both managed care and FFS Medicaid.

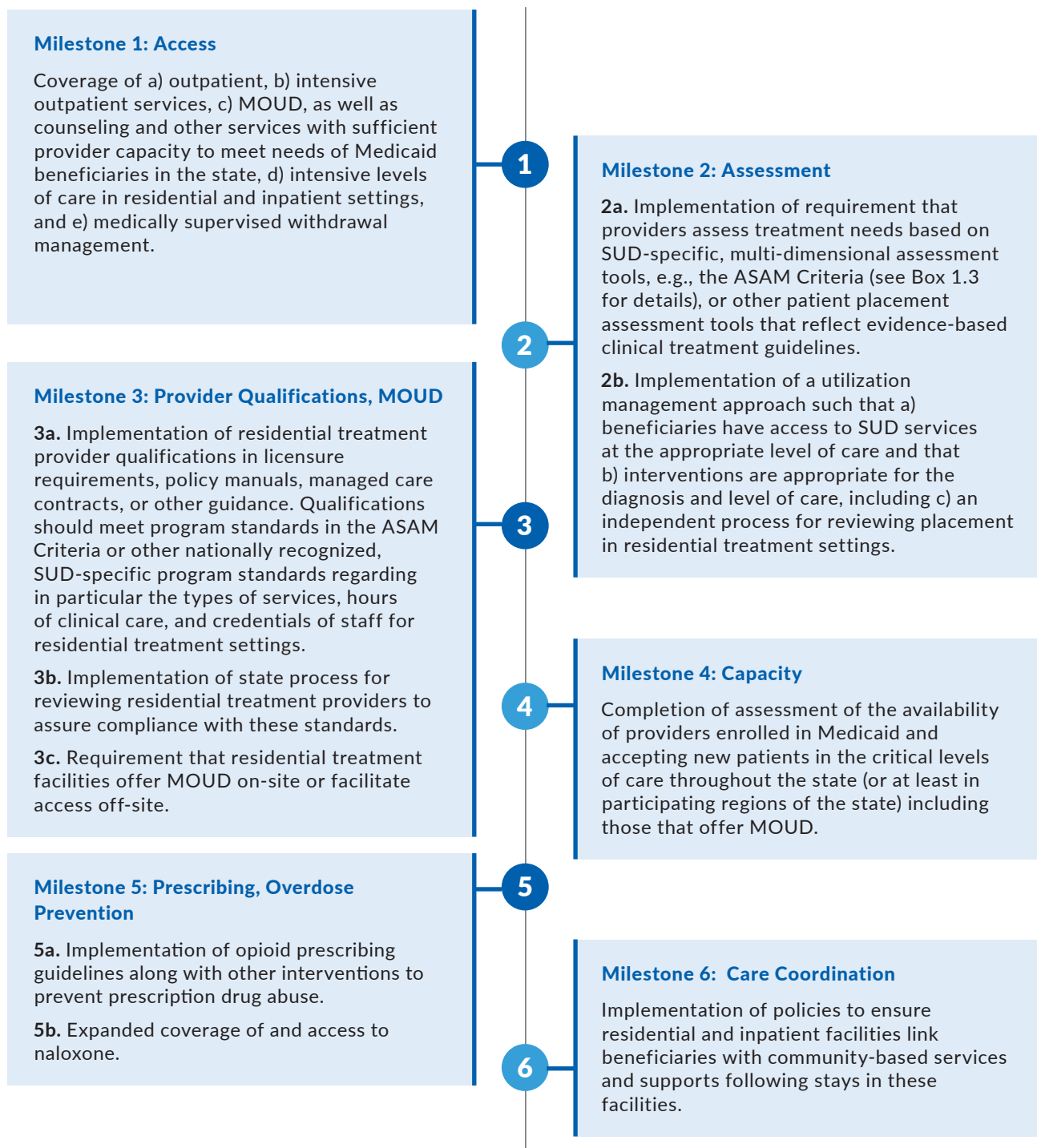
Milestones

To obtain federal funding under the SUD waiver, Washington agreed to demonstrate progress on a set of six milestones identified by CMS:⁸

- 1 Access to critical levels of care for OUD and other SUDs ("Access").
- 2 Widespread use of evidence-based, SUD-specific patient placement criteria ("Assessment").
- 3 Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications ("Provider Qualifications, MOUD").
- 4 Sufficient provider capacity at each level of care, including MOUD ("Capacity").
- 5 Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD ("Prescribing, Overdose Prevention").
- 6 Improved care coordination and transitions between levels of care ("Care Coordination").

Exhibit 1.3 below describes the milestones in further detail. The state outlined its strategic approach and implementation plan for achieving these milestones in the SUD Implementation Plan Protocol. Implementation actions focus on improving admissions assessments for residential SUD treatment (milestone 2), ensuring sufficient provider capacity (milestone 4), expanding access to MOUD (milestone 3), and enhancing care coordination (milestone 6).

Exhibit 1.3: SUD Waiver Milestones



Source: CMS Letter to State Medicaid Directors RE: Strategies to Address the Opioid Epidemic, November 11, 2017.

Box 1.3: The ASAM Criteria

Use of a nationally developed SUD care continuum helps states ensure that a full range of treatment services are available and delivered in adherence to industry standards. The American Society of Addiction Medicine (ASAM) Criteria are one current industry standard for categorizing levels of SUD and co-occurring services and assessing clients for placement in them.

The ASAM Criteria include points along five levels of care, starting at 0.5 (Early Intervention) and going to 4 (Medically Managed Intensive Inpatient). Residential and inpatient services addressed by the SUD waiver occur within Level 3. To determine which level of care is appropriate for an individual, clinicians perform a six-dimensional assessment that includes aspects of psycho-social and physical health characteristics; the sixth dimension also encompasses physical and social environment. For further details, see <https://www.asam.org/asam-criteria/about>.

Performance Measures

To gauge progress on SUD delivery system improvements, including milestone progress, CMS required that the state report on a set of performance measures. Each measure, described in Washington's SUD Monitoring Protocol, is associated with a directional target (increase/decrease/maintain) and tracked on either a monthly or annual basis. The SUD Monitoring Protocol divides measures into seven "domains" as follows:

- 1 Assessment of need and qualification for SUD treatment services.
- 2 Access to critical levels of care for OUD and other SUDs (milestone 1).
- 3 Sufficient provider capacity at critical levels of care, including MOUD (milestone 4).
- 4 Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD (milestone 5).
- 5 Improved care coordination and transitions between levels of care (milestone 6).
- 6 SUD health information technology (HIT).
- 7 Other SUD-related metrics.

Mid-Point Assessment

HCA agreed to provide CMS with an independent assessment of the SUD component of its 1115 waiver by December 31, 2020. Per the waiver's terms, the independent assessor must collaborate with key partners (including tribes, MCOs, SUD treatment providers, and beneficiaries) in designing, planning and conducting the assessment. The assessment must contain the following components:⁹

- Examination of progress toward meeting milestones and time-frames approved in the SUD Implementation Plan Protocol.
- Assessment of annual progress toward closing the gap between baseline and target on the performance measures in the SUD Monitoring Protocol.
- Determination of factors affecting current and future achievement of milestones and performance targets, as well as the risk of missing milestones and performance targets.

- Status update on budget neutrality requirements.
- Recommendations for adjustments to the state's implementation plan or other steps the state can take to support improvement.

In August 2019, HCA contracted with CHSE to conduct the MPA. CHSE is the Independent External Evaluator (IEE) conducting the evaluation of Washington's 1115 waiver, or MTP.

Assessment Tasks

To complete this assessment, the CHSE team undertook six main tasks which directly aligned with CMS requirements described above. These tasks were:

- 1 Facilitate meetings to engage key stakeholders and tribes.
- 2 Assess progress toward (a) meeting each milestone of the SUD Implementation Plan Protocol, and (b) annual goals and targets per the SUD Monitoring Protocol.
- 3 Determine factors affecting achievement of milestones and performance targets to date, factors likely to affect future performance, and risks of possibly missing milestones and performance targets.
- 4 Provide a status update on budget neutrality requirements.
- 5 Provide recommendations on actions for milestones and targets at risk of not being met.
- 6 Deliver a final MPA Report (preceded by a Draft Report).

Our overall approach to each of these tasks is summarized in Exhibit 1.4 below. To complete assessment activities, the team received input and information from HCA staff; this included data, technical documentation, policy documents, assistance with outreach to key informants, and expenditure reports. We met regularly with HCA staff to provide progress updates, clarify expectations, and request additional information.

Exhibit 1.4: Mid-Point Assessment Tasks

Task/description	Approach & Activities	Chapter
TASK 1: Facilitate meetings to engage key stakeholders and tribes	<ul style="list-style-type: none"> • With input from HCA, met with representatives of MCOs, SUD treatment providers, recovery support organizations, tribes, and other key partners to inform the design, planning, and conducting of the MPA. • Facilitated group session at Washington's annual Co-occurring Disorders Treatment conference and presented at a monthly MCO/HCA meeting. • Presented on the MPA at two monthly tribal HCA meetings and held an in-person listening session with tribal representatives. 	Appendix A, Chapter 4
TASK 2A: Assess progress toward meeting each milestone of the SUD Implementation Plan Protocol	<ul style="list-style-type: none"> • Reviewed various documents and reports to assess progress on implementation actions for milestones 2, 3, 4, and 6. • Reviewed MCO/BHO contract language and guidelines in the Washington Administrative Code (WAC) to assess achievement of implementation actions for milestones 3 and 6. • Reviewed Washington's self-assessment report to CMS on the availability of SUD and MOUD providers to assess achievement of implementation actions for milestone 4. • Reviewed the state's SUD Billing Guide for fee-for-service Medicaid providers to assess milestone 2 implementation progress. 	Chapter 2, Appendix E
TASK 2B: Assess progress toward annual goals and demonstration targets in the SUD Monitoring Protocol	<ul style="list-style-type: none"> • Analyzed administrative and claims data obtained from HCA to calculate metrics specified in the SUD Monitoring Protocol. • Used statistical techniques to assess target achievement with data covering the years 2017 through 2019. 	Chapter 3, Appendix C
TASK 3: Determine factors affecting achievement of milestones and performance targets to date, factors likely to affect future performance, and risks of possibly missing milestones and performance targets	<ul style="list-style-type: none"> • With HCA input, identified key informants with detailed knowledge of Washington's SUD treatment delivery system, comprised of providers (including tribal providers), MCO representatives, recovery support organizations, and state program staff involved with waiver implementation. • Conducted 14 key informant interviews. • Analyzed interview transcripts to identify factors key informants perceived as affecting milestone progress, as well as risk of not attaining milestones. 	Chapters 3 and 4, Appendix D
TASK 4: Provide a status update of budget neutrality requirements	<ul style="list-style-type: none"> • Reviewed budget neutrality guidance from CMS. • Reviewed budget neutrality monitoring reports submitted by HCA to CMS in 2019 and 2020. 	Appendix B
TASK 5: Provide recommendations on actions for milestones or targets at risk of not being met	<ul style="list-style-type: none"> • Drawing from interviews with key informants, identified pertinent factors the state can influence to address performance gaps and barriers to further milestone improvement. 	Chapter 5
TASK 6: Deliver a report to the state	<ul style="list-style-type: none"> • Developed MPA report including a description of methodologies used for examining progress and addressing risk, limitations of these methodologies, results, and recommendations. 	

Structure of This Report

Chapter 2 of this report provides an assessment of actions Washington has taken to implement the SUD waiver. We outline steps the state needed to take to achieve each milestone required by CMS and describe methods the MPA team used to assess completion of each activity.

Chapter 3 outlines the performance measures used to assess milestone achievement. We describe the methodology for evaluating performance and report results on each measure. To interpret these results, Chapter 3 also brings in contextual information from interviews with 14 SUD delivery system key informants, including representatives from providers, MCOs, and recovery support organizations. These interviews provided stakeholder perspectives on factors affecting milestone performance to date, as well as factors likely to affect performance in the future, and generated stakeholder recommendations for improving performance.

Chapter 4 describes the assessment team's collaboration with tribes and findings from discussions with tribal representatives and tribally operated SUD treatment facilities.

Finally, **Chapter 5** summarizes work from the metrics evaluation and key informant interviews, synthesizing these into a series of key findings on waiver implementation to date. Based on these findings, Chapter 5 provides recommendations for how the state can continue to promote attainment of the waiver milestones and successful outcomes for Medicaid beneficiaries with SUD.

Appendix A summarizes findings from outreach and engagement activities.

Appendix B provides a review of budget neutrality in Washington's implementation of the waiver.

Appendix C provides technical details on the construction of performance measures and statistical methods.

Appendix D reproduces the interview guide used for key informant interviews.

Appendix E reproduces data tables from Washington's July 2019 assessment of SUD provider availability.

Does this report include information about the effects of COVID-19?

The COVID-19 outbreak began in Washington State in early 2020, causing widespread disruption to the state's health care delivery system. However, the COVID-19 outbreak had little to no effect on Washington's delivery system during the time period described in this report (through December 2019), as this period pre-dates the first known case of the virus in the United States. Later reports will address whether and how COVID-19 impacted progress on MTP.

State Actions to Implement Milestones

Overview

As part of CMS' approval of the SUD waiver, the state submitted an SUD Implementation Plan Protocol (hereafter “implementation plan”) outlining its approach to meeting waiver milestones. For each milestone, the implementation plan described the “current state” of SUD service delivery in Washington, the “future state” consistent with the state’s strategic approach, a “summary of actions needed” to reach the future state, and a projected timeline for completing these actions. Exhibit 2.1 below summarizes the activities Washington planned to undertake for each milestone.

Exhibit 2.1: Washington's Actions per the SUD Implementation Plan Protocol

Milestone	State Actions	Complete by
1. Access	No actions needed.	N/A.
2. Assessment	Update SUD FFS Billing Guide to include a requirement that any FFS SUD residential stay admission be preceded by an independent assessment for residential ASAM level of care.	February 2019.
3. Provider Qualifications, MOUD	Update MCO/BHO contracts and Washington Administrative Code (WAC) to include new requirement that residential treatment facilities offer MOUD on-site or facilitate off-site access.	June 2019 (contract updates); January 2020 (effective date of WAC changes).
4. Capacity	Complete assessment of the availability of providers enrolled in Medicaid and accepting new patients in critical levels of care throughout the state, including those that offer MOUD; submit report to CMS.	April 2019.
5. Prescribing, Overdose Prevention	No actions needed.	N/A.
6. Care Coordination	Update MCO/BHO contracts and the WAC to include new requirement that MCOs, residential treatment providers, and outpatient providers work to develop policies and practices that enhance care coordination, including transitions between levels of care following residential treatment stays.	June 2019 (contract updates); January 2020 (effective date of WAC changes).

Source: Washington State Medicaid Transformation Project Special Terms & Conditions, pp. 305-324 (Attachment K, SUD Implementation Plan Protocol)

KEY FINDINGS

- The state has completed the majority of the necessary actions for implementing the SUD waiver's six milestones. Actions specified in the SUD Implementation Plan Protocol for milestones 1, 2, 4, and 5 are complete.
- The state has made progress on milestone 3: it has updated managed care contracts to include the requirement that residential facilities offer MOUD on-site or facilitate off-site access. HCA has implemented emergency WAC changes, with formal DOH rule-making underway.
- On milestone 6, the state has updated managed care contracts with requirements for care coordination and care transitions. It has also developed draft language which it expects will be incorporated into the WAC by mid-2021.
- The remaining work to complete milestones 3 and 6 is relatively straightforward, and the state should be able to address these within a short time frame.

Findings on Milestone Implementation

Milestone 1: Access

At the time of its application for the SUD amendment, Washington had already implemented a framework of rules and requirements to ensure Medicaid beneficiaries' access to critical levels of care for OUD and other SUDs. The State Plan included requirements for outpatient, withdrawal management, and inpatient services, and IMC contracts required that MCOs provide access to these services. The WAC specified requirements for the service categories Outpatient SUD, Residential SUD, ASAM 3.5 Intensive Inpatient SUD, ASAM 3.1 Recovery House, ASAM 3.1 Long-Term Residential SUD, Withdrawal Management, and Opioid Treatment Programs. Inpatient and withdrawal management services had to be provided in state-certified facilities, and SUD counseling could only be provided by a state-licensed Chemical Dependency Professional (CDP) or trainee (CDP-T).

Since these activities were already in place at the time of the SUD amendment application, no further implementation actions were required per the implementation plan.

During key informant interviews, a respondent noted that the state had inadvertently omitted ASAM 3.3, Clinically Managed Population-Specific High-Intensity Residential Services, from the WAC revisions. Per our informant, residential programs for pregnant and parenting women typically are delivered within this level. Our informant expected DOH to add this level to the State Plan when the WAC is next revised.

Milestone 2: Assessment

As of 2018, the WAC (388-877-0738 to 0753 and 388-877-1108 to 1116) required that SUD providers in Washington use ASAM criteria for admission, continued services, and discharge decisions. For Medicaid managed care beneficiaries, admissions to residential SUD facilities were subject to an additional level of monitoring via the BHO/MCO authorization process that reviewed placements on the basis of medical necessity and ASAM criteria. Thus, further implementation for milestone 2 focused on assessment practices for beneficiaries in the FFS program.

Admission to residential SUD facilities for FFS beneficiaries required a prior assessment by an outpatient provider not associated with the facility. If the independent outpatient provider determined that ASAM criteria for residential care were met, they would refer the beneficiary to a residential facility. The majority of FFS beneficiaries affected by this requirement were individuals identifying as American Indian or Alaska Native (AI/AN). Due to the limited number of tribal providers in the state, the requirement that assessments be completed by an entirely separate organization often meant that AI/AN individuals needed to seek care from non-tribal providers, creating additional barriers to care and delays for AI/AN beneficiaries.

Implementation Plan Actions

To address this problem as part of milestone 2, Washington planned to modify the assessment requirement for FFS SUD residential treatment so that assessments “must be completed independently of the SUD residential facility.”¹⁰ In practice, this would mean that assessments for AI/AN beneficiaries could be completed by tribal providers affiliated with the residential facility. The change would be implemented through an amendment to the SUD FFS Billing Guide and associated modifications to the data reporting system as necessary, to be completed by February 2019.

State Progress on Implementation Actions

To verify completion of this action, we reviewed versions of the Substance Use Disorder FFS Billing Guide posted on HCA’s website. Beginning with the version dated April 1, 2020, the guide contains the following language:¹¹

*A residential facility must have an independent assessment.***

***In accordance with Washington State’s approved 1115 waiver with the Centers for Medicare and Medicaid Services (CMS), fee-for-service residential providers must ensure Medicaid clients have an independent assessment from an outpatient provider. The independent provider will determine whether the client meets the American Society of Addiction Medicine (ASAM) residential level of care.*

This matches the language in the implementation plan. We verified in conversations with HCA staff that corresponding modifications have been made to Provider One, Washington’s MMIS claims payment system.

Summary

Based on the actions described above, we consider Washington’s action for milestone 2 completed.

Milestone 3: Provider Qualifications, MOUD

Implementation Plan Actions

At the time of its amendment application, Washington already met most of the requirements under milestone 3; the WAC rules contained provisions requiring providers to satisfy ASAM treatment standards for types of services, hours of clinical care, and staff credentials. The state committed to improving the availability of MOUD in residential treatment settings by introducing a requirement that residential facilities offer MOUD on-site or facilitate off-site access. This requirement would be implemented by updating MCO/BHO contracts and the WAC to incorporate new language. These updates would be completed by June 2019 and January 2020, respectively.

State Progress on Implementation Actions

To verify completion of milestone 3 actions, we reviewed IMC and PIHP contracts covering calendar year 2019 and the relevant sections of the WAC. These contracts are typically amended twice annually (effective January 1st and July 1st) for language changes. To avoid duplicative effort, we did not review individual MCO/BHO contracts with HCA, but instead requested contract templates. HCA confirmed that individual contracts are identical, with the exception of funding amounts and contact information for the contracted entity. Exhibit 2.2 below summarizes the language included in IMC and PIHP contracts corresponding to the new MOUD requirement for residential treatment facilities.

Exhibit 2.2: IMC and PIHP Contract Language for Milestone 3

Contract Type	Effective Date (Start)	Section(s)	Excerpt(s)
Washington Apple Health Fully Integrated Managed Care	July 1, 2019	16.10.40 - Residential treatment facilities to offer MAT on-site or facilitate access off-site.	“The Contractor must require that residential and inpatient treatment agencies develop policies and procedures to offer MAT on-site or facilitate access off-site on July 1, 2019. Any new policies or procedures must take effect on or before January 1, 2020.”
BHO Program Agreement – Prepaid Inpatient Health Plan	July 1, 2019	12.2.7 - Residential treatment facilities to offer MAT on-site or facilitate access off-site.	“The Contractor must require that residential and inpatient treatment agencies develop policies and procedures to offer MAT on-site or facilitate access off-site on July 1, 2019. Any new policies or procedures must take effect on or before January 1, 2020.”

Source: Standard IMC and PIHP contracts obtained from Washington Health Care Authority.

Note: Although we use the term MOUD throughout this report, we use Medication Assisted Treatment (MAT) here for consistency with contract language.

As shown in Exhibit 2.2, both MCO and BHO contracts were updated effective July 1, 2019 to include language specific to the milestone 3 MOUD requirement.

DOH has yet to complete updates to the WAC in accordance with milestone 3. HCA filed an emergency rule-making order effective April 24, 2020 which is anticipated to move to a permanent rule at a later date.¹² The order adds a new rule, 182-502-0016A Continuing Requirements – Residential Treatment Facilities. Text of the rule is reproduced below.

In addition to the requirements in WAC 182-502-0016, to continue to provide services for eligible clients and be paid for those services, residential treatment facilities (as defined in chapter 246-337 WAC) must:

- 1. Not deny entry or acceptance of clients into the facility solely because the client is prescribed medication to treat substance use disorders (SUD).*

2. *Facilitate access to medications specific to the client's diagnosed clinical needs, including medications used to treat SUD.*
3. *Not mandate titration of any prescribed medications to treat any SUD as a condition of clients receiving treatment or continuing to receive treatment. Decisions concerning medication adjustment must be coordinated with the prescribing provider and be based on medical necessity.*
4. *Coordinate care upon discharge for client to continue medications specific to a client's diagnosed clinical needs, including medications used to treat SUD.*

Summary

Our review found that the state has completed some, but not all actions for milestone 3 specified in the SUD Implementation Plan. Whereas updates to MCO and BHO contracts were completed as of July 1, 2019, the state has not yet completed formal updates to the WAC to reflect milestone 3 requirements. However, HCA has implemented emergency WAC language to this effect, and we expect that the remaining work will be completed within a short time frame.

Milestone 4: Capacity

Implementation Plan Actions

To satisfy milestone 4, the state's SUD Implementation Plan Protocol identified the following requirement:

The state will complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state including those that offer MOUD:

- *Outpatient services.*
- *Intensive outpatient services.*
- *MOUD (medications as well as counseling and other services).*
- *Intensive care in residential and inpatient settings.*
- *Medically supervised withdrawal management.*

The assessment will help the state determine whether it has sufficient provider capacity in the areas listed above. If any area is determined to be below capacity, the report will include the state's plans to increase availability of this service.

State Progress on Implementation Actions

In July 2019, the state delivered a report to CMS describing Washington's provider capacity in each of the care levels above, as well as actions undertaken or planned to increase capacity. To assess the state's fulfillment of the milestone 4 requirement, we have carefully reviewed this report (hereafter, "milestone 4 report"). Below we provide a summary of the data used by the state to assess capacity, key findings of the report, and plans identified in the report to increase capacity.

Data to Assess Capacity

To assess the availability of providers in each of the critical levels of care, the report presented the following data:

- 1 Licensed SUD facilities as of June 2018 for outpatient, inpatient and withdrawal management.
- 2 Licensed SUD outpatient facilities per 1,000 Medicaid beneficiaries with SUD, as of June 2018.
- 3 Number of prescribers submitting Medicaid claims for non-Methadone MOUD (January 2016 to June 2018).
- 4 SUD treatment penetration rate for Medicaid beneficiaries with SUD treatment need (January 2016-September 2018).
- 5 MOUD penetration rate for Medicaid Beneficiaries with OUD (January 2014-September 2018).

Data were reported by Accountable Community of Health (ACH) region. At the time the report was finalized, the state did not have the means to report whether a licensed SUD facility accepted Medicaid, nor whether the facility accepted new clients. Therefore, items 1 and 2 include all licensed SUD facilities in Washington as of June 2018. Significant changes to the state's management of behavioral health benefits and provider licensing in 2018-2019 (described in Chapter 1) affected data availability. The state is continuing to work on improvements to provider tracking.

Outpatient Services and Intensive Outpatient Services

As of June 2018, the state had 449 licensed outpatient SUD facilities. Table 1 of the state's report (reproduced in Appendix E) provides a breakdown of facilities by ACH region. Across the state, there were on average three licensed SUD outpatient facilities per 1,000 Medicaid clients with SUD, with substantial variation between ACH regions. (See Figure 2 of the report, reproduced in Appendix E.) The report noted that this variation highlights an opportunity for improvement in the state to increase access to outpatient SUD treatment.

At the time the milestone 4 report was finalized, intensive outpatient services were not reported as a distinct type of service in Washington. The Washington State Service Encounter Reporting Instructions did not contain administrative codes for intensive outpatient services as a unique service for the treatment of SUD. All outpatient services, including intensive outpatient services, were billed under a broad definition of "outpatient services." Therefore, no data were available on the number of providers offering intensive outpatient services.

Medications for Opioid Use Disorder

MOUD is available to Washington Medicaid beneficiaries through two types of treatment settings; Opioid Treatment Programs (OTP) and Office Based Opioid Treatment (OBOT) programs. OTPs dispense either methadone or buprenorphine, naltrexone, or combination buprenorphine/naloxone. OBOT prescribers offer buprenorphine, naltrexone, or combination buprenorphine/naltrexone.

As of June 30, 2019, there were 26 OTPs in Washington, three of which were tribally owned and operated. All ACH regions had two or more OTPs, except for Olympic Community of Health, Greater Columbia, and North Central, which had no OTPs.

To capture statewide availability of non-methadone MOUD providers (both OTP and OBOT), the state analyzed billing claims to determine the number of prescribers submitting claims by ACH region.

Statewide, the number of prescribers submitting claims for buprenorphine and/or naltrexone increased from 673 for the period January-December 2016 to 1,060 for the period July 2017-June 2018, representing an increase of 58%. Each ACH region saw increases during this time frame, with larger increases in more urban areas (see Table 3, reproduced in Appendix E).

The state also reported that the MOUD penetration rate (percentage of Medicaid-covered individuals with OUD receiving any type of MOUD) increased from 33% in calendar year 2016 to 48% in the 12 months ending September 2018. All ACH regions saw increases in MOUD penetration during this time frame (see Table 7, reproduced in Appendix E). Increased MOUD penetration was mainly driven by an increase in the number of individuals receiving buprenorphine/naltrexone.

Inpatient and Withdrawal Management Services

As of June 2018, there were 49 licensed inpatient SUD facilities and 28 licensed withdrawal management facilities in Washington (see Table 1, reproduced in Appendix E). Compared to outpatient services, beneficiaries had considerably fewer options for receiving inpatient and withdrawal management services. As a result, the state noted that individuals with SUD may have to travel outside of their region of residence to receive these services.

Overall Access to SUD Treatment Services

Overall access to SUD/ODU services among Washington Medicaid beneficiaries, as measured by the statewide SUD treatment penetration rate, increased between 2016 and 2018. The statewide SUD treatment penetration rate (i.e., the percentage of Medicaid beneficiaries aged 12 and older with an SUD treatment need who received any type of SUD treatment service) increased from 27% in calendar year 2016 to 32% in the 12 months ending with September 2018. Each ACH region also saw increases in SUD treatment penetration rates during this period (see Table 5, reproduced in Appendix E).

Plans to Increase Availability of SUD Treatment Services

The report outlined an array of current and planned initiatives to expand accessibility of SUD and OUD treatment in Washington to meet growing needs. Made possible by both state and federal funding, these activities were intended to increase awareness of the opioid epidemic, increase the supply of MOUD providers, and improve uptake of best practices related to treatment.

A number of initiatives being implemented under MTP would target SUD and OUD service delivery. The Foundational Community Supports (FCS) initiative would make available supported employment and housing services for persons requiring outpatient SUD services. MTP also requires ACHs to implement projects to “address the opioid use public health crisis.” Other initiatives underway included grant programs such as the State Targeted Response (STR) Hub and Spoke model, State Opioid Response (SOR), Opioid Treatment Network (OTN), and the Low Barrier Buprenorphine model. The state had requested a State Plan Amendment for SUD peer services. DOH was also processing four applications for new OTPs, one of which was for a tribally owned and operated OTP, and anticipated approving these in 2019.

HCA planned to continue to expand treatment in rural areas of the state, use SOR grant funds to address access barriers, expand services to pregnant and parenting women and individuals with Hepatitis C, and contract with OTNs in jails, homeless shelters, syringe exchanges, and hospitals.

HCA also outlined plans to examine strategies for applying value-based payment models for OTPs, which it anticipated would spur the creation of additional OTPs. The state also planned to develop strategies to increase the supply of qualified clinicians at all levels of treatment intensity. This would include exploring opportunities to support recruitment, retention and training for Medicaid providers offering SUD/LOUD services, as well as improved reimbursement for Medicaid providers authorized to dispense MOUD.

Summary

Washington delivered a report to CMS in July 2019 that included data on the number of providers in the state offering inpatient, outpatient, MOUD, and withdrawal management services. The report also outlined plans to increase the availability of SUD treatment services in Washington. We therefore consider the SUD Implementation Plan action for milestone 4 completed.

Due to data constraints, the state's report on SUD provider availability did not identify whether a licensed SUD facility accepted Medicaid, nor whether the facility was accepting new clients. Since the report was finalized, the state has made improvements to its provider tracking capabilities and is now able to report on the number of SUD facilities enrolled in Medicaid that are actively providing SUD services to Medicaid beneficiaries (see Chapter 3 of this report).

Milestone 5: Prescribing, Overdose Prevention

Washington identified in the implementation plan various programs, rules and requirements that set the state on a path toward meeting milestone 5. These included:

- Guidelines on prescribing opioids for pain developed by the Washington Agency Medical Director's Group (AMDG).
- The adoption by five prescribing profession boards of rules, codified in the WAC, for opioid prescribing and the management of non-cancer pain.
- The requirement that practitioners licensed to prescribe opioids complete at least one hour of continuing education on these rules.
- HCA's implementation of clinical policies for opioid prescriptions, applicable in both the managed care and FFS setting.
- Annual opioid prescribing reports sent to the highest prescribers of opioids to drive quality improvement.
- Washington State law RCW 69.50.315, which allows anyone "at risk for having or witnessing a drug overdose" to obtain naloxone and administer it in an overdose.
- Various collaborative grant projects between DBHR and the University of Washington Alcohol and Drug Abuse Institute (ADAI), including a comprehensive website providing naloxone education and purchasing information, and a statewide network of opioid overdose experts and interventions.
- Washington State law RCW 69.41.096 ("Naloxone law"), which permits naloxone prescribing directly to an "entity" such as police department, homeless shelter, or social service agency.
- So-called "good Samaritan" laws (RCW 4.24.300 and RCW 69.50.315) protecting overdose victims and persons assisting an overdose victim from prosecution for drug possession.
- Distribution of naloxone at all Syringe Exchange programs in the state.

- DOH’s Prescription Monitoring Program, a centralized database of substance prescription information which allows prescribers to review patients’ prescription history before prescribing drugs.

Since these activities were already in place at the time of the amendment application, no further implementation actions were required.

Milestone 6: Care Coordination

Implementation Plan Actions

The implementation plan noted that although mental health providers had long been coordinating care between inpatient and outpatient settings through discharge planning requirements and “hospital liaison” staff, the same level of coordination may not be occurring between SUD residential and outpatient systems. To promote greater coordination of SUD care across settings, the state would implement a requirement that MCOs, residential treatment providers, and outpatient providers work to develop policies and practices that enhance care coordination, including transitions between levels of care following residential treatment stays. This would be implemented by adding the requisite language to BHO/MCO contracts and updating the WAC. These updates would be completed by June 2019 and January 2020, respectively.

State Progress on Implementation Actions

To verify that milestone 6 actions had been completed, we reviewed IMC and PIHP contracts covering calendar year 2019 and the relevant sections of the WAC. We reviewed contract templates rather than individual MCO/BHO contracts to avoid unnecessary duplication of effort. Exhibit 2.3 below summarizes the language included in IMC and PIHP contracts corresponding to the care coordination requirements under milestone 6.

Exhibit 2.3: IMC and PIHP Contract Language for Milestone 6

Contract Type	Effective Date (Start)	Section(s)	Excerpt(s)
Washington Apple Health Fully Integrated Managed Care	July 1, 2019	14.18.4	(14.18.4.1) “The Contractor must require that behavioral health treatment agencies develop policies and procedures that enhance care coordination, including transitions between all levels of care, by July 1, 2019. Any new policies or procedures must take effect on or before October 1, 2019.”
		14.18.5	
BHO Program Agreement – Prepaid Inpatient Health Plan	January 1, 2019	12.1.6	(12.1.6) “The Contractor must ensure that there is coordination with the other service delivery systems responsible for meeting the identified needs.”
		12.2.1	(12.2.1) “For continuity of care the Contractor must encourage the Subcontractor(s) to assign Enrollees to clinicians who are anticipated to provide services to the Enrollee throughout the authorization period.”
		15.4.5	(15.4.5) “Case management is used ... to support them as they move through stages of substance use disorder treatment within or between separate treatment agencies.”

Source: Standard IMC and PIHP contracts obtained from Washington Health Care Authority.

Milestone 6 language was incorporated into MCO contracts effective July 1, 2019. Based on our review, corresponding updates were not made to BHO contracts. However, as shown in Exhibit 2.3, the latter already (as of January 2019) included a number of provisions addressing the need for care coordination and case management.

At the time of writing, WAC changes for milestone 6 are in progress under a delayed timeline. DOH has developed draft language on care coordination and care transitions which is expected to be incorporated into the WAC (246-341) by mid-2021.¹³ The draft language has undergone stakeholder review and input. It requires that agencies providing SUD services (under WAC 246-341-1100 through 246-341-1116) or mental health services (under WAC 246-341-1118 through 246-341-1158) meet these requirements:

(g) Coordinate with the individual's current treatment provider, if applicable, to assure continuity of care during admission and upon discharge.

(h) Develop and provide to the individual a discharge summary that includes:

(i) A continuing care recommendation; and

(ii) Scheduled follow-up appointments, including the time and date of the appointment(s)

(i) Document referrals made to behavioral health providers including documentation that a discharge summary was provided to the receiving behavioral health provider; and

(j) Document contact or attempts to follow-up with the individual post-discharge including the date of correspondence.

Summary

Our review found that the state has completed some, but not all actions for milestone 6 specified in the SUD Implementation Plan. Whereas updates to MCO and BHO contracts were completed as of July 1, 2019, the state has not yet updated the WAC to reflect milestone 6 requirements. However, we expect that the remaining work will be completed within a short time frame.

Washington's Progress on Milestones and Metrics

Overview

In this chapter, we assess Washington's performance on meeting each milestone of the SUD Implementation Plan Protocol and targets for SUD metrics in the SUD Monitoring Protocol. We use a two-pronged approach, combining quantitative analysis of performance metrics with qualitative information collected from key informant interviews.

We assess progress on each milestone separately, taking into account interrelationships between milestones and metrics. First, using data provided by the state for the years 2017 through 2019, we quantitatively assess changes associated with the SUD waiver amendment for each metric. We then analyze findings on milestone progress from key informant interviews, highlighting factors that could affect performance on specific milestones and metrics. We also describe key informants' views on the likelihood of meeting milestones and targets.

KEY FINDINGS

- *We assessed changes across 25 measures in seven domains. Overall, these measures moved in the targeted direction, suggesting significant progress in expanding access and provider capacity, improving treatment quality, and increasing care coordination for Medicaid beneficiaries with SUD.*
- *There were substantial improvements in, for example, measures of Initiation of Alcohol and Other Drug Dependence Treatment, and Access to Preventive Services for Individuals with SUD. Measures that moved in the opposite of the targeted direction included Follow-up after Emergency Department Visit for Mental Illness (7- and 30-day measure) and a small decrease in the number of Medicaid beneficiaries treated in IMDs for SUD.*
- *Despite this progress, there were implementation challenges, particularly in the state's IMC transition. According to providers, the transition created delays in payment and adversely affected provider organizations' financial stability. As MCOs took on financial risk for residential services, disagreements emerged between payers and providers about the role of residential care in SUD treatment.*

Methodology for Assessing Progress

Our assessment of progress on SUD milestones and metrics relies on both quantitative analyses of outcomes for SUD performance measures and qualitative data from key informant interviews. We summarize our approach below, with further details provided in Appendices C and D.

SUD Performance Measures

Washington's SUD Monitoring Protocol specifies the SUD performance metrics to be tracked as part of the MPA. Whereas some metrics correspond to specific milestones, others have more general relevance to assessing the performance of the state's SUD delivery system. Exhibit 3.1 summarizes the 29 SUD metrics included in the MPA and their directional targets per the SUD Monitoring Protocol. Detailed measure specifications, information on data sources, and population/subgroup definitions can be found in Appendix C.

Exhibit 3.1 SUD Metrics Included in the Mid-Point Assessment

Domain	Metric	Target
1. Assessment of need and qualification for SUD treatment services	Medicaid Beneficiaries with an SUD Diagnosis	↑
	Medicaid Beneficiaries Treated in an IMD for SUD	↑
	Any SUD Treatment	↑
	Early Intervention	↑
	Outpatient Services	↑
2. Access to critical levels of care for OUDs and other (milestone 1)	Residential and Inpatient Services	↑
	Withdrawal Management	↑
	Medications for Addiction Treatment	↑
	Average Length of Stay in IMDs	↔ ↓
3. Sufficient Provider capacity at critical levels of care including MOUD (milestone 4)	Facilities Enrolled in Medicaid that Billed for SUD Services	↑
	Providers Enrolled in Medicaid who Billed for MOUD	↑
4. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD (milestone 5)	Alcohol or Other Drug Treatment: Initiation	↑
	Alcohol or Other Drug Treatment: Engagement	↑
	People with an Opioid Prescription >90mg MED	↓
	People with an Opioid Prescription who were Prescribed a Sedative	↓
	Continuity of Pharmacotherapy for Opioid Use Disorder	↑
5. Improved care coordination and transitions between levels of care (milestone 6)	30-Day Follow-Up after ED Visit for Alcohol/Drug Abuse/Dependence	↑
	7-Day Follow-Up after ED Visit for Alcohol/Drug Abuse/Dependence	↑
	30-Day Follow-Up after ED Visit for Mental Illness	↑
	7-Day Follow-Up after ED Visit for Mental Illness	↑

6. SUD Health IT (HIT)	Statewide Deaths due to Drug Overdoses	↓
	Substance Use Disorder Treatment Penetration	↑
	FCS Beneficiaries with Inpatient or Residential SUD Service(s)	↑
7. Other SUD-related metrics	All-Cause Emergency Department Visits per 1,000 Beneficiaries	↓
	Inpatient Admissions for Substance Use Disorder per 1,000 Beneficiaries	↓
	Readmissions Among Beneficiaries with SUD	↓
	Overdose Deaths (count)	↓
	Overdose Deaths (rate)	↓
	Access to Preventive/Ambulatory Health Services for People with SUD	↑

Source: Washington Medicaid Section 1115 SUD Demonstration Monitoring Protocol, Version 3.1, 2019.

To assess performance, we calculated metrics using Medicaid claims, enrollment, and other data provided by HCA. We report measure results for two time periods; the “SUD Baseline Year” from July 2017 through June 2018, and “SUD Year 1” covering July 2018 through June 2019. We present results separately for each measurement domain.

We compare performance in the SUD Baseline Year to SUD Year 1 using pre-post regression analysis to measure the change in each metric associated with the SUD waiver. The pre-post analysis takes the following form:

$$Y_{it} = m(b_0 + b_1 * \text{PostWaiver}_t + a * X_{it} + e_{it}) \quad (1)$$

Where Y_{it} is the outcome of interest for individual i in year t , $\text{PostWaiver}_t = 1$ if the observation occurs after the effective date of the SUD waiver (July 1, 2018), and 0 otherwise; X_{it} is a vector of demographic covariates and risk adjusters, and e_{it} is a random error term associated with the unmeasured variation in the outcome of interest. The coefficient of interest, b_1 , estimates how much the outcome variable changed with the SUD waiver. For the measure of Adult Access to Preventive/Ambulatory Health Services, we compare calendar year 2017 with calendar year 2019, excluding 2018 as a “transition” year.

To adjust for individual characteristics such as demographics and risk adjusters, we include in our regression models chronic condition indicator variables, age group, gender, race, ethnicity, urban/rural residence, and a zip-code level poverty indicator.

Below we report results for 25 measures across the seven domains, including outcomes in the SUD Baseline Year and Year 1, and the change (adjusted for demographics and risk where possible). Count metrics are calculated as the number of qualifying members, with no denominator or comparison group, so adjusted change is not provided; instead we show unadjusted changes. We did not have data to assess changes in Overdose Deaths, Statewide Deaths due to Drug Overdoses, or Facilities Enrolled in Medicaid that Billed for SUD Services.

Key Informant Interviews

The assessment team conducted a series of interviews with key informants representing the waiver's main stakeholder groups (SUD providers, MCOs, and beneficiaries) as well as tribes. The three main aims of these interviews were:

- 1 To identify factors that have affected achievement of milestones and targets to date and/or are likely to affect future performance in meeting milestones and targets.
- 2 To assess the risk of potentially missing milestones and performance targets.
- 3 To identify strategies (e.g. changes in policy, payment, outreach, and enforcement) that the state could use to address performance gaps.

In collaboration with HCA, the assessment team identified a list of potential informants with experience-based knowledge of SUD treatment systems affected by the waiver. The team selected informants to represent multiple sectors within the treatment delivery system, including providers (with an emphasis on residential treatment providers), tribal providers, recovery support organizations, MCOs, and representatives from HCA and the Department of Corrections. Within the provider category, the team aimed to maximize variation in geographic regions, provider size, tribal and non-tribal affiliation, and payer mix (predominantly Medicaid versus broad payer mix).

Once the assessment team and HCA had agreed upon a list, the agency emailed an introductory letter to informants providing background on the assessment. The team followed up to schedule interviews; invitations were sent to potential informants at 25 organizations. Eight informants did not respond to the invitation, and three informants declined (two for availability issues during the COVID-19 pandemic, the other for lack of pertinent information), yielding 14 completed interviews with 19 participants (some organizations including more than one representative). Organizations declining for COVID-19 reasons included two of the three SUD treatment facilities operated by tribes or Urban Indian Health Programs (UIHPs) we contacted, leaving one tribally specific provider in the sample. Exhibits 3.2 and 3.3 summarize key informants by category and ACH region.

Exhibit 3.2: Key Informant Interviews Completed, by Category

Key Informant Category	Interview Count
SUD provider organizations, general	6
Tribe- or UIHP-operated SUD provider organizations	1
MCOs	2
Recovery support organizations	3
State agency staff (HCA, Corrections)	2

Exhibit 3.3: ACH Regions Represented by Key Informants

Region	SUD Provider Organizations, General	Tribe- or UIHP-operated SUD Provider Organizations	Recovery Support Organizations
Better Health Together	X		X
Olympic Community of Health	X		
Cascade Pacific Action Alliance	X		
SWACH			
Elevate Health			
Greater Columbia	X		
North Central			
North Sound	X		
Healthier Here		X	X

Interviews lasted approximately one hour and followed a semi-structured interview guide, reproduced as Appendix D. They were conducted remotely using the WebEx platform, allowing informants to connect via web video plus audio, web audio only, or phone, according to their preference. Interviews were recorded with informant permission, professionally transcribed, de-identified, and loaded into the Atlas.ti qualitative software application for analysis. The interview guide asked interviewees to describe how the SUD waiver affected SUD service delivery by their organization and across the state. We asked participants to identify and describe factors likely to affect progress toward milestones, as well as factors that might contribute to changes (or lack thereof) in metrics. We also asked interviewees to offer recommendations on actions the state might take to facilitate progress.

The assessment team developed an analytic codebook centered on milestones and related aspects of waiver implementation, creating additional codes inductively in response to interview content. Three team members reviewed and coded initial interviews jointly, meeting at least weekly, to refine the codebook and develop consistency in coding practice. Subsequent interviews were coded individually. Team members reviewed output by code to summarize the content on each milestone and related themes.

In the following sections, we use key informant interview data for two key purposes: (a) to identify factors affecting progress on milestones and the risk of not achieving milestones, and (b) to contextualize and interpret results from analysis of SUD measures. We discuss findings for each milestone separately, while highlighting interrelationships between milestones. We then apply these findings to our interpretation of measure results. We incorporate input from SUD provider organizations, MCOs, recovery support organizations, and state agency staff here. Findings from our interview with an Urban Indian Health Program are provided in Chapter 4.

Results

Integrated Managed Care: A system transition affecting multiple milestones

Although the assessment did not include questions about Washington's IMC transition, providers universally brought up this recent system change as a predominant factor in SUD milestone progress. As one recovery advocate said,

We've had more change in our behavioral health system in Washington in the last five years than we've had in the 50 years that preceded it.

-Key informant 2, recovery advocate

As the most recent among these changes, IMC had impacts that providers described as affecting SUD service delivery globally, across milestones. We discuss these cross-cutting aspects of IMC here, before reviewing findings for individual milestones.

Protracted contracting disrupts provider cash flows

The transition to IMC occurred in a staggered fashion, with the earliest region transitioning in 2016 and the final group of regions transitioning in January 2020. Thus, we spoke with providers whose experience with IMC varied between six months to several years.

Provider and recovery support organization representatives portrayed the IMC transition as working in opposition to gains in residential SUD treatment access promoted by the waiver. Some of the challenges providers associated with IMC arose from the transition itself, which all parties agreed had been difficult. Other challenges, such as utilization management by MCOs, are ongoing features of the new contracting arrangement.

Providers and recovery support organizations described an SUD treatment system that, prior to IMC, was substantially unaccustomed to contracting with national, medically oriented commercial payers. Prior to the transition to IMC, residential providers held contracts directly with the state or with BHOs. With the transition to IMC, residential providers entered into contracts with MCOs, who had traditionally focused on managing physical health care. This change disrupted provider operations on several fronts. Delays in negotiating and signing contracts and establishing billing systems led to significant disruption to revenue streams. In combination with providers' lack of history with commercial insurance management and MCOs' reliance on claims for billing and payment, this made for a chaotic transition.

You took a whole system that was used to a single payer, send them the invoice for what they did, and they sent you a warrant and you all moved on to processing commercial claims... That said, many of the MCOs they picked have not done a very good job of preparing and being able to process those claims.

-Key informant 4, provider representative

According to one provider, contracting delays resulted in accounts receivable balances in excess of one million dollars for some facilities in their first IMC year. This threatened financial sustainability, especially for smaller and Medicaid-focused providers.

It took us until September to get paid from all of 2019. That's how crazy it was. It was like the AR [accounts receivable balance] was insane because it was, we're billing in January 1st and it's all the way into September.

-Key informant 13, provider representative

Providers complimented HCA for stepping in to resolve problems once they came to the agency's attention. One residential provider described overwhelming turnout at a September 2019 statewide meeting of residential providers that brought the issue to the fore.

They all got together and they all found out everybody's struggling with this, nobody's getting through this. And we went to the Healthcare Authority. And they really have responded, and over this last five or six months we've come a long way in resolving this.

-Key informant 4, provider representative

These payment challenges (including some still unresolved) left some providers in a weakened financial state coming into the COVID-19 pandemic, which has reduced residential facilities' capacities and revenues by 20-40%, according to one provider leader.

Providers take on new utilization management role, EHR infrastructure

Even with contracts in place, providers described continuing friction in working with MCOs to gain authorization for residential services. As one recovery advocate explained, providers were accustomed to having SUD utilization managed by local, publicly managed BHOs with extensive knowledge of Washington's SUD systems.

They were run either by single counties or by clusters of counties, but they were run by individuals who really deeply understand the population of folks with behavioral health challenges...We handed that population over to the managed care organizations, who were really good at the provision of medical care, via MCO managed care model, that didn't well understand the behavioral health population.

-Key informant 2, recovery advocate

A new feature of IMC allowed residential providers to perform their own intake assessments. Under the previous BHO arrangements, clients had been required to obtain an assessment and referral from an outpatient provider before entering residential treatment; IMC removed this potential barrier. While some residential providers mentioned this as a benefit, it also meant an increased administrative burden. Under their new IMC contracts, residential providers found themselves needing to complete different forms for each of the five MCOs to obtain treatment authorization or reimbursement, inflating staffing needs and administrative overhead. These interviewees described struggles associated with working with out-of-state MCO utilization management teams with a "checkbox" approach and insufficient training on SUD assessment.

If you didn't hit those 10 checkboxes, the answer was "No." Or, a couple of them hired national firms that, they didn't truly understand.

-Key informant 4, provider representative

Several providers described how the combination of the move to IMC and the state's preparations for the waiver had required them to invest heavily in electronic health record (EHR) systems. This introduced an overhead expense for which they received no additional support.

[A] lot of us have invested hundreds of thousands of dollars into our electronic networks ... to provide the data they want, to do the billing.

-Key informant 4, provider representative

Even though acquiring the EHR platforms was described as a costly and complex transition, some providers were starting to see efficiency gains. This was especially true for those who had been required to enter detailed encounter data for multiple BHOs prior to IMC.

Now that we've integrated into this new system ... it's much quicker and much more efficient and easy to find and easy to locate. If you just open up a patient, you're like, "Oh, I know everything about them." Whereas before, with paper documentation, it was absolutely crazy.

-Key informant 13, provider representative

MCO representatives interviewed for the assessment were aware of challenges to providers resulting from varying administrative practices. They spoke of talking with counterparts at other MCOs to align forms and processes and reduce the burden on providers. One more philosophical provider representative expressed hope that partners in the new contracting relationships were starting to learn and adapt to each other's needs.

There are some learning curves on both sides of the house. Providers are learning and getting better at it, and MCOs are getting better at it.

-Key informant 3, provider representative

Providers, MCOs exhibit differing views on uses of residential treatment, length of treatment stays

Providers and recovery support organizations saw MCOs as having views on the utility of residential treatment fundamentally different from those of the provider and recovery communities. Providers viewed the prior BHOs as having deep familiarity and investment in Washington's communities and behavioral health needs. In contrast, several informants pointed to the commercial status of the MCOs (four of which are for-profit entities) as motivation for them to provide less treatment rather than more.

How can I be polite here? Commercial insurance is all about saying no to services. That's how they make money.

-Key informant 4, provider representative

For their part, MCO representatives raised questions about whether "medical necessity" criteria had traditionally been strictly applied for residential treatment utilization within the state. They also questioned whether providers had become accustomed to using residential services to fill social service rather than medical needs.

Summary

The state's IMC transition, phased in concurrently with the early years of the waiver, produced challenges in revenue streams and utilization management as providers adapted to the new contracting structure. This shift had implications for providers' financial sustainability and the provision of SUD services, while exposing tensions between different stakeholders' understanding of the role of residential treatment.

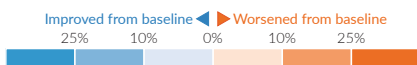
Milestone 1: Access

Performance on Metrics

Table 3.1 displays unadjusted statewide results for each metric in the SUD Baseline Year and Year 1, and the adjusted change in each metric. All of these measures moved in the desired direction. The average length of stay in IMDs was relatively unchanged. However, there were increases in number of beneficiaries receiving any treatment, outpatient services, residential and inpatient services, early intervention, medications for addiction treatment, and withdrawal management.

Table 3.1: Performance on Milestone 1 Metrics

	Baseline Year	SUD Year 1	Unadj. Change
Any SUD Treatment	64,601	70,292	5,691
Average Length of Stay in IMDs (adjusted change)	19.5	20.3	0.3
Early Intervention	1,482	1,740	258
Medications for Addiction Treatment	30,251	37,898	7,647
Outpatient Services	37,854	39,729	1,875
Residential and Inpatient Services	9,823	11,156	1,333
Withdrawal Management	8,697	9,548	851



Note: Adjusted change shown for Average Length of Stay in IMDs.

Key Informant Comments

Assessing stakeholder input on the “access” milestone in isolation from other milestones – particularly patient assessment and provider capacity – presents challenges. In this section, we discuss stakeholder perceptions of changes in access to SUD services at the beneficiary level, with an emphasis on factors that contributed to milestone progress in these areas. More detailed discussion of the patient placement and capacity issues contributing to these perceptions is included with discussions of progress on milestones 2, 3, and 4.

Overall, clients see improved access to residential treatment, especially adult men

Generally, most stakeholders viewed the SUD waiver as increasing access to residential treatment without harming the delivery of services at other levels identified by ASAM (see Chapter 1, Box 1.3 for an overview of the ASAM levels). By providing Medicaid funding for up to an average of 30 days of treatment, the SUD waiver reduced providers' needs to rely on multiple funding sources to support treatment stays of longer than 15 days and reduced patient anxiety about completing

treatment stays. One provider noted that young men, in particular, had benefited from the combination of expanded Medicaid coverage under the Affordable Care Act and the SUD waiver.

Adult males really were the last of the priority list, the last on any priority list. So if you didn't have a disability, there really weren't any pots of money for the 35-year-old male drug addict that wasn't attached to anybody or anything. ... Now, they qualify. So they qualify, they have resources and have access to services. And we've certainly seen a huge demand in adult males seeking services.

-Key informant 4, provider representative

Waiver offers providers more agility for meeting clients' "window of willingness"

Aside from funding, recovery support organizations and providers saw delivery advantages to the waiver. Most providers identified a minimum 28- to 30-day stay as their programmatic preference. They described how the prior 15-day limit had led them to take in clients around the 15th day of the month, allowing them to stitch together two Medicaid-funded 15-day stays across two months to achieve 30 covered days. This meant that clients presenting with a need for treatment would routinely be asked to wait until mid-month for admission, missing what several stakeholders described as a "window of willingness" when clients were motivated to enter treatment. This discrepancy between client needs and system availability was perceived as a significant barrier, given the need to capitalize on a client's motivation to enter treatment. One recovery advocate described a collective provider "sigh of relief" at the improved flexibility.

IMC offers improved outpatient access, greater parity with physical health services

Although tangential to the waiver, MCOs pointed out that access to outpatient treatment presented fewer hurdles to clients now. Under IMC, Medicaid beneficiaries can self-refer for outpatient treatment with no prior approval.

These benefits notwithstanding, stakeholders commented on various obstacles to improving access closely tied to other milestones, including patient placement (milestone 2) and provider capacity (milestone 4). We discuss obstacles from a patient access perspective here, reserving further discussion for subsequent sections dedicated to the relevant milestones.

Prior authorization delays entry into residential services

While removing the 15-day limit led to greater calendar flexibility for admitting clients to residential treatment, MCO prior authorization reviews added back other delays. Providers reported that the transition to MCOs had increased the complexity of the prior authorization process. The resulting delays impacted their ability to provide timely care. A typical timeline might involve a client obtaining an assessment, then waiting two to six weeks to have their MCO review and approve a residential stay.

They can start looking for a bed only when they say, "Okay, you're sick enough to necessitate this level of care..." By the time their bed date comes up, they have died, or they have lost their willingness, or they can't find them anymore.

-Key informant 2, recovery advocate

Providers encounter push-back from MCOs on authorizing continued treatment stays

Providers reported expending large amounts of staff time obtaining approvals for additional seven-day authorizations for residential treatment stays beyond the first 14 days. This countered their view

of the waiver's intent, which they saw as enabling longer stays. In contrast, MCOs questioned the evidence for providers' preferred 30-day program models. In the experience of one recovery support organization representative, 14 days remained the prevailing treatment period, even for clients with complex addictions.

For quite some time now, we've only been seeing people get treatment for 14 days... I know that treatment centers can ask the ... bill the insurance or ask the insurance for an additional allotted time. And so people have been successful in that, but 70% of the time they don't get granted that.

-Key informant 11, recovery support organization representative

One long-time system observer saw the "Maintain/Reduce" target for the residential stay metric as a predictor for future utilization directions:

I think that's the transition that's going to happen for folks who move into fully integrated managed care, is residential stays will become shorter. The move will be to outpatient services.

-Key informant 3 provider representative

Access challenges for withdrawal management linger from early IMC period

Access to withdrawal services (informally referred to as "detox") was described as a problem by all categories of stakeholders. Most providers saw earlier access challenges as products of initial MCO prior authorization requirements, which HCA had since helped resolve. However, three withdrawal management facilities had permanently closed doors in the process, and access still lagged.

As an example, a residential provider in the Spokane region without its own medically supervised withdrawal capacity spoke about hurdles facing clients in obtaining these services before entering residential treatment. The region had two supervised withdrawal management centers, both of which were frequently full.

So for [local agency], specifically for the medical [withdrawal management], they can be extremely difficult for a patient to obtain [withdrawal management] there. It's not always, but I have worked with some individuals who report calling multiple times a day every day for a week and never reaching someone to schedule...And then as far as the community [withdrawal management], they have to check in through the sobering unit. And the sobering unit the vast majority of the time is at capacity. So if they show up at the door, or if we are calling requesting a bed for somebody, we're told either, "Yes, there's a bed – come on in," or "No, there's not – check back in two hours." And you just keep checking back every two hours until there's a bed open, which can be days.

-Key informant 12, provider representative

Regional factors, transportation affect treatment access

Key informants frequently commented on regional disparities in access to SUD services across the care continuum. (We discuss this in further detail under milestone 4 below.) Provider distance from Medicaid beneficiaries' homes impacted access to outpatient services, particularly for those lacking transportation options. One key informant described clients having to drive up to 50 miles to attend an outpatient program. Several residential providers described a significant portion of their client base as coming from other regions of the state. These clients may face additional hurdles in accessing

outpatient care once they return home after discharge. Some informants also noted that access to MOUD is more limited in rural areas that have fewer prescribers and opioid treatment programs.

Summary

Access to SUD treatment and providers increased in concordance with the implementation of the SUD waiver. Most stakeholders viewed the waiver as increasing access to residential treatment, without harming delivery of services at other ASAM levels. Furthermore, the SUD waiver allowed providers to offer treatment options that aligned more closely with their clinical preferences. Whereas most providers believed that a minimum 28- to 30-day stay was preferable, this view was not always supported by MCOs. The waiver also enabled providers to offer flexibility in admission dates to accommodate client needs. One area remains of significant concern: access to withdrawal management services was described as a problem by all categories of stakeholders. In particular, there appear to be capacity challenges that may limit the availability of essential withdrawal management services.

Milestone 2: Assessment

Performance on Metrics

The SUD Monitoring Protocol does not include any SUD metrics associated with milestone 2; our findings are therefore confined to interviews with stakeholders.

Key Informant Comments

Stakeholders exhibited widespread consensus that ASAM criteria for assessment had been adopted within Medicaid SUD treatment systems. Providers indicated familiarity and acceptance with ASAM standards, which they viewed as being industry standard. Interviews revealed provider challenges with processes and requirements for authorizing residential services; these were related to the IMC transition rather than the waiver itself. At a more fundamental level, providers and MCOs expressed different views on the role of residential treatment and withdrawal management in the SUD continuum of care. Providers had sought support from the state in dealing with several of these challenges and were pleased at the state's response and level of intervention. They also referenced recent legislation (House Bill 2642; see Box 3.1) intended to address issues around authorization and assessment.

Providers, MCOs differ in application of patient-placement criteria

First, providers noted that two of the five MCOs with which they had contracts had initially required them to use non-ASAM criteria (specifically, InterQual) to obtain authorization. Providers had obtained support from the state in resolving that barrier.

Second, providers described frequent challenges in obtaining authorization for residential levels of treatment from MCOs. Despite using the same ASAM criteria, each MCO had its own documentation requirements, increasing administrative burden. When providers were denied authorizations for residential services (or reauthorizations beyond the initial 14 days), they described needing to get on the phone with MCO representatives who might be out of state and unfamiliar with Washington's criteria or behavioral health service delivery. One provider described how an out-of-state MCO office wanted to obtain an assessment from a physician, refusing to have a "peer-to-peer" authorization conference with a Washington-based certified SUD professional.

Providers spoke of receiving frequent push-back from MCO utilization reviewers for reasons that contradicted their understanding of ASAM.

They'll [MCO] come back and say, "Well, the patient reports they have hope, so therefore they don't meet criteria anymore." It's like, well, we want them to be hopeful. It's simple things like that they'll say that's the reason they're denied. It's just not consistent.

-Key informant 9, provider representative

One provider that did not offer on-site mental health services described difficulty with MCOs' authorization of residential SUD services for clients with co-occurring mental health conditions:

If the patient is too high [needs] mental health, we are told to discharge because he's not appropriate for our level of care. If he doesn't have any mental health conditions whatsoever, we are questioned why he's in inpatient in the first place. So there's very thin line that we have to walk for what is appropriate for intensive inpatient substance abuse and what is not.

-Key informant 13, provider representative

MCOs, providers offer different views on the role of residential treatment, withdrawal management

Providers and MCOs exhibited differing views on the role of residential treatment. This difference shaped their explanations of the specific criteria for patient placement. Providers spoke of themselves as treating complex social-behavioral disorders and described residential treatment as an opportunity to remove clients from potentially destructive environments so that they could focus on learning new behaviors.

We've always been really pretty committed to a low-cost residential treatment model that gets them out of their environment and gets their concentration, which is really hard to do in outpatient. And I've always done outpatient, but I'm very partial to residential because of the fact that you do get them away from their drug dealers and you get them away from distractions. We also do a lot of gender-specific, so we even reduced the distractions further.

-Key informant 5, provider representative

For clients with complex, longer-term addictions, providers viewed 30 days as the minimum desirable treatment period, with even longer stays desirable. Providers indicated that it could take up to two weeks for clients to get focused and able to start treatment activities.

MCOs, however, spoke of residential treatment in terms of "medical necessity" and, in one case, were skeptical of the need and evidence base for much current use of inpatient treatment.

If [MCO] were going to speak, one of our biggest concerns overall is that we're paying for a lot of housing under the umbrella of SUD residential, mental health residential, whatever it's going to be. And that really, if we could direct those monies to the medical services, and if the state could own what's housing and pay for housing, if the systems could come together, we could probably over time save a lot money.

-Key informant 7, MCO representative

These competing interpretations aligned with contrasting views of recidivism. While providers generally viewed recidivism as evidence that residential treatment stays had not been long enough (or care coordination or recovery supports were inadequate), MCO representatives viewed recidivism as evidence of the residential treatment model's ineffectiveness.

Withdrawal management services were another area of differing interpretations, with providers and MCOs expressing different views on the necessity of withdrawal management before admission to residential treatment. Providers spoke of the service as an important preliminary step, while one MCO questioned the medical necessity of clients with certain drug diagnoses (for example, methamphetamine) to complete inpatient withdrawal management. One provider commented,

I think we have a little problem coming up right now with one or two health plans who believed that for opiates, you shouldn't do [withdrawal management] at all. And that you should only have [MOUD] not recognizing that not all of your clients will comply with [MOUD] and not all of your clients are interested in or want it. And so you've got to have that, plus they're often needing [withdrawal management] for other drugs. So they may be an [MOUD] person, they may have opiates, but they may also have, up here, a lot of methamphetamine and tranquilizers and benzodiazepine.

-Key informant 5, provider representative

One MCO expressed concern about residential treatment facilities providing level 3.2 withdrawal management without oversight by medical personnel.

My bigger concern honestly is ASAM 3.2, often referred to as social [withdrawal management], because we see folks joining into ASAM 3.2 because of the construct of the program. There's no medical personnel oversight that if our members go sideways ... that they'd be taken to an emergency room. If they're prescribed medication to assist with any withdrawal symptoms they may experience, they have to self-administer those.

-Key informant 7, MCO representative

Providers described how MCOs had initially required prior authorization for withdrawal management stays, a process they found surprising because this had previously been considered a crisis service. In response, state legislators had passed House Bill 2642 (see Box 3.1 below) removing prior authorization for both withdrawal management and admission to residential treatment. Providers and recovery support organizations viewed the new law as a solution to utilization management delays, giving beneficiaries a clearer path to treatment. One MCO representative, however, raised the specter that beneficiaries might, under the new law, enter residential treatment expecting to stay, only to find (following MCO utilization review three days later) that their assessment did not meet medical necessity standards.

If criteria is not met, and they can't stay, I don't know that a lot of thought is given to a step-down from that or a transition, right process. Or as I like to say, 'What now?'

-Key informant 7, MCO representative

Box 3.1: House Bill 2642 – Changes to utilization review for residential services

House Bill 2642, also referred to as the “No Wrong Door” bill, addresses health coverage barriers for Washingtonians seeking SUD treatment.¹⁴ The law, effective January 2021, prohibits Medicaid MCOs and other health plans from requiring prior authorization for withdrawal management and residential treatment services. Plans must cover a minimum of two days of residential treatment or three days of withdrawal management before conducting a utilization review. If the utilization review indicates that the residential admission was not medically necessary, the health plan is not required to continue paying for residential services. The new law includes additional refinements to SUD service delivery and patient assessment.

Summary

In the area of assessment, there was general consensus that ASAM criteria had been adopted within Medicaid SUD treatment systems, with its focus on multidimensional assessment, treatment driven by outcomes and clinical considerations, and movement from fixed to variable length of treatment. Although these changes are closely in line with the goals of the SUD waiver, the state’s efforts to integrate behavioral health as part of its IMC initiative may have created irregularities in assessment. For example, some of the new MCOs initially relied on non-ASAM criteria. Providers and MCOs also have differing views of the role of residential treatment, a contrast that may inhibit effective assessment. Providers noted that some MCOs had initially required prior authorization for withdrawal management, services which, in their eyes, should have been considered crisis services and exempted from prior authorization considerations. Many providers expressed hope that new legislation (House Bill 2642) would reduce the potential barriers to greater patient access, although there were also concerns that the law might result in increased admissions to residential treatment that were not justifiable as medically necessary. Overall, the waiver appears to have improved the use of standardized assessment criteria, although the transition to IMC may have introduced new barriers.

Milestone 3: Provider Qualifications and Medications for Opioid Use Disorder

Performance on Metrics

After the introduction of the SUD waiver, the number of providers enrolled in Medicaid who billed for MOUD increased by 367, from 3,172 to 3,539, in the period between July 1, 2018, and June 30, 2019. Over this same time period, as shown in Table 3.1, we also observed an increase in the number of Medicaid beneficiaries who received these medications, increasing from 30,251 in the year before the waiver to 37,898 in the waiver’s first year.

Key Informant Comments

Waiver and HCA outreach have helped improve access to medications

Interviewees generally agreed that the accessibility of MOUD in residential treatment facilities had improved in recent years and that the waiver contributed to this trend. MCO representatives observed that the MOUD requirement implemented in IMC contracts had prompted discussions with residential facilities about providing access and increased providers’ willingness to offer MOUD.

I think the fact that that's been applauded in the state for making sure that our residential providers are offering [MOUD] across the board. That did not use to always be the case, and there was definitely some cultural resistance from some of the abstinence-only ideology of old. But I think that, coupled with the waiver, has expanded who can go to treatment and do well.

-Key informant 2, recovery advocate

One residential provider indicated that they had contracted with a physician who could prescribe MOUD and used a member of the residential staff to coordinate medication-related services.

[We] just contracted with this person. So they are able to bill the client's insurance for collaborative billing. ... They still do all the regular stuff except they just make themselves available to us. So I think the only real obstacle was finding a good fit and just getting on the same page. ... We do have a medical coordinator ... that does all the appointments and makes sure the medications are good.

-Key informant 13, provider representative

One of the MCOs we interviewed recognized HCA's work on provider outreach.

[The] Health Care Authority has done a good job of pushing forward that those medications need to be provided and supported on site.

-Key informant 7, MCO representative

Although acceptance of MOUD has generally improved, one provider indicated that some residential facilities had ceased to accept Medicaid clients as a result of the MOUD requirement.

Cultural shift is underway but not complete

Both MCOs and providers acknowledged the inherent tension between the use of medications for addiction treatment and the abstinence-based model historically adhered to by the majority of SUD treatment providers in Washington. Providing access to MOUD has required a cultural shift. However, one informant argued that abstinence and MOUD were not mutually exclusive:

We believe that abstinence is the ultimate goal. It may take years or they may never get there, but just because you believe that abstinence might be an ultimate goal doesn't mean you're not amenable or working with medication.

-Key informant 5, provider representative

Availability of waived providers is limited in rural areas

In some areas of the state, particularly rural areas, there are few providers waived to prescribe MOUD. These shortages made it difficult for residential facilities to find local prescribers to work with.

More rural providers are going to struggle more with finding waiver prescribers for things like buprenorphine ... [P]re-COVID the initial appointment had to be done in person for prescribing bup [sic], and then subsequent visits could be done via telemedicine ... So that's obviously the biggest barrier on the buprenorphine side.

-Key informant 4, provider representative

Methadone poses particular challenges

Several key informants pointed to methadone as the most challenging to offer in residential settings. Many providers lack the staffing resources needed to regularly transport clients to a methadone clinic. The lack of reimbursement for transportation costs and the existence of “methadone deserts” in some regions of the state created additional challenges.

Methadone is very challenging in terms of – this is true for rural areas but even some urban areas – finding access to staff capacity. So, residential providers do not get paid for the staff time or the gas mileage or the car insurance, or whatever it takes to drive a van full of clients every morning to and from a methadone clinic in their area. They're just figuring out the logistics of that.

-Key informant 2, recovery advocate

One residential SUD provider noted a critical need for additional guidance from the state on safely storing and disposing of methadone.

Providers feel need to factor in client preferences

Some providers emphasized that client preferences should be taken into account in the decision to prescribe MOUD, as certain clients may not want to be on medication.

If a patient is expressing that they do not want to be on medications, they want to taper off them, whatever, we want to be able to acknowledge that the patient still has a right to ask for what they want in their recovery plan.

-Key informant 9, provider representative

Behavioral health care, recovery supports seen as key to successful MOUD continuation

Several providers expressed the opinion that optimal MOUD treatment would combine medication with other behavioral health services. One provider raised concern that MOUD prescribers were not required to offer such services, and many did not.

And of course, obviously, for folks to be successful with [MOUD], it's very important that they have access to those other types of services. It shouldn't be just a med-management situation ... And so the suboxone is really not too big a barrier for all providers. What's sad is that if they're not required to do any treatment and they've got behavioral health issues, then you're not really doing them any favors, you're handing them a drug and sending them out into the world.

-Key informant 5, residential SUD provider

One recovery support organization also spoke emphatically about the need to provide ongoing support (for example, through peers) to individuals on MOUD, noting that persons in recovery often experience stigma for being on medications. Additionally, because MOUD dosage needs to be titrated, the transition from opiates to MOUD could be difficult.

And the reality of that, when our folks need to go on to [MOUD], there's a titration period if they have to titrate up onto their medication if they're on an opiate replacement therapy. And I can tell you that when you're using that X amount of drugs, you don't get to just stop and start all over again. So what happens in that titration time is that you're supplementing with street heroin until you can get on ... And so this is where people get lost, between the stigma, the inability to seek support, inability to find the same peer community that we're talking about in the midst of what's happening with your brain while you're trying to do this, is where people need support the most.

-Key informant 14, recovery support organization representative

Summary

The introduction of the SUD waiver coincided with an increase in the number of Medicaid providers billing for MOUD as well as the number of enrollees receiving MOUD. The waiver appears to have improved the accessibility of MOUD in residential treatment facilities. Areas of concern include rural regions, where workforce capacity continues to restrict the use of MOUD. Methadone, which requires additional resources and staffing to transport clients to methadone clinics, is a particular challenge in these areas.

Milestone 4: Capacity

Data and Metrics

Based on state licensing data (see Table 3.2 below), as of June 2019, Washington had a total of 36 licensed IMD facilities, consisting of eight Mental Health Hospital IMDs, four Mental Health Evaluation and Treatment (E&T) IMDs, 22 SUD Residential IMDs, and two Mental Health Residential IMDs. In July 2018, Washington licensed one additional SUD Residential IMD with a total of 210 beds. Washington also added four Mental Health Hospital IMDs between October 2018 and May 2019, totaling 398 new licensed beds. (Licensed bed counts do not necessarily reflect actual bed capacity, as facilities may be licensed for more beds than they are staffed for.) In addition, as previously noted, the number of providers enrolled in Medicaid who billed for MOUD increased by 367 (from 3,172 to 3,539) in the first year of the SUD waiver.

Table 3.2: Licensed IMD Facilities in Washington as of June 2018 and June 2019

Facility Type	June 2018		June 2019		2018-2019 Change (Beds)
	Number of facilities	Number of beds	Number of facilities	Number of beds	
Mental Health Hospital IMD	4	285	8	683	398
Mental Health E&T IMD	4	229	4	229	-
SUD Residential IMD	21	1,742	22	1,952	210
Mental Health Residential IMD	2	54	2	54	-
TOTAL	31	2,310	36	2,918	608

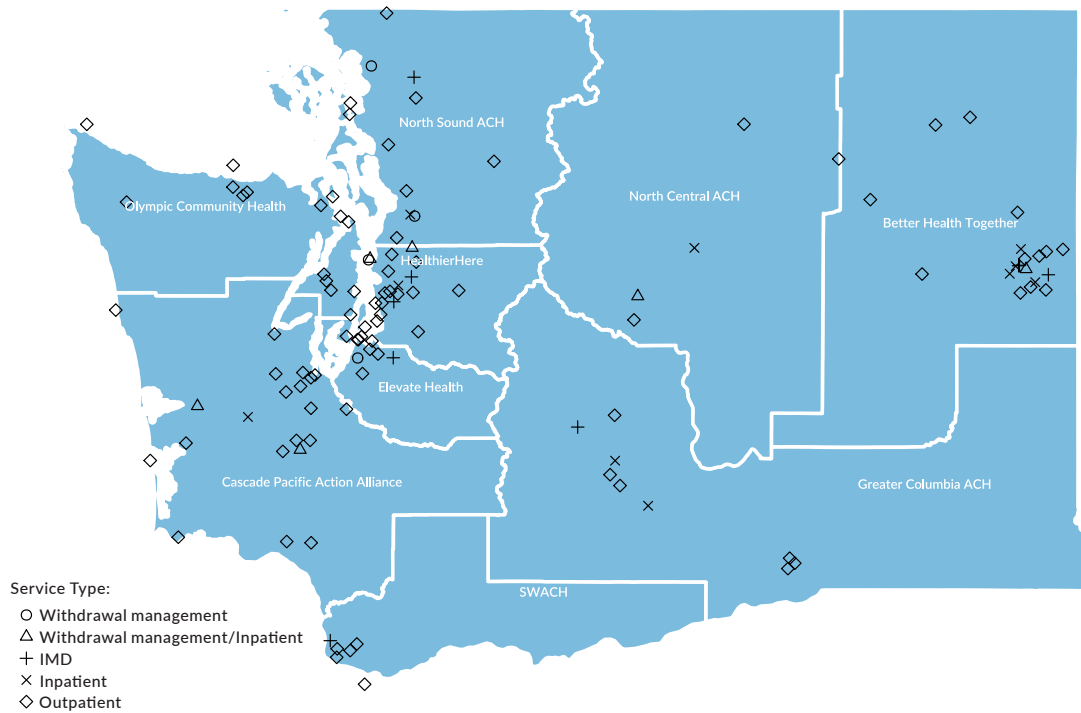
Source: Washington Health Care Authority, IMD Facility Billing Reconciliation List, June 1, 2020.

As of January 2020, Washington had approximately 118 SUD treatment facilities serving Medicaid beneficiaries. This figure reflects active entities listed in the state's Behavioral Health Agency

directory that billed for SUD services to Medicaid beneficiaries in the 2015-2019 time period. We did not have data to describe whether or not the number of SUD treatment facilities accepting Medicaid beneficiaries increased with the waiver.

Figure 3.1 displays the location of the 118 SUD facilities in Washington that serve Medicaid beneficiaries. These facilities are concentrated in the western part of the state, with relatively few in the central and eastern regions, except for a number of facilities located near Spokane.

Figure 3.1: SUD Treatment Facilities Serving Medicaid Beneficiaries



Source: Washington Health Care Authority (2020).

Note: Due to lack of space in the figure, symbol placement may not reflect precise geographic location.

Key Informant Comments

Key informants opined that the state's SUD delivery system lacked capacity, with particular shortages for inpatient residential and withdrawal management services. Here, we outline key factors affecting capacity.

IMD exclusion constrained facility size

Prior to the waiver, the IMD exclusion had led residential SUD providers to limit their facilities' capacity to 16 beds. Residential providers frequently operated multiple, separately licensed 16-bed programs to avoid the restrictions of the IMD exclusion.

So for example, you could run 16 intensive inpatient SUD beds and, say, 16 withdrawal management beds. And the way it was structured at the state level, in that the withdrawal management beds would have been considered medical beds covered by the Health Care Authority, and the 16 intensive SUD beds were considered RTF beds licensed by DOH and DSHS, but run by DSHS, that agency could have a total of 32 beds and not be subject to the exclusion.

-Key informant 3, provider representative

Providers we spoke to generally agreed that 16-bed facilities were inefficient and costly to operate.

Sixteen-bed facilities are really becoming a thing of the past, because you can't afford them. ... You just cannot afford to run a program like this particularly at the reimbursement rates that Medicaid has. So people can't run them. You'd have no capacity.

-Key informant 4, provider representative

Key informants emphasized the importance of scale economies in providing SUD services, including residential and outpatient services.

As far as large and small, on a residential side and even on an outpatient side, all the small outpatient programs are pretty much gone away. You have to have some economies of scale to survive in this market. So you can't have a small office with maybe one proprietor who is a counselor with a couple of associates in there, running a couple of groups. Ten years ago, you could do that in an outpatient office, you couldn't do that today, you really need to have more scale.

-Key informant 4, provider representative

One provider observed that scale is particularly important for Medicaid due to the greater administrative burden of operating in the Medicaid environment compared to the commercial market.

Also, as you know, it's hard to do a little Medicaid. There's a lot of requirements. There's a lot of administrative things you have to do. So, it's really hard to do a little bit of it. You got to do enough of it to really warrant the amount of additional administrative. ... Medicaid has got 10 times the administrative burden of any commercial plan. I may be underestimating that.

-Key informant 4, provider representative

Both providers and MCOs also noted the relationship between scale and quality in residential SUD provision. Limited scale precludes providers from offering more specialized and integrated services across the care continuum.

You don't have the ability to have the variation in staff. You have to have a good core staff, and then you can't bring in the specialist who might know, for instance, we're actually going to get a grant now for infant mental health, but you don't have the money and the volume to be able to buy one of those counselors.

-Key informant 5, provider representative

SUD waiver helped consolidate, maintain existing residential capacity

Several providers described how the SUD waiver had prompted residential SUD providers previously operating multiple 16-bed entities to consolidate their operations and become IMDs.

So we, in fact, ... we had a 16-bed intensive inpatient and a 16-bed withdrawal management for a total of 32. Once this IMD waiver went in, we went from 16 to 24 on the intensive inpatient and then we went ahead and discontinued withdrawal management up there because it was a subacute process and that's where we just secured another 24 beds for [co-occurring disorders].

-Key informant 3, provider representative

Several providers also observed that the SUD waiver had led some residential SUD facilities to increase their bed capacity beyond 16 beds, typically by adding beds in existing space. However, only one of the five IMD providers we spoke with reported having added new physical capacity in response to the waiver. Providers further noted that consolidation and expansion of bed capacity had generally improved their financial viability, in some cases allowing them to avoid closure.

Interviewer: Has the IMD waiver had any impact on the provider market?

Interviewee: Again, it's allowed those with larger programs to survive and be viable. ... [I]f that wasn't happening, I don't know that you would have a residential program or a system across the state, because you just couldn't survive.

-Key Informant 4, provider representative

IMC transition substantially impacted SUD providers, potentially restricting capacity

As previously discussed, the transition to IMC was associated with new requirements for prior authorization and other administrative processes, as well as severe payment delays. According to several providers we interviewed, these challenges brought some residential SUD facilities to the brink of closure and, indeed, three residential withdrawal management facilities had closed in early 2020. One interviewee attributed these closures to MCOs' reluctance to reimburse for inpatient withdrawal management services, whereas another noted that these programs were financially unsustainable under Medicaid reimbursement rates.

We've seen, I think it's four if not five [withdrawal management] programs close in the last 90 days or 120 days. I don't think any of them were directly related to COVID. The ones that have closed here recently were in line to do that. They just couldn't generate enough revenue to fund the programs under the Medicaid reimbursement, under the system we have.

-Key Informant 4, provider representative

Regulatory uncertainty and limited capital access hamper large-scale capacity expansion

Key informants noted that although many residential treatment facilities had expanded bed capacity in existing space, the waiver had not prompted them to invest in new facilities or seek state investment for new construction. They cited uncertainty about the waiver's renewal, a lack of access to capital, and workforce shortages as barriers to expansion.

It's just that you're so sunk, right, when you build a building. You would be really between a rock and a hard place if you've already got this facility and you can't bill for the beds, and the permanency of a capital project and not wanting it to go to waste. I think if they did the waivers for longer you would see a significant interest from both the state as well as private partners and the non-profit partners wanting to build larger facilities.

-Key Informant 2, recovery advocate

One key informant described access to capital (e.g., financial reserves or lines of credit) as a significant barrier to large-scale capacity expansion, contrasting the limited financial resources of SUD providers compared to medical providers.

[O]ur SUD providers tend to be much smaller and don't have that kind of reserve, and they get hit hard by waves of change and are not able to bounce back as easily, and they also don't have the same access to the lines of credit and things like that of some of these larger organizations. So it's hard for them to engage in capital projects.

-Key Informant 2, recovery advocate

Another key informant argued that it may still be too early to assess the waiver's impacts on physical treatment capacity, given the lengthy timeline for planning, construction, and opening of new facilities.

Workforce shortages continue to constrain capacity

Several key informants described the shortage of licensed SUD professionals in the state and its impact on residential bed capacity.

I think that, from what I've heard from our treatment networks, is that there is availability, but there is still a shortage of professionals and workforce. I think with a higher degree of workforce, they could probably open more beds.

-Key Informant 8, state agency representative

Key informants pointed to low reimbursement rates for SUD services as the main driver of workforce shortages, particularly in rural areas.

But the big challenge across the state is counselors. Partially due to, not partially, in large part due to the reimbursement rates. ... So it's an ongoing struggle to recruit and maintain our staff.

-Key Informant 4, provider representative

In addition, a long and cumbersome process for becoming a licensed and credentialed SUD professional was also identified as contributing to workforce shortages. Workforce shortages were also identified as limiting capacity for the treatment of individuals with co-occurring mental health and SUD. One informant suggested that this shortage might be alleviated by reducing the requirements for mental health providers to become licensed SUD professionals.

[We] haven't been able to have mental health providers become SUD providers in a shorter time-frame ... Right now, I think they have to actually go through another year of service delivery or collecting hours for that time period in order to be both mental health and SUD.

-Key Informant 10, provider representative

These requirements are codified in RCW 18.205.105, described in Box 3.2 below.

Box 3.2: The Co-Occurring Disorder Specialist Enhancement

House Bill 1768, passed in 2019, created a co-occurring disorder specialist enhancement to be added to the license or registration of masters-level mental health professionals, allowing them to provide SUD treatment with some limitations.¹⁵ Under the revised code, a practitioner can receive the enhancement by completing 60 hours of addiction-medicine instruction, passing an exam, and providing 40-80 hours of supervised SUD counseling experience. Clinicians eligible to receive the enhancement include psychologists, clinical social workers, marriage and family therapists, mental health counselors, and agency-affiliated counselors.

Prior to this legislation, the path to achieving the state's SUD professional credential involved completing a full year of academic coursework in addiction medicine.¹⁶

Capacity for co-occurring mental health services, culturally appropriate services remain limited

A limited number of residential SUD providers are licensed as co-occurring facilities and provide on-site treatment for mental health conditions. One informant from a facility not licensed for co-occurring services described its mental health care as being limited to medication management for clients whose mental health condition was already stable:

[W]e have a provider that we're contracted with who will do medication management. So, if they're stable on mental health medications and they just need the substance abuse focused on, because their mental health is stable, other than the substance abuse factor, we can work with them. But, if they need the mental health stabilized and addressed, we don't have mental health professionals on staff. ... They have to go either to a co-occurring facility or they need to somewhere to have mental health stabilized first and then come to [facility name].

-Key Informant 12, provider representative

One of the MCO informants pointed to inadequate staffing as the main obstacle facing residential SUD providers in offering treatment for co-occurring disorders.

A lack of culturally appropriate SUD treatment services for members of racial, ethnic, and sexual/gender minorities was another capacity challenge raised by two informants. Their concerns included frequent racial mis-categorizations of individuals identifying as AI/AN and other minority clients within SUD treatment delivery, a shortage of culturally specific care models for minorities and lesbian, gay, bisexual, transgender, or queer (LGBTQ) clients, and a lack of safe accommodations for transgender clients entering residential treatment.

Regional factors result in uneven capacity

There is significant regional variation in SUD provider capacity across the state, particularly for residential and withdrawal management services. Residential providers in urban areas such as King County face higher costs, including facilities, workforce compensation, and other operating expenses. However, state payments for residential room and board are the same across all regions of Washington. This may incentivize residential providers to move away from high-cost areas to lower-cost regions. One provider cited this as the reason behind a gradual “migration” of residential capacity out of King County and toward Eastern Washington.

It’s very difficult to pay staff and to have a building in King County. ... So most of the alcohol drug treatment beds are in Eastern Washington, where you have a lower cost of living and your properties are less expensive.

-Key Informant 5, provider representative

One key informant noted that, compared to BHOs, MCOs were less willing to factor in regional cost variations when negotiating payment rates.

When we were under the BHO arrangement, we were able to negotiate based on the region. And, say, in King County, the cost of living is much higher than it is in Kitsap County. They recognized that and were willing to pay you a little bit higher rate than what you would get in a rural community.

-Key Informant 9, provider representative

Washington is currently reopening the contracting process to allow additional MCOs into service areas with fewer than five MCOs. In reflecting on this, one provider noted the tension between expanding MCOs’ residential provider networks and ensuring sufficient volume to sustain existing Medicaid providers. He worried that additional MCOs might contract with new residential providers, potentially “diluting” revenue available to current and long-time facilities serving Medicaid clients.

Summary

As of January 2020, Washington had approximately 118 SUD treatment facilities serving Medicaid beneficiaries. Removal of the IMD exclusion with the SUD waiver appears to have created opportunities for residential providers to take advantage of economies of scale. However, increases in capacity may have been hampered by workforce shortages and the transition to IMC, which was associated with higher administrative costs and delays in payment. Treatment for individuals with co-occurring disorders appears to be an important service area that has not benefited from the SUD waiver. The recent reopening of contracting to more MCOs may add provider capacity in some regions. However, some observers expressed concerns that more competition may dilute revenue for current and long-time facilities serving Medicaid clients.

Milestone 5: Prescribing, Overdose Prevention

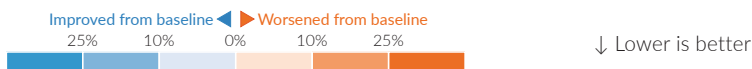
Performance on Metrics

Table 3.3 displays results for metrics relating to milestone 5. Most of these measures moved in the desired direction, with statistically significant increases in Initiation and Engagement of Alcohol and Other Drug Treatment and statistically significant decreases in the percentage of clients prescribed opioids concurrently with sedatives and the percentage of patients prescribed high-dose

(>90mg) chronic opioid therapy. One measure did not move in the desired direction: Continuity of Pharmacotherapy for Opioid Use Disorder decreased by more than four percentage points.

Table 3.3: Performance on Milestone 5 Metrics

	Baseline Year	SUD Year 1	Adjusted Change
Alcohol or Other Drug Treatment: Engagement	12.9 %	14.8 %	1.8***
Alcohol or Other Drug Treatment: Initiation	34.2 %	37.5 %	3.1***
Continuity of Pharmacotherapy for Opioid Use Disorder	60.0 %	56.2 %	-4.2***
People with an Opioid Prescription >90mg MED ↓	17.4 %	16.4 %	-1.4***
People with an Opioid Prescription who were Prescribed a Sedative ↓	21.4 %	19.0 %	-2.6***



Key Informant Comments

Naloxone access widespread and accepted, though more plentiful in some regions

Key informants reported that naloxone is generally available and dispensed throughout the state, with some variations in supply. One provider was excited to be able to offer naloxone “kits” to departing clients, “just in case.” Another, whose county had made naloxone available well before the waiver, recalled distributing it “like crazy” to help prevent overdoses in the community, a practice which has slowed somewhat.

Now, I think we’re a little more careful with it, because we know it’s in shorter supply, but we can prescribe it. And so our prescribers in our [withdrawal management] unit do.

-Key informant 5, provider representative

Several key informants pointed to wider naloxone use and distribution as a reason for overdoses decreasing. A recovery support organization representative had noticed that many more people in the community are now familiar with the drug and its purpose.

Before people, you would say “naloxone” and they wouldn’t know what you were talking about. And now they understand it, and people can have those conversations of “Here’s the different kind of medicated assisted treatment that we have. These are stuff they can do for you.”

-Key informant 11, recovery support organization representative

Prescribing guidelines seen as effective

Legislation to address over-prescribing of opioid medications had occurred prior to the waiver, and key informants perceived them to be effective. One recovery advocate who was also in a statewide policy-making role felt that the state had taken prescribing guidelines and “really hit that out of the park,” curtailing the ability of prescribers, including dentists, to over-prescribe opioids for acute pain.

One residential provider, however, had experienced problems with clients who were offered opioid medications for headache or tooth pain while visiting the hospital during a residential SUD treatment stay.

We will call in advance to tell the nurses, “This person is in substance abuse treatment,” and we will still see patients come back with prescriptions for oxycodone.

-Key informant 12, provider representative

This may suggest areas of the state or of provider networks in which new prescribing guidelines have not yet fully taken hold.

Summary

Claims-based measures indicate that there have been decreases in opioid prescribing and improvements in the treatment of OUD. Stakeholders indicated that these changes were in line with their experiences, noting that a variety of statewide efforts, including prescription guidelines, had been beneficial. Stakeholders also noted that there has been wider use of naloxone and believed that its use had led to a decrease in overdose deaths. One concerning finding was the decline in continuity of pharmacotherapy for OUD, which may be linked to the availability of ongoing recovery supports and engagement in behavioral health treatment.

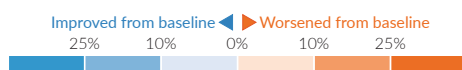
Milestone 6: Care Coordination

Performance on Metrics

Table 3.4 displays results for metrics relating to milestone 6. Changes in this domain exhibited an unusual dynamic. Follow-up after Emergency Department Visit for Alcohol or Drug Dependence (7-day and 30-day measures) increased, while Follow-up after Emergency Department Visit for Mental Illness (7-day and 30-day measures) decreased. These changes suggest that providers and MCOs have been focused on SUD, but have not yet incorporated changes that benefit individuals with mental health conditions.

Table 3.4: Performance on Milestone 6 Metrics

	Baseline Year	SUD Year 1	Adjusted Change
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	23.9 %	26.2 %	2.2***
30-Day Follow-Up After ED Visit for Mental Illness	73.6 %	71.1 %	-2.1***
7-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	14.9 %	16.2 %	1.3**
7-Day Follow-Up After ED Visit for Mental Illness	63.3 %	59.8 %	-3.2***



Key Informant Comments

While the state has yet to complete its implementation of policies to enhance care coordination and facilitate transitions between levels of care (see Chapter 2), key informant interviews suggest that supporting SUD clients through these transitions is standard practice among providers, with some

support from MCOs and other systems partners. Nevertheless, informants identified weaknesses in these linkages. Some providers sounded an urgent alarm for addressing social determinants of health (for example, the role of stable housing in recovery) to protect the state's investment in SUD treatment. Other parts of Washington's Section 1115(a) Medicaid waiver, including the Foundational Community Supports program, may provide pathways for solutions.

Planning now routine for transitions from residential to outpatient care, though hand-off sometimes fragile

Informants agreed that planning for transitions between levels of care is common practice for providers, including setting up "warm hand-offs" for the transition from residential to community-based outpatient treatment. One statewide recovery advocate described the practice as generally effective.

They've been usually able to get a patient into services fairly quickly after discharge. And the availability of outpatient is broader than the availability of inpatient, even in more rural areas. I'm not saying it's great, but it's easier to find an outpatient provider than an inpatient one.

-Key informant 2, recovery advocate

However, regional shortfalls in outpatient capacity or uncertain hand-offs could be points of risk for losing clients from the treatment continuum. One residential facility in Spokane could not always secure a follow-up appointment for clients returning to the "left" (west) side of the state because outpatient programs would not schedule in advance, requiring a patient to come on-site to schedule an intake.

So the expectation is we're going to discharge from inpatient, send them back to his home city. The next day or a couple days later, whenever he's ready, he's supposed to walk into outpatient and check in. And so that lack of responsibility, lack of continuity of care, I imagine we lose a lot that way.

-Key informant 12, provider representative

Informants from both providers and MCOs wished for better data to assess the success of these transitions. Another provider whose facility frequently discharged clients across the state expressed concern about his inability to track outcomes.

Are we doing as good a job as we think we're doing, or do we need to make changes? Does that hand-off have to be warmer or more tightly wrapped? ... Do we need to go back and talk to the state about, "We need more funding to ensure that transition takes place?" Whether that's peer support folks, or some other interim service to make sure that that's not a warm hand-off, it's a really hot hand-off, and we're sitting there watching it happen?

-Key Informant 4, provider representative

One provider of a program for pregnant and parenting women noted the high stakes of transitioning planning for this group of clients. For them, discharge planning involved not only outpatient treatment for the client but planning for the safety of accompanying children and coordination with case workers from Children's Protective Services and the Department of Corrections.

We really focus in on where are you going to go? How are you going to get there? Where are you going to stay? Because every decision that they make will really impact them and their children's lives to such a high degree.

-Key informant 13, provider representative

Care coordination and recovery supports viewed as tools to maintain the treatment investment

Case management and “recovery supports” were identified as areas of greatest need to maximize the state’s investment in SUD treatment and produce continued success on waiver milestones. These supports were typically not clinical and not reimbursable by Medicaid, but essential to enabling continued and long-term progress in treatment.

Informants viewed case management as a critical bridge for clients transitioning back to the community after residential care. Several providers who had worked with these programs praised their potential to address gaps in the hand-off to outpatient care.

I see the greatest success with the programs that provide some transitional care coordination, where there's a case manager when he gets out of inpatient, goes home. The case manager shows up at his door the next morning, 8:00 AM, to pick him up and take him to that outpatient appointment. Because now there's somebody holding them responsible, somebody providing the transportation. All the excuses are gone. You remove all the excuses, all the barriers.

-Key informant 12, provider representative

Using “peer” services to meet these transitional needs is an innovative practice in SUD care delivery recognized by numerous key informants. Since July 2019, Washington’s Medicaid plan has covered services by Certified Peer Counselors (CPCs),¹⁷ people with lived experience (or parents of children with lived experience) of behavioral health issues who complete a training and certification process. To qualify for reimbursement, CPCs services must be provided under the consultation, facilitation, or supervision of a SUD or mental health professional. In addition to CPCs, Washington also recognizes community-based peers, who, while not directly reimbursable under Medicaid, may provide transitional support under contract with treatment centers. Community-based peers are not tied to particular SUD providers and may provide services not directly related to a client’s SUD treatment plan.

While many providers in our sample were aware of peer services and excited for their potential, knowledge of how to access them or use them systematically was less widespread. As one provider stated,

There's a handful of programs around the state, but they're individual self-contained programs. It's not anything provided by the state, or it's not part of an overarching structure.

-Key informant 12, provider representative

An MCO representative also pointed to funding as the limiting factor for greater use of these services, despite strong interest.

I think there's a lot of energy, particularly around the care transitions and care navigation. I think that everybody kind of says the same thing, which is we don't have any funding for that. I think there is some little pools of funding. But I think we need more robust funding.

-Key informant 7, MCO representative

Establishing channels for providers to access Medicaid reimbursement for CPC services and educating providers on how to engage peers may be opportunities for the state to continue making progress on milestone 6.

Recovery supports address critical social determinants of health to maintain outcomes beyond treatment

Many of the individuals we spoke with looked beyond clinical treatment and into the other factors affecting their clients' abilities to rebuild healthy lives. One statewide advocate summed up a view expressed by many:

I think it's a very common misconception that the reason people have repeated stays in inpatient care is because the treatment did not work. I think that is wildly inaccurate. It's because we give people incredible care for 28 or 30 days, and then we drop them on their head the second they leave. We frequently discharge individuals to homelessness. We discharge them absent natural supports. We do not provide sufficient education to their families, to their partners. We do not provide substance use disorder peer bridgers.

-Key informant 2, recovery advocate

This advocate, who held a dual role as a policy-maker, outlined six “buckets” of recovery supports, which (excepting CPC peer services) were not Medicaid-reimbursable:

- Recovery housing.
- Education and employment support, including assistance for clients with criminal-justice system involvement.
- Peer support or recovery coaching.
- Technological supports (for example, “apps” that support retention in long-term recovery).
- Community support (for example, “recovery cafes”).
- Family education.

Housing compatible with ongoing SUD treatment was cited near-universally as the top priority by informants. Providers and MCOs alike agonized over the implications of discharging clients from residential treatment back to either homelessness or to unstable housing environments that added to clients' risk of relapse. Although social circumstances like housing were not part of formal patient assessment processes, some informants acknowledged that clients might be treated at lower levels of services (for example, intensive outpatient instead of residential) if supportive housing were available.

The lack of Medicaid funding mechanisms for most of these recovery supports meant they had to compete with a host of other social needs for scarce state funding, an advocate pointed out.

Those dollars are spread like peanut butter across education and prisons and higher ed and early learning and everything else.

-Key informant 2, recovery advocate

Foundational Community Supports offer a promising new pathway

Other parts of Washington's Section 1115(a) Medicaid waiver provide potential new avenues for funding to support residential SUD clients transitioning back to the community. Initiative 3 of the Medicaid Transformation Program, Foundational Community Supports (FCS), establishes contracts with providers in the state for supportive housing and employment for vulnerable Medicaid beneficiaries, including those with behavioral health needs. Several SUD provider organizations in our sample held contracts to provide these services. One large provider was starting in four counties, with plans to expand statewide.

We actually got a contract with AmeriGroup [FCS vendor] for those new services...We think that should help, again, with that care transition, care management between residential and outpatient to make sure, in addition, that we've got supported employment and housing in place. The evidence is good.

-Key informant 3, provider representative

It is notable that only a subset of informants brought up this initiative during the assessment, suggesting that awareness of FCS may still be developing. Educating providers and MCOs on opportunities to engage with these services could support continued progress on milestone 6.

Summary

Performance measures for care coordination suggest system-wide improvements in follow-up after emergency department visits for SUD and alcohol use disorders, although similar gains for follow-up after mental health emergency department visits were absent. Residential providers indicated that they routinely provided warm hand-offs for clients moving to community-based outpatient services. However, wider availability of face-to-face care navigation (such as peer services) and other supports addressing social determinants of health, particularly housing, could strengthen these transitions and increase clients' likelihood of maintaining recovery. Data on post-residential care utilization could help MCOs and providers identify systematic gaps in care coordination.

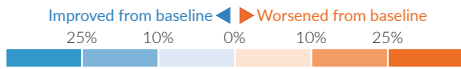
Other SUD Metrics

Performance on Metrics

We tested outcomes for a range of other measures, including those listed in Domains 1, 6, and 7 above. The results are summarized in Tables 3.5, 3.6, and 3.7 below. In Domain 1 (Assessment of Need and Qualification for SUD Treatment Services), the number of Medicaid beneficiaries diagnosed with SUD and the number of beneficiaries treated in an IMD for substance use disorders decreased slightly.

Table 3.5 Performance on Domain 1 Metrics

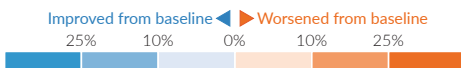
	Baseline Year	SUD Year 1	Unadj. Change
Medicaid Beneficiaries Treated in an IMD for SUD	6,861	6,838	-23
Medicaid Beneficiaries with an SUD diagnosis	170,587	168,505	-2,082



In Domain 6 (Health IT), beneficiaries who were part of the FCS program had increases in their use of inpatient or residential SUD services; there were also increases in the measure of Substance Use Disorder Treatment Penetration.

Table 3.6: Performance on Domain 6 Metrics

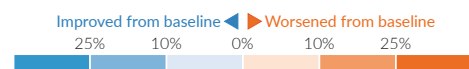
	Baseline Year	SUD Year 1	Adjusted Change
FCS Beneficiaries with Inpatient or Residential SUD Service(s)	0.5 %	4.0 %	3.5***
Substance Use Disorder Treatment Penetration	33.0 %	36.4 %	2.7***



Domain 7 includes a variety of other SUD-related metrics. Adult Access to Preventive/Ambulatory Health Services for Medicaid beneficiaries with SUD increased by 4.4 percentage points. There was relatively little change in other measures, including emergency department and hospital utilization and readmission measures.

Table 3.7: Performance on Domain 7 Metrics

	Baseline Year	SUD Year 1	Adjusted Change
Access to Preventive/Ambulatory Health Services for People with SUD	83.7 %	89.4 %	4.4***
All-Cause Emergency Department Visits per 1000 Beneficiaries	49.0	51.0	-0.7
Inpatient Admissions for Substance Use Disorder per 1000 Beneficiaries	18.6	19.8	0.2
Overdose Deaths (count)	567	NA	NA
Overdose Deaths (rate)	0.03 %	NA	NA
Readmissions Among Beneficiaries with SUD	17.8 %	17.5 %	-0.2



The final MTP evaluation report will include information on changes in overdose deaths and the overdose rate that occurred after the SUD waiver. (These data were not available at the time this report was created, although in the year prior to the SUD waiver, there were 1,187 total fatal

overdoses, with 764 attributable to opioids. In the Medicaid program, the state recorded 567 overdose deaths, resulting in an overdose death rate of 0.03%.)

Key Informant Comments

The readmissions metric reported in Table 3.7 captures readmissions for all causes among beneficiaries with SUD. This measure is limited to acute readmissions (e.g., ED, intensive care, withdrawal management, and emergency psychiatric care). Key informants suggested that there would be value in tracking readmission rates to residential SUD treatment within six months of initial discharge. This measure could assess the effectiveness of care coordination, access to housing, and the quality of treatment.

One key informant argued that to ensure adequate system capacity, the state needed better data to assess prevalence of SUD in the community and demand for SUD services. They cited data on the number of calls to the Washington Recovery Helpline and the size of wait-lists for residential treatment as being informative for this purpose. Occupancy rates at inpatient facilities could provide a misleading picture of demand for services due to prior authorization and other access barriers.

Other Cross-cutting Factors Affecting Progress across Milestones

Key informants identified a number of factors that affected Washington's SUD delivery system broadly, even if they were not tied to specific milestones. These included features of how the waiver was implemented, the ongoing COVID-19 pandemic, and more long-standing challenges around reimbursement.

Communication and engagement for SUD providers

Behavioral health providers in Washington may have been unfamiliar with the waiver and the details of the milestones and metrics. Several providers described feeling uninformed about the state's goals for remaking the SUD delivery system.

Several key informants indicated that they would have preferred to have been involved in planning leading up to the waiver and requested better communication from HCA. SUD providers emphasized the importance of including them as a separate constituency in state-level planning and communications. One informant argued that allowing the mental health system to speak for SUD providers did not represent their unique perspectives, including different funding mechanisms and other historical factors.

Oftentimes, in this state, "behavioral health" includes us. But, then, you talk to the mental health system, and the mental health system is happy to say, "We're speaking for SUD." The two systems have very different histories, very different funding mechanisms and all of that. So, we've not always been at the table we needed to be at, for these things to have our priorities or actually work well under our system.

-Key informant 4, provider representative

Providers acknowledged, however, that compared to previous system reforms, state agencies had provided more opportunities for SUD providers to be heard during the waiver's implementation and concurrent work on IMC. One residential provider mentioned having received excellent information from their ACH leaders.

[ACH leaders] have been absolutely fantastic. They have convened lots of trainings and meetings and engagement activities and templates and coordination of meetings with the Health Care Authority or Department of Health. External programs from other states have been brought in to share how they've been dealing with their waiver process. It's been really helpful.

-Key informant 9, provider representative

One MCO highlighted statewide capacity planning and assessment as an area of focus for future conversations between state agencies, MCOs, provider organizations, and community stakeholders. This planning process could also address coordination with recovery supports beyond medical necessity, which are not covered by MCOs.

I think that struggle with SUD system is that when we create a capacity for services, we tend to, just, "Oh, there's an emergency -- so, we need to put this facility in place right away." But we don't really look at that whole continuum of prevention, early intervention, treatment, front door, ... back door support. I feel like that is lacking.

-Key informant 6, MCO representative

Reliance on MCO contracting to implement waiver provisions

One MCO representative noted that the onus for educating providers about licensing and other requirements contained in the waiver (for example, the requirement for all residential facilities to support access to MOUD) had fallen on the MCO's provider-relations team, rather than state agencies.

We're the ones communicating some of the intent to the providers. ... I think it's good clinical care. But again, sometimes we're the first to be talking to the providers about some of the milestones and metrics in the waiver.

-Key informant 6, MCO representative

The MCO saw this disconnect as a possible shortcoming in agency coordination, with HCA using the waiver as a "lever" to put into place provider requirements that typically would be handled via licensure by DOH.

Funding and payment models

All residential providers we interviewed described how low Medicaid reimbursement rates for residential SUD services and withdrawal management made it challenging for them to cover the costs of services and remain financially viable. Providers noted that Medicaid reimbursement rates are significantly below commercial rates. Across payers, mental health services were perceived to be compensated more generously than SUD services. However, reimbursement rates improved significantly under the BHO system, and some providers had seen further rate increases under MCOs.

We've been historically underfunded as an SUD system in this state. As we moved to a Medicaid system, it's gotten actually a little better. ... Through the MCOs we've been able to get a little better reimbursement. It's still way short of what the commercial is, and really what they need to be doing to adequately fund the system. Some are barely covering the costs and some actually aren't to provide the service.

-Key informant 4, provider representative

One provider noted that reimbursement rates for an MOUD prescription provided in a medical office are higher than for the same service provided at an SUD treatment facility.

A doctor can have an ARNP do the service and they'll get paid twice as much as I'd get paid by using my ARNP.

-Key informant 5, provider representative

Low reimbursement rates have impacted capacity in the state's SUD delivery system by contributing to facility closures and making it difficult for providers to accumulate reserves to finance capacity expansion and investments in new care delivery models. Low reimbursement rates also translate to low compensation for licensed SUD professionals, contributing to workforce shortages.

One MCO noted that under the BHO system, the state held reserves that providers could use to invest in capacity building and quality improvement. They were unaware of any such funding under the MCO system.

We don't have some bucket sitting somewhere to invest in providers to help them move dial, where before there were reserves, before the MCOs, there were reserves that were held at the state level that could help out for certain kinds of allocations. So it was unfortunate those monies went away.

-Key informant 7, MCO representative

MCOs generally reimburse residential providers on a fee-for-service (per diem) basis, whereas most outpatient SUD services are part of a capitated, per-member-per-month (PMPM) payment model. One MCO we spoke to argued that per diem payments incentivize residential providers to keep clients in treatment for longer periods with potentially little benefit to long-term outcomes. They recognized, however, that moving to an alternative payment model requires providers to have sufficient volume, experience with risk-based arrangements, and the ability to engage in population health management.

You've got to have enough volume to kind of make it up, then they've got to be able to contain their population well enough. So we've been leery around having the providers enter into risk arrangements because we haven't wanted to have them not have the experience and then not being able to keep their business whole.

-Key informant 7, MCO representative

One residential provider observed that the transition (under IMC) toward capitated payments for outpatient SUD services had driven a reduction in referrals to residential treatment, with adverse impacts on access.

[A]s you pay an outpatient provider to keep somebody, the incentive to send them to a residential program and the incentive for positive outcomes isn't as strong as keeping the person in your capitation that month.

-Key informant 5, provider representative

COVID-19

Key informants generally described COVID-19 as causing severe and ongoing disruption to the SUD delivery system. Social distancing measures have required residential treatment facilities to operate at below capacity. SUD providers have had to reduce services, resulting in permanent closures in some instances.

Now with COVID, we're seeing more programs close. They just can't stay open doing services in this hybrid fashion, whether telehealth or reduced capacity. We're still operating with reduced capacity here at [facility], and it's hard. Financially it's a challenge. We've been grateful to get some of the federal dollars to kind of help cover the shortages that we're experiencing, but I don't know how much longer we'll be able to do it.

-Key informant 9, provider representative

One key informant noted that a lack of financial reserves had made many SUD providers, particularly smaller facilities, vulnerable to the precipitous revenue drop caused by COVID-related service disruptions.

Whereas the pandemic has reduced system capacity, COVID-19 may have increased the demand for SUD services among Medicaid beneficiaries. One residential provider noted that since the pandemic began, they had seen an increase in their Medicaid payer mix. In the longer term, increased Medicaid demand could encourage providers catering to the commercial market to begin offering Medicaid services, potentially offsetting capacity reductions due to closures. An MCO representative reported that the pandemic had prompted some providers to consider offering Medicaid services as a new line of business.

There are a fair number of providers with COVID that are starting to outreach that are thinking about expanding their businesses that have not had Medicaid clients served, and you look at that as a new population, a new line of business for them.

-Key informant 7, MCO representative

Across the health care system, the pandemic has led to a considerable expansion in the use of telehealth services. This has also been true for the delivery of SUD services. HCA has worked to ensure providers have adequate technological resources (e.g. laptops and Zoom licenses) to provide services via telehealth. Nevertheless, many beneficiaries lack hardware, internet connectivity, and the technology know-how to successfully complete video visits. One MCO reported, however, that for some groups, the growing prevalence of telehealth has helped reduce barriers to accessing care. A provider we spoke to noted that for some clients, COVID has increased access to MOUD by allowing longer prescriptions to be mailed. Another residential facility said the pandemic had facilitated methadone access for its residents by allowing more doses to be carried out of the clinic at a time.

One MCO expressed optimism that increased use of telehealth would create new opportunities for residential SUD providers to offer whole-person care through virtual consultations with psychiatrists and medical providers.

Limitations

The assessment's findings from both SUD performance measures and key informant interviews have important limitations. For example, our ability to measure the quality of life, addiction severity, and changes in mortality or morbidity are limited in administrative data. In addition, the SUD waiver represents one piece of larger statewide and national efforts to address the opioid epidemic. We cannot attribute the positive changes in this study to the SUD waiver alone. Future reports evaluating MTP will provide additional information on the changes occurring in subsequent years, with some increased ability to discern trends in mortality and overdoses.

The key informant interviews were limited in both quantity (14 in total) and scope. In terms of scope, interview questions focused on the state's Medicaid population as a whole. We did not seek to elicit detailed information on subpopulations, such as incarcerated individuals, pregnant and parenting women, and persons referred to involuntary treatment. While some of our key informants had insights into these populations, our data did not permit a comprehensive discussion of their needs. Tribal providers and representatives shared important information about Medicaid delivery for AI/ANs at a listening session early in the assessment, but curtailed subsequent participation due to demands of COVID-19. Our initial outreach included some outpatient SUD providers, but all provider interviews were with representatives of residential SUD treatment facilities. We did not interview any hospitals. Given these limitations, our depiction of factors contributing to milestone progress reflects the perspectives of our 14 key informants and should not be interpreted as a complete picture of the SUD delivery system in Washington State.

Conclusions

Overall, these results suggest that, across several measurement domains and milestones, the waiver has been associated with improvements in the state's efforts to prevent and treat SUD. Among 25 measures for which we had data to measure change after the waiver's implementation, 19 improved, and six demonstrated no change or slightly worse performance. These findings point to significant progress in expanding access and provider capacity, increasing treatment quality and availability, and improving care coordination. Interviews with key informants identified some unintended consequences of the IMC transition, which has been associated with payment delays and a new level of administrative burden. However, stakeholders also pointed to multiple benefits of the waiver, including increased financial sustainability and greater flexibility in meeting Medicaid beneficiaries' residential treatment needs.

SUD Treatment Services for American Indians and Alaska Natives

Overview

Twenty-nine federally recognized tribal governments lie within the boundaries of Washington State. AI/AN individuals, some of whom are members of these tribes, receive health care services through an array of federal and state programs, including Medicaid. As of September 2020, a total of 82,966 individuals enrolled in Washington's Medicaid program self-identified as AI/AN.

The assessment team collaborated with HCA and tribal representatives to invite tribes' participation in the assessment and explore factors affecting SUD treatment access and quality for AI/ANs. This chapter begins with an overview of the systems through which AI/ANs in Washington State receive Medicaid-covered SUD services, then describes assessment activities involving the tribes, ending with a summary of the feedback received.

KEY FINDINGS

- *Limited access to culturally appropriate services and traditional Native American treatment modalities impedes healing and long-term recovery from SUD.*
- *Low FFS reimbursement restricts availability and access to residential SUD services for AI/ANs.*
- *Tribal residential providers face significant staffing costs associated with offering MOUD, prohibiting some from offering these medications.*
- *Challenges with post-treatment care coordination and recovery supports, experienced by Medicaid beneficiaries in general, are especially acute for AI/ANs.*
- *HCA's recent State Plan Amendment introducing a cost-based per diem rate for SUD residential treatment facilities operated by Indian Health Services or tribes should, if approved, help to address some of these challenges.*

Medicaid Options for SUD Treatment for AI/ANs in Washington

AI/AN individuals in Washington have two options for Medicaid coverage: enrolling in the FFS program, which is the default for AI/ANs, or opting to enter managed care by enrolling with one of

the state's five MCOs. As of September 2020, approximately 64% of AI/AN Medicaid beneficiaries were enrolled in FFS.

Indian Health Care Providers

The Indian Health Care Delivery System (I/T/U) in Washington includes programs operated by three discrete branches:¹⁸

- **Indian Health Services (IHS) Direct Service:** Three federally operated service units on the Colville, Spokane, and Yakima reservations serve AI/ANs.
- **Tribal Health Programs:** While every tribe operates a health program, 27 tribes operate clinics that provide various outpatient services, which may include physical, behavioral and dental health services. Tribal health programs also coordinate inpatient and specialty care from other providers, including providers outside the I/T/U system and other tribal health programs.
- **Urban Indian Health Programs (UIHPs):** Two private, non-profit corporations (Seattle Indian Health Board and NATIVE Project of Spokane) serve AI/AN individuals with culturally appropriate health care and traditional health care services.

Providers within these programs are often collectively referred to as Indian Health Care Providers (IHCPs). Since there are no IHCPs in Washington State that offer inpatient care and few IHCPs that offer specialty care, clients are often referred to non-IHCPs for such services.

The state has two residential SUD facilities operated by tribes, one of which is an IMD, and one UIHP-operated SUD residential IMD, which is currently closed for construction. As of November 2020, there were a total of 27 IHCPs offering outpatient SUD treatment.

Each tribe has its own unique traditions, culture, and infrastructure that shape its health care services. Tribal health programs have expertise in a range of culturally appropriate treatment modalities, including, for example: holistic health care, wrap-around services, the Medicine Wheel – Wellbriety model, integrated physical and behavioral health care, traditional health practices, tribally-driven population health, community connectedness, and Seven Generation strategies.

Funding and Reimbursement

Washington's IHCPs are funded primarily through federal appropriations via IHS and third-party billing (especially Medicaid). Federal laws designate IHS as a "payer of last resort," which means that all other funding resources must be exhausted before IHS funds may be used to pay for services at non-tribal facilities, including Medicaid, Medicare, commercial insurance and casualty insurance.

The state receives 100% federal match for services (including residential SUD treatment) provided to IHS-eligible AI/AN Medicaid beneficiaries by tribally operated and IHS facilities, but not by UIHPs. In 2016, CMS expanded this federal match policy to apply to services from non-IHS and non-tribal providers that were requested (under a care coordination agreement) by a health care practitioner at a tribal or IHS facility.¹⁹ A law passed by Washington's legislature in 2019 created a Reinvestment Account into which the additional federal funding resulting from this expansion would be placed (See Box 4.1.).

Outpatient services (including SUD services) provided to Medicaid beneficiaries by tribally operated and IHS providers are reimbursed at the IHS encounter rate. This is a cost-based rate negotiated annually between IHS and CMS, and it is generally higher than standard Medicaid FFS

reimbursement. This rate applies only to the Medicaid FFS program. In 2019, CMS approved a State Plan Amendment to apply the IHS encounter rate to both fee-for-service and managed care if a tribally operated facility becomes designated with the state Medicaid program as a federally qualified health center.

HCA has recently submitted a State Plan Amendment introducing a cost-based per diem rate for SUD residential treatment facilities operated by IHS or tribes.²⁰ This rate would apply to IHS-eligible AI/AN Medicaid beneficiaries and represents a significant increase in reimbursement compared to current FFS rates. The rate increase reflects the higher costs of operating tribal facilities with additional programming such as culturally appropriate services and ongoing support after discharge.

Box 4.1: The Washington Indian Health Improvement Act

In 2016, CMS expanded the 100% federal match policy for AI/AN Medicaid beneficiaries to apply to services from non-IHS and non-tribal providers that were requested (under a care coordination agreement) by a health care practitioner at a tribal or IHS health care facility.²¹ In 2019, Washington's legislature passed SB 5415, directing the additional funds accruing to the state as a result of this policy change to be deposited into a Reinvestment Account.²² This account would fund services and programs for AI/AN communities, including programs to reduce health inequities and increase access to culturally appropriate health care, and facilities providing SUD, behavioral health, and specialty care services.

By enabling Washington to obtain federal funding for IMD stays for Medicaid FFS beneficiaries, HCA anticipated that the waiver could produce benefits that were specific to AI/AN beneficiaries.²³ As described in Chapter 1, prior to July 1, 2018, federal Medicaid dollars could not be used to pay for treatments in IMDs for persons enrolled in Medicaid FFS; state funds were used for this purpose. For all residential IMDs that participate in the Medicaid FFS program, including tribal IMDs and the UIHP-operated IMD, the waiver should result in increased federal match and make available state general fund dollars previously spent on these services.

Tribal Collaboration for the Mid-Point Assessment

Activities

The state routinely collaborates and consults with tribes in developing Medicaid and other government policies that directly affect AI/AN individuals, IHCPs, and tribal communities. In 2017-2018, HCA held two roundtable sessions with representatives from tribes and UIHPs and a formal tribal consultation to discuss the content of the SUD waiver and its potential impacts on tribes.

Continuing this collaboration, the MPA team held meetings with tribal representatives and SUD treatment providers in 2019-2020 to inform assessment activities. Topics discussed included the specific needs of AI/AN individuals with SUD, the challenges faced by IHCPs, and access barriers encountered by AI/AN Medicaid beneficiaries in seeking SUD treatment.

HCA Monthly Tribal Meeting

As a preliminary step in tribal outreach and engagement, the assessment team participated in HCA's Monthly Tribal Meetings, held on August 7, 2019 and January 8, 2020. This regularly occurring meeting convenes Washington tribal health leaders, as well as MCO tribal liaisons and

representatives from HCA and DOH. It is held at HCA's offices in Olympia, WA with webinar and call-in options.

The purpose of our participation was to understand tribes' preferences for collaboration on the MPA, including meeting format, timing, and invitees. We gave a presentation to introduce the MPA and describe objectives for collaboration. We then asked tribal representatives to provide feedback and suggestions (either at the meeting or in follow-up communication with our team) for obtaining meaningful input from tribes and IHCPs. Based on this feedback and consultation with HCA's tribal liaisons, we worked with HCA to host a listening session with representatives of tribes and IHCPs.

Listening Session

The listening session took place on January 31, 2020, at HCA's offices in Olympia, WA, with a phone conference line for remote participation. Participants included representatives and executives from a number of tribal health care and SUD programs in Washington, a tribally operated residential facility, a UIHP, the American Indian Health Commission, the Northwest Portland Area Indian Health Board, and an MCO. Tribes represented were Cowlitz, Squaxin Island, Nooksack, Lummi, Yakama, Shoalwater Bay, Colville, and Port Gamble S'Klallam. The session was also attended by HCA staff and tribal liaisons.

We presented information on the SUD waiver, milestones, and requirements for the assessment. To start the discussion, we solicited participants' thoughts on the following discussion topics:

- What is working well with SUD treatment for AI/ANs now? What are the major pain points?
- How does access to residential SUD treatment work for AI/ANs? What factors constrain access?
- How might the SUD waiver affect residential SUD treatment access and quality for AI/ANs?

Key Informant Interviews

Based on recommendations from participants at the listening session and input from HCA's tribal liaisons, the assessment team identified a list of providers to contact for key informant interviews. The team sent interview invitations to three residential SUD treatment facilities (two operated by tribes and one by an UIHP). Both tribally operated facilities declined due to organizational strain resulting from the COVID-19 pandemic, and the team completed an interview with the UIHP. To supplement the single provider interview and clarify our understanding of the delivery system for SUD treatment services to AI/AN Medicaid beneficiaries, the team also spoke further with representatives of HCA's Tribal Affairs division.

Summary of Feedback

Collaboration with tribal leaders, tribal representatives, and IHCPs yielded feedback and comments on a number of themes, some related to waiver milestones and others touching on broader topics.

Culturally Appropriate SUD Services

IHCPs emphasized the importance of culturally appropriate services and traditional Native American treatment modalities to promote AI/AN healing from SUD and enable long-term recovery. AI/AN

clients frequently suffer from historical and generational trauma, which necessitates a trauma-informed treatment approach that may require more than 30 days in a residential facility.

Availability of these services is limited by the lack of Medicaid funding for such treatments, low FFS reimbursement for other residential services, and the shortage of tribally operated facilities. However, one UIHP representative noted that their program had reached agreement with some MCOs to reimburse traditional Indian medicine services, either as a one-time annual fee or based on the IHS encounter rate schedule.

IHCPs noted challenges in coordinating with the dominant approach to health care delivery in the state. Several IHCPs pointed to the need to understand the effectiveness of culturally centered treatment compared to other treatment models for SUD. IHCP representatives also described racial misclassification as a significant problem in non-IHCP health care settings.

Barriers to AI/AN Access to Residential SUD Treatment

Tribal representatives indicated that the waiver had not yet directly impacted access to residential SUD treatment for AI/AN Medicaid beneficiaries. The low reimbursement rate for Medicaid FFS (relative to Medicaid managed care and other payers) was described as a significant access barrier for AI/AN beneficiaries, with non-IHCP facilities frequently being unwilling to accept these reimbursement rates.

Another factor viewed as a barrier to residential treatment was the requirement by certain residential facilities that clients either undergo withdrawal management or be prescribed MOUD prior to admission. IHCPs pointed to a shortage of withdrawal management facilities contributing to long wait times for AI/AN clients to be admitted to residential treatment. For MOUD, tribal representatives observed that some residential providers require that referring tribal agencies facilitate and coordinate prescriptions, which leads to further admission delays.

Working with MCOs

One tribal informant noted that tribes generally viewed MCOs' prior authorization and continuing review policies as an intrusion on IHCPs' decision-making. They argued that MCOs did not have the necessary expertise to make appropriate placement decisions for AI/ANs. Residential treatment stays for FFS beneficiaries, in contrast, were not subject to prior authorization or length of stay limits.

One IHCP described challenges of working with MCOs:

Educating them about our communities, Native communities, it is so challenging. They don't have a government responsibility. [...]. They asked tribal presidents to come all the time or tribal chairs, that's like asking the president of United States to show up at your governing board meeting [...]

-Key informant 10, UIHP representative

During the MCO transition, IHCPs were initially required to "balance bill" the state to obtain the full IHS encounter rate for outpatient services, a process which one tribal informant described as cumbersome. HCA is currently working to facilitate MCO payment of the full encounter rate to providers and setting up a system to reimburse MCOs for the balance.

Obstacles to Providing MOUD at Tribal Facilities

Tribal residential providers noted several obstacles associated with the MOUD requirement and the resources needed to manage induction. They pointed to the high cost of having a provider on staff who could prescribe MOUD. These costs were driven by the requirement that providers obtain a DEA-X license and the patient volume restrictions associated with this license. One listening session participant described the MOUD requirement as an obstacle for tribally-operated residential providers looking to increase capacity beyond 16 beds.

IHCPs also expressed concern about prescribing MOUD in a residential facility when clients would be unable or unlikely to continue to receive and adhere to their treatment plan after discharge. Tribal representatives attributed this to the limited availability of outpatient MOUD providers in many communities and inadequate funding for care coordination services. However, one UIHP representative described success in setting up an outpatient buprenorphine program with startup funding from the county and subsequent funds from a SAMHSA grant.

Care Transitions and Recovery Supports

Listening session participants talked at length about the importance of wrap-around services and “warm hand-offs” between residential and outpatient SUD services. AI/AN clients need to access both health and social services, which are often sourced from multiple providers through a complex system that is difficult for clients to navigate. Many AI/AN clients discharged from residential facilities lack adequate housing, which may severely impede their recovery. Although Medicaid reimbursement for SUD peers was viewed as helpful, IHCPs saw a need for more funding mechanisms to provide care coordination and support services in the community.

One tribally managed residential program had instituted an after-care model that includes a full year of follow-up with frequent phone contacts and other supports for discharged clients. This program was described as a model for post-residential care coordination and maintaining the cultural connections established during tribally specific residential treatment.

Conclusions

Any effects of the SUD waiver on AI/AN beneficiaries in Washington are obscured by the overlap of Medicaid and IHS funding for services to tribal members, in addition to different policies for services provided by tribal/IHS and non-tribal providers. Input from tribal representatives indicated that the SUD waiver might benefit residential treatment access for AI/AN beneficiaries by adding federal match for AI/ANs in the FFS program receiving treatment at IMDs, although such impacts had not been observed to date. Tribal members continue to experience access challenges due to lower reimbursement rates in the FFS program and limited availability of culturally appropriate treatment options. Challenges with post-treatment care coordination and recovery supports experienced by Medicaid beneficiaries in general are especially acute for AI/ANs. HCA’s recent State Plan Amendment introducing a cost-based per diem rate for SUD residential treatment facilities operated by IHS or tribes should, if approved, help to address some of these challenges.

Summary and Recommendations

The assessment points to significant progress in expanding access and provider capacity, increasing treatment availability, and improving care coordination within Washington State's SUD treatment systems. Overall, the state has made progress on implementing the care standards embedded in the six SUD waiver milestones. Across most measurement domains, the state improved its ability to provide SUD treatment to Medicaid enrollees. Among 25 measures, 19 improved, and the others showed no change or slightly worse performance. In addition, the number of licensed SUD residential IMD facilities did not change in the year following the waiver's implementation, while budget neutrality was maintained (see Appendix B). However, interviews with key informants revealed hurdles as the state reformed its Medicaid delivery system. Below we summarize ongoing and potential challenges to improving SUD-related outcomes via the SUD waiver.

Ongoing challenges

IMC has created unintended consequences

The IMC transition was associated with delays in payment, increases in administrative costs and burdens, and barriers to access. Some of these challenges may be short-term and related to the transition. For example, the IMC transition required many providers to invest heavily in EHR systems. In the short run, this introduced new expenses and interrupted workflows. However, now that they are in place, providers and their clients may see benefits as these systems create efficiency gains and opportunities to collect and analyze systematic data on clients. Payment delays that severely impacted providers during the early days of IMC were mostly resolved by late 2020. Other factors may represent ongoing challenges. These include a perceived higher level of utilization management by MCOs and philosophical differences about the evidence for and role of residential SUD treatment. Finally, the shift to IMC had differential effects on providers, with smaller providers particularly struggling to maintain financial viability.

Uncertainty around future federal support for IMDs may inhibit capital investments in capacity

Federal funds provided by the current SUD waiver appear to have assisted in preserving existing SUD residential capacity. However, it is unclear if those funds have catalyzed new investments. Several stakeholders expressed concerns about uncertainty surrounding the waiver's renewal and future IMD policy at the federal level. This uncertainty may have inhibited further investment in new residential facilities.

Some SUD services continue to face access and capacity challenges that do not appear to have been mitigated by the SUD waiver

While the SUD waiver appears to have improved access for many SUD services, access to withdrawal management services, and capacity for these services, were described as problems by all categories

of stakeholders. Culturally specific services were also noted as remaining limited, in addition to the ability to provide co-occurring mental health and substance use treatment.

Gaps in care coordination and recovery supports threaten clients' sustained recovery from SUD

Although residential providers routinely provide warm hand-offs for clients moving to community-based outpatient services, gaps in care coordination remain that endanger smooth transitions between service levels for many clients. In-person case management and peer services were viewed as promising strategies, though not universally available. Adverse social determinants of health, particularly insecure housing, presented barriers to keeping clients successfully engaged in community-based treatment following residential stays.

COVID-19 has placed additional strain on the SUD treatment delivery system

COVID-19 created a significant drop in utilization and revenue for many SUD providers. At the same time, some providers indicated that the pandemic may have increased the demand for SUD services, even while creating complexities in how those services could be provided safely. The impact of the financial strain on provider capacity is not yet known. However, the pandemic may have prompted some providers to consider offering Medicaid services as a new line of business while also opening up the potential for telehealth to expand access and treatment options for SUD, including prescribing and monitoring MOUD.

Recommendations

Engage multiple stakeholders to assess and plan for the future of Washington's SUD and behavioral health systems

The state may benefit from a longer-term planning process that would assess current and anticipated gaps in different levels of services and address needs in a coordinated way. This assessment could include input from various stakeholders, including providers of services at different ASAM levels, Medicaid beneficiaries and recovery support organizations, corrections departments, counties, ACHs, and MCOs, as well as consultation with tribes. If the SUD portion of the Section 1115 waiver were renewed, this assessment could guide future investments by the state, providers, and other funders. Given the state's IMC contracting framework, it could incorporate data on co-occurring capacity among SUD and mental health providers, creating the potential for greater partnerships and coordination. The assessment could also weigh the value of additional funding to support infrastructure investments or finance innovations in care delivery.

Develop the state's evidence base and consensus on the best uses for residential treatment services

MCOs exhibited different frameworks from residential treatment providers and recovery support organizations for assessing the value of residential treatment. There are also competing interpretations of ASAM criteria and "medical necessity." The state could combine local data and national evidence to develop guidelines for residential treatment authorizations and find consensus for appropriate length of stays in residential settings. Ideally, these guidelines would align with ASAM, reduce recidivism, and promote recovery.

Consider the value of expanding the Foundational Community Supports program

Although outside the realm of clinical services, providers considered factors such as stable housing, supported employment opportunities, transportation, and peer services as essential for residential clients' success once they transitioned to community settings. Stakeholders emphasized the need for recovery supports to address these factors. Recent SUD-related contracting for FCS – part of Washington's larger Medicaid Transformation Program – could be a mechanism for providing such supports. However, in its current form, FCS may not be able to scale to meet the full demand for these services.

Sustain the advances in telehealth for SUD that were catalyzed by COVID-19

The COVID-19 pandemic resulted in an expansion of telehealth, including services for SUD. Although the pandemic created a separate set of challenges around access and utilization, telehealth's increased availability appears to have been beneficial. The state should assess how telehealth for SUD and mental health services can be continued in the future. In particular, telehealth for SUD may improve access in rural areas or increase the ability to provide medications for addiction treatment.

Factor in the changing concentration, delivery, and intensity of opioids as well as growth in other substances

Although not part of the formal assessment design, the state should also consider the universe of available substances in future planning. A recent report identified a sharp increase in fentanyl overdoses on the West Coast.²⁴ Confronting the potential for greater fentanyl use may require adjustments from providers and payers. For example, a review of the standard prescribed dose of naloxone may be warranted, because overdoses from fentanyl may require larger doses of naloxone to reverse the effects.

The state should also assess its response in the context of increased mortality from methamphetamines.²⁵ HCA may improve outcomes for Medicaid beneficiaries with SUD by explicitly acknowledging the growing prevalence of methamphetamine use and supporting evidence-based treatments and therapies for methamphetamine abuse.

Outreach & Engagement

Overview

As a starting point for the MPA, the assessment team conducted outreach and engagement activities with stakeholders representing MCOs, SUD treatment providers, and beneficiaries. The purpose of these activities was to solicit input on assessment design, planning, and implementation of the midpoint assessment, as well as the anticipated impact of the SUD waiver on each of these groups.

We received assistance from HCA to identify suitable venues, invite participants, encourage attendance, and coordinate meeting logistics. This Appendix describes our tribal outreach and stakeholder engagement efforts, summarizes key learnings from these activities, and discusses implications for the assessment.

Activities

CODTx

The assessment team attended the Co-Occurring Disorders & Treatment Conference (CODTx) in Yakima, Washington, on October 7, 2019. This annual conference is sponsored by HCA, Department of Corrections, and DSHS. It brings together professionals from behavioral health, developmental disabilities, adult and youth corrections, and physical health, to share knowledge on current programs, practices, policies, and therapies for meeting the needs of individuals with co-occurring disorders. Conference participants included behavioral health providers, representatives from MCOs and BHOs, Medicaid beneficiaries, advocates for persons in recovery, and officials from government agencies at the state, county, and local levels.

The team hosted a breakout session entitled “Cracker Barrel: Assessing Washington’s SUD Residential Treatment Waiver.” The session consisted of a short presentation describing the waiver (context, requirements, and milestones) and the MPA goals and methods. We then asked attendees to break into smaller groups (4-6 persons) and discuss the following questions:

- 1 How will these changes affect your practice and/or the care individuals receive?
- 2 What are key measures to evaluate success?
- 3 What factors will aid or hinder changes?

As reference for group discussions, we provided one handout listing the SUD metrics included in the SUD Monitoring Protocol and another listing the waiver milestones. Fifteen conference participants attended the session. Attendees included representatives from behavioral health providers, state agencies (HCA, DBHR, DSHS, DOC), counties, a recovery advocacy group, and the state senate.

MCO Meeting

On October 23, 2019, the assessment team participated remotely in the MCO Quarterly Workgroup Meeting hosted by HCA. This meeting convenes MCO representatives, DOH and HCA to discuss topics relating primarily to Healthier Washington and MTP, providing a forum for MCO feedback. For this meeting, HCA also encouraged attendance by MCO subject matter experts on SUD service delivery, capacity, and access. Representatives from the five MCOs (United Health Care, Amerigroup, Community Health Plan of Washington, Molina, and Anthem) attended the meeting.

The team's participation consisted of a short presentation followed by Q&A and discussion. The presentation introduced the MPA, its goals and methods, and described objectives for stakeholder engagement. To prompt discussion and feedback, we posed three questions to participants:

- 1 How are these changes affecting your ability to provide residential SUD IMD services for your members and the quality of services?
- 2 What are key measures to evaluate success?
- 3 What factors will aid or hinder changes?

As reference for group discussions, we provided handouts listing the waiver milestones and SUD metrics included in the SUD Monitoring Protocol.

Integration into Assessment Activities

Stakeholder input received during the activities described above was incorporated into the design of subsequent assessment tasks, including key informant interviews and interpretation of milestone progress. The initial stakeholder engagement activities elicited comments on a number of themes and questions which the assessment team explored further with key informants. These questions included:

Has the waiver stabilized the financial position of SUD IMDs?

Stakeholders described how the 15-day limit on IMD stays threatened the financial viability of IMDs in Washington. It also led to organization fragmentation whereby providers split their organizations into separate operating units with less than 16 beds to avoid being designated an IMD. We heard from stakeholders that without additional funding, IMDs would have reduced capacity or been forced to close. State "backfill" funding for longer IMD stays, as obtained in 2018, was an unreliable funding mechanism, as the amount of funding would depend on shifting legislative priorities.

The federal rule change limiting IMD stays to 15 days, effective July 1, 2017, represented a reduction in federal funding for IMDs in Washington. Prior to the change, IMD stays for WA Medicaid beneficiaries were federally funded through the state's 1915(b) managed care behavioral health waiver.

In the short run, how did the waiver affect capacity planning by residential SUD treatment facilities?

The state believed the waiver would lead to an expansion of residential SUD bed capacity. We heard some statements to support this, although we did not have the opportunity to ask an IMD representative about how the waiver impacted capacity plans. A BHO director and a former DBHR

employee we spoke with both claimed that the waiver prompted IMDs to expand capacity or make plans to do so.

How can the assessment distinguish impacts of the SUD waiver from co-occurring program changes, in particular the integration of behavioral health into MCOs?

MCO stakeholders saw the ongoing integration of behavioral health into MCOs as a huge shift for both providers and MCOs. They described a “cultural divide” between MCOs and SUD providers on treatment paradigms for SUD. Stakeholders provided a number of examples of these differences:

- **Adherence to ASAM standards.** Whereas SUD providers adhere strongly to the ASAM standard, this is not always consistent with the MCOs’ behavioral health treatment structure.
- **Effectiveness of MOUD.** MCOs generally have a favorable view of MOUD as long as it is accompanied by care for mental health and other comorbidities, which are common among SUD clients. In contrast, some SUD providers (e.g., tribal providers) were more skeptical of MOUD.
- **Residential vs. outpatient care.** As part of their commitment to evidence-based care, MCOs generally do not support offering residential care as the default treatment for SUD. Rather, they believe residential treatment should be available as an option, along with outpatient behavioral health care. MCOs noted that although SUD providers have strong views on how to care for clients, often based on personal experiences with recovery, there is scant evidence on what works in residential treatment.
- **Residential length of stay.** MCOs expressed concern about length of stay in residential facilities, noting that clients should stay in residential care only for as long as this is medically necessary. In practice, many clients stay longer for programmatic reasons or because they are homeless. The goal of residential treatment should be for clients to advance to outpatient level of care. There is an acute need for housing assistance for SUD clients to ensure that residential clients are not discharged to homelessness.
- **Withdrawal management services.** MCOs would like to see ambulatory withdrawal management (detoxification, or “detox”) made available in residential facilities to avoid the need for inpatient withdrawal management.

Key informant interviews probed these delivery system questions in more depth to understand interactions between the managed-care shift in behavioral health and implementation of the SUD waiver.

What are effective roles for contractual and licensing requirements in implementing the MOUD requirement (milestone 3)?

The MOUD requirement (milestone 3) was implemented via changes in MCO/BHO contracts and WAC. These changes required that MCOs contract only with residential providers who offered MOUD on-site or facilitate off-site access. MCOs suggested that direct requirements on residential treatment facilities were necessary to ensure that providers offer MOUD.

What factors (such as HIPAA and privacy rules and payment structures) hinder information sharing and care coordination/integration (milestone 6) between different SUD provider levels?

Providers noted that efforts to enhance care coordination and transitions between residential and outpatient treatment settings (milestone 6) are hampered by HIPAA and privacy rules, as these

impose restrictions on information sharing between MCOs, residential treatment providers, and outpatient providers. Additionally, stakeholders suggested that payment models (such as episodic payments for residential stays with no integrated outpatient services) could hamper effective care transitions.

How does the requirement that FFS clients be “independently” assessed prior to admission to a residential facility for SUD (milestone 2) affect access to care for some populations?

Providers observed that the requirement (milestone 2) that FFS clients be “independently” assessed prior to admission to a residential facility for SUD presents a significant barrier to care, particularly for rural and incarcerated populations. In rural areas, the nearest assessment location may be 15-20 miles away, and many clients have transportation limitations (e.g., no car).

Formerly incarcerated individuals also face considerable mobility constraints, which could preclude them from obtaining an independent assessment. Probation conditions may prevent travel to SUD facilities outside the parolee’s county of residence, and inmates who need SUD treatment are typically taken directly to a residential facility.

Will expanded capacity allow residential SUD facilities to provide higher quality treatment at a lower cost?

A representative from a recovery advocacy group we spoke with, as well as a BHO director, noted that larger residential facilities benefit from lower costs due to scale economies. Larger facilities may also be able to provide more tailored treatment, since clients can be split into smaller groups based on the type of counseling needed (e.g., grief, etc.).

Do mental and physical health providers have adequate training to provide SUD treatment?

According to MCOs, mental health and medical providers need additional training to better integrate SUD treatment with other care, especially given that mental health and other comorbidities are common among SUD clients. One MCO noted that medical providers are currently offering MOUD without also connecting the patient to behavioral health care services.

Budget Neutrality

Washington is subject to a limit on the amount of federal Title XIX funding it may receive under the SUD waiver. “Budget neutrality,” a stipulation of the SUD waiver, requires that Washington’s spending on SUD services provided to beneficiaries in IMDs not exceed hypothetical expenditures projected to have been incurred in the absence of the SUD waiver (“without waiver” expenditures).

To assess budget neutrality, we reviewed Washington’s Budget Neutrality Workbooks as reported to CMS in July 2019 and July 2020 and met with HCA Finance staff. This appendix describes the budget neutrality test for SUD and summarizes the state’s budget neutrality performance for the period July 2018 through December 2019. The data shown here were obtained from HCA’s Finance division.

The Budget Neutrality Test 4

Under the Supplemental Budget Neutrality Test 4, SUD services provided in IMDs for beneficiaries with a primary diagnosis of SUD (hereafter “SUD IMD expenditures”) are treated as hypothetical expenditures. As such, projected expenditures “without waiver” are based on the assumption that SUD IMD expenditures would have been allowed as Medicaid state plan services (e.g., there would have been no IMD exclusion). Exhibit B1 below reproduces the per member per month (PMPM) expenditure limits “without waiver,” by Medicaid Eligibility Group (MEG), for SUD IMD services. These limits were specified in the waiver special terms & conditions.²⁷

Exhibit B.1: Without Waiver PMPM Expenditure Limits for SUD Services in an IMD

SUD MEG	DY1 PMPM*	DY2 PMPM	DY3 PMPM	DY4 PMPM	DY 5 PMPM
Medicaid Disabled		\$1,084	\$1,142	\$1,149	\$1,189
Medicaid Non-Disabled		\$292	\$300	\$311	\$322
Newly Eligible		\$462	\$478	\$500	\$524
American Indian/ Alaska Native		\$3,009	\$3,079	\$3,174	\$3,273

Source: Washington State Medicaid Transformation Project Section 1115(a) Medicaid Demonstration Special Terms & Conditions, p. 58, 102(d)(i).

* There is no PMPM spending limit for DY1 (calendar year 2017), as the SUD waiver came into effect in the second half of DY2.

Total “without waiver” spending is calculated as the PMPM dollars multiplied by the state’s actual member months, aggregated across all MEGs and Demonstration Years. This single budget neutrality limit is the sole determinant for assessing budget neutrality. If the total FFP received by the state

over the demonstration period is equal to or less than the total FFP that would have been paid in the “without waiver” scenario, the waiver is considered “budget neutral.”

Budget Neutrality Summary

Exhibit B2 summarizes Washington’s budget neutrality status as of July 2020, reproducing data reported to CMS as part of the state’s Budget Neutrality Workbook. Panel 1 shows “without waiver” spending for demonstration years 2 (2018) through 5 (2021) based on the PMPM expenditure limits. Member months for DY 2 and 3 are actuals, whereas DY 4 and 5 are projected. For each MEG, total spending “without waiver” is simply the PMPM amount multiplied by the number of member months. Washington’s total SUD IMD spending under the waiver is not to exceed \$32,254,903.

Exhibit B2, Panel 2 shows the state’s actual expenditures under the SUD waiver for 2018 (DY2) and 2019 (DY3) and projected spending for 2020-2021 (DY4-5). Expenditures reported for 2018 and 2019 were substantially lower than projected. In DY2, actual spending under the waiver was \$157,536 lower than the “without waiver” limit; in DY3 it was \$1,294,774 lower. Exhibit B2, Panel 3 applies the budget neutrality test by comparing this variance on a cumulative basis to the allowed cumulative variance under the CMS determined Cumulative Target Percentage (CTP). As of July 2020, Washington expects its total expenditures under the SUD waiver (2018-2021) to be below the hypothetical spending cap by \$1,450,344.

Reporting Delays

Washington is allowed a two-year grace period to report SUD IMD expenditures and member months to CMS. Although costs were incurred beginning in 2018, the state did not report any spending under the SUD waiver until the first quarter of 2020. The state recently discovered a discrepancy between its process for mapping SUD IMD expenditures and the criteria for identifying SUD costs for budget neutrality assessment. The state is currently working on validating the SUD data and will update the member months and expenditures in future CMS reports. HCA staff also described delays related to data systems integration and turnover in agency staff. For these reasons, the expenditures shown in Exhibit B2 underrepresent the state’s true spending on SUD IMD services.

Exhibit B.2: Budget Neutrality Summary

Panel 1: Without Waiver Total Expenditures

MEG		Demonstration Years				Total
		2 (Actual)	3 (Actual)	4 (Projected)	5 (Projected)	
Medicaid Disabled	Total	\$14,092	\$93,644	\$1,738,437	\$1,823,926	\$3,670,099
	PMPM	\$1,084	\$1,142	\$1,149	\$1,189	
	Mem-Mon	13	82	1,513	1,534	
Medicaid Non-Disabled	Total	\$4,380	\$116,400	\$805,179	\$844,928	\$1,770,887
	PMPM	\$292	\$300	\$311	\$322	
	Mem-Mon	15	388	2,589	2,624	
Newly Eligible	Total	\$35,574	\$607,538	\$5,124,000	\$5,515,100	\$11,282,212
	PMPM	\$462	\$478	\$500	\$524	
	Mem-Mon	77	1,271	10,248	10,525	
American Indian/Alaska Native	Total	\$312,936	\$1,274,706	\$6,786,012	\$7,158,051	\$15,531,705
	PMPM	\$3,009	\$3,079	\$3,174	\$3,273	
	Mem-Mon	104	414	2,138	2,187	
Without Waiver Total		\$366,982	\$2,092,288	\$14,453,628	\$15,342,005	\$32,254,903

Panel 2: With Waiver Total Expenditures

	Demonstration Years				Total
	2 (Actual)	3 (Actual)	4 (Projected)	5 (Projected)	
Medicaid Disabled	\$987	\$7,213	\$1,739,103	\$1,823,190	\$3,570,493
Medicaid Non-Disabled	\$685	\$9,262	\$804,558	\$844,797	\$1,659,302
Newly Eligible	\$13,514	\$49,652	\$5,127,587	\$5,513,732	\$10,704,485
American Indian/Alaska Native	\$194,260	\$731,387	\$6,786,931	\$7,157,701	\$14,870,279
With Waiver Total	\$209,446	\$797,514	\$14,458,179	\$15,339,420	\$30,804,559
Variance (With Waiver - Without Waiver)	(\$157,536)	(\$1,294,774)	\$4,551	(\$2,585)	(\$1,450,344)

Panel 3: Budget Neutrality Test 4

	Demonstration Years			
	2 (Actual)	3 (Actual)	4 (Projected)	5 (Projected)
Cumulative Target Percentage (CTP)	1.50%	1.00%		
Cumulative Budget Neutrality Limit (CBNL)	\$366,982	\$2,459,270	\$16,912,898	\$32,254,903
Allowed Cumulative Variance (= CTP*CBNL)	\$5,505	\$24,593		
Actual Cumulative Variance	(\$157,536)	(\$1,452,310)	(\$1,447,759)	(\$1,450,344)

Source: Washington Annual Budget Neutrality Monitoring Workbook, July 2020.

Analysis of Performance Metrics

In this appendix, we describe the performance metrics presented in this report, the data sources and specifications used to calculate metrics, and the statistical methods applied in measuring the change in metrics associated with the SUD waiver.

Metric Selection

We selected 29 metrics from the state's Substance Use Disorder Demonstration Amendment Evaluation Design, listed in Table 3, Section 6 of the state's Section 1115(a) Evaluation Design.²⁷ The state chose these metrics based on inclusion in the SUD Monitoring Protocol Metric Workbook and timely data availability. Measure definitions are provided (in alphabetical order) below.

Data Sources

We used a combination of metrics calculated by the state and metrics calculated from raw claims, including Medicaid enrollment records for information about each person's demographics, and Medicaid claims/encounters records that identified diagnoses and services each person received. For metrics not provided by the state, we used CMS or HEDIS specifications (HEDIS (R) Technical Specifications for Health Plans, NCQA) to develop our metrics. Data on overdose deaths were obtained from the Washington State Center for Health Statistics. Data on facilities that billed Medicaid for SUD services and providers who billed for MOUD were obtained from HCA.

Statistical Analyses

Of our 29 metrics, 16 were developed at the beneficiary level. We conducted statistical analyses on these with adjustments described below. We did not conduct adjusted statistical analyses on the remaining 13 metrics. For example, we reported on the annual number of Medicaid beneficiaries and how this number changed over time, but we did not make statistical adjustments when reporting these changes. In some cases, we did not have data for the post-waiver period, and we report baseline levels only.

The majority of measures were calculated on a "fiscal year" basis, and the analyses compare a pre-waiver period of July 2017-June 2018 to a post-waiver period of July 2018-June 2019. The one exception was the measure Adult Access to Preventive/Ambulatory Health Services for Medicaid beneficiaries with SUD. This measure was calculated on a calendar year basis. For this measure, we excluded 2018 (which can be considered a washout year), and ran regressions comparing 2017 to 2019.

Pre-post regressions

The pre-post analysis takes the following form:

$$Y_{it} = b_0 + b_1 * \text{PostWaiver}_t + a * X_{it} + e_{it} \quad (1)$$

where Y_{it} is the outcome of interest for individual i in year t , $\text{PostWaiver}_t = 1$ if the observation occurs after the effective date of the SUD waiver, and 0 otherwise; \mathbf{X}_{it} is a vector of demographic covariates and risk adjusters, and e_{it} is a random error term associated with the unmeasured variation in the outcome of interest. The coefficient of interest, b_1 , estimates how much the outcome variable changed with the SUD waiver.

For computational ease and interpretability, we generally used ordinary least squares to estimate equation (1).

Covariates

We used the following covariates in our pre-post and difference-in-difference models: age groups (under 18, 18-24, 25-34, 35-44, 45-54, 55-64), race (Alaska Native, American Indian, Asian, Black, Hawaiian, Not Provided, Other, or Pacific Islander), ethnicity (Hispanic or non-Hispanic), risk adjuster indicators based on the Chronic Illness and Disability Payment System (CDPS), indicators of chronic conditions based on the Chronic Conditions Warehouse, indicators of serious mental illness (SMI), and high poverty zip code (defined as mean income for the ZIP code is below 20% of the statewide median income).

We identified a person as having SMI in a given month if he or she received at least one of the following diagnoses within the last year: schizophrenia, bipolar disorder, major depression, cyclothymic disorder, post-traumatic stress disorder (PTSD), or obsessive-compulsive disorder (OCD). For schizophrenia, bipolar disorder, depression, and PTSD, we used diagnosis codes from the CCW. For cyclothymic disorder and OCD, we translated ICD-9 codes used to identify people with SMI, as shown in Exhibit C.1.

Exhibit C.1: Diagnosis Codes Used to Identify People with Severe Mental Illness

Diagnosis	ICD Code Name	ICD-9	ICD-10
Cyclothymic disorder	Cyclothymic disorder	301.13	F34.0
	Schizotypal personality disorder	301.22	F21
	Other specific personality disorders	301.11	F60.89
	Borderline personality disorder	301.83	F60.3
Obsessive-compulsive disorder	Mixed obsessional thoughts and acts	300.3	F42.2
	Hoarding disorder	300.3	F42.3
	Other obsessive-compulsive disorder	300.3	F42.8
	Obsessive-compulsive disorder, unspecified	300.3	F42.9

Clustering of Standard Errors

We adjusted our regressions by clustering at the level of the Primary Care Service Area (PCSA). PCSAs are groups of zip codes that were originally developed and validated by previous research to represent natural markets of primary care.

Measure Definitions

1. Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD

Description: The percentage of Medicaid beneficiaries, 20 years of age and older, with a diagnosed SUD who had an ambulatory or preventive care visit in the measurement year

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS (R) Technical Specifications for Health Plans, NCQA (modified)

2. Any SUD Treatment

Description: The number of Medicaid beneficiaries enrolled for at least one month during the measurement year who received any SUD treatment service in the measurement period

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

3. Average Length of Stay in IMDs

Description: The average length of stay for Medicaid beneficiaries enrolled for at least one month during the measurement year, discharged from an IMD residential treatment facility for SUD

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

4. Continuity of Pharmacotherapy for Opioid Use Disorder

Description: The percentage of Medicaid beneficiaries 18 years of age and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS (R) Technical Specifications for Health Plans, NCQA

5. Early Intervention

Description: The number of Medicaid beneficiaries enrolled for at least one month during the measurement year, who were screened for SUD using the Screening, Brief Intervention, and Referral to Treatment (SBIRT) during the measurement year

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

6. Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries

Description: The rate of Medicaid beneficiaries who had an emergency department encounter related to a SUD during the measurement year. Results are reported as a rate per 1,000 members

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

7. Engagement in Alcohol and Other Drug Abuse or Dependence Treatment

Description: The percentage of Medicaid beneficiaries 13 years of age and older with a new episode of alcohol and other drug abuse or dependence who initiated treatment and had two or more additional services related to AOD or MOUD within 34 days of the initiation visit

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS (R) Technical Specifications for Health Plans, NCQA

8. Facilities Enrolled in Medicaid that Billed for SUD Services

Description: Number of behavioral health facilities offering SUD treatment services that billed for services to Medicaid beneficiaries during the time period 2015-2019

Source: Washington Behavioral Health Agencies Directory, January 2020, ProviderOne Medicaid claims/encounter data

Steward: CMS (modified)

9. FCS Beneficiaries with Inpatient or Residential SUD Service(s)

Formal Name: HIT: FCS Beneficiaries with Inpatient or Residential SUD Service(s)

Description: The percentage of Medicaid beneficiaries, 12 years of age and older, with a SUD treatment need identified within the past two years, who received at least one qualifying SUD treatment during the measurement year and participated in the FCS program

Source: ProviderOne Medicaid claims/encounter data

Steward: WA State

10. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 days)

Formal Name: Follow-up After Discharge from Emergency Department for AOD (within 30 days)

Description: The percentage of emergency department (ED) visits for Medicaid beneficiaries, 13 years of age and older, with a principal diagnosis of AOD abuse or dependence, who had a follow up visit for AOD within 30 days of the ED visit (31 total days)

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS (R) Technical Specifications for Health Plans, NCQA

11. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)

Formal Name: Follow-up After Discharge from Emergency Department for AOD (within 7 days)

Description: The percentage of ED visits for Medicaid beneficiaries, 13 years of age and older, with a principal diagnosis of AOD abuse or dependence, who had a follow up visit for AOD within 7 days of the ED visit (8 total days)

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS (R) Technical Specifications for Health Plans, NCQA

12. Follow-up after Emergency Department Visit for Mental Illness (30 Days)

Formal Name: Follow-up After Discharge from Emergency Department for Mental Illness (within 30 days)

Description: The percentage of ED visits for Medicaid beneficiaries, 6 years of age and older, with a principal diagnosis of mental illness or intentional self-harm, who had a follow up visit for mental illness within 30 days of the ED visit (31 total days)

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS (R) Technical Specifications for Health Plans, NCQA

13. Follow-up after Emergency Department Visit for Mental Illness (7 Days)

Formal Name: Follow-up After Discharge from Emergency Department for Mental Illness (within 7 days)

Description: The percentage of ED visits for Medicaid beneficiaries, 6 years of age and older, with a principal diagnosis of mental illness or intentional self-harm, who had a follow up visit for mental illness within 7 days of the ED visit (8 total days)

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS (R) Technical Specifications for Health Plans, NCQA

14. Initiation of Alcohol and Other Drug Abuse or Dependence Treatment

Description: The percentage of Medicaid beneficiaries 13 years of age and older with a new episode of AOD abuse or dependence who initiated treatment within 14 days of diagnosis.

Source: ProviderOne Medicaid claims/encounter data

Steward: HEDIS (R) Technical Specifications for Health Plans, NCQA

15. Inpatient Admissions for Substance Use Disorder per 1,000 Members

Formal Name: Inpatient Admissions for SUD per 1,000 Medicaid Beneficiaries

Description: The rate of Medicaid beneficiaries who had an inpatient stay for a SUD during the measurement year. Results are reported as a rate per 1,000 members

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

16. Medicaid Beneficiaries Treated in an IMD for SUD

Description: The number of Medicaid beneficiaries enrolled for at least one month during the measurement year, who received residential treatment for a SUD in an IMD during the measurement year

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

17. Medicaid Beneficiaries with SUD Diagnosis (annually)

Description: The number of Medicaid beneficiaries enrolled for at least one month during the measurement year, with a SUD diagnosis and a SUD related service during the measurement year and/or in the 12 months before the measurement year

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

18. Medicaid Beneficiaries with SUD Diagnosis (monthly)

Description: The number of Medicaid beneficiaries enrolled during the measurement month with a SUD diagnosis and a SUD related service during the measurement month and/or the previous 11 months

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

19. Medications for Addiction Treatment

Formal Name: Medication assisted treatment (MAT)

Description: The number of Medicaid beneficiaries enrolled for at least one month during the measurement year, who used MOUD for SUD during the measurement year

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

20. Outpatient Services

Description: The number of Medicaid beneficiaries enrolled for at least one month during the measurement year, who used outpatient services for SUD during the measurement year

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

21. Overdose Deaths (count)

Description: The number of overdose deaths among Medicaid beneficiaries during the measurement year

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

22. Patients Prescribed Chronic Concurrent Opioids and Sedatives

Formal Name: Concurrent Use of Opioids and Benzodiazepines

Description: The percentage of Medicaid beneficiaries prescribed chronic opioids and a concurrent chronic sedative prescription, among beneficiaries prescribed chronic opioids

Source: ProviderOne Medicaid claims/encounter data

Steward: Bree Collaborative

23. Patients Prescribed High-Dose Chronic Opioid Therapy (>90mg)

Formal Name: Use of Opioids at High Dosage in Persons Without Cancer

Description: The percentage of Medicaid beneficiaries without a cancer diagnosis who were prescribed chronic opioid therapy greater than or equal to 90mg morphine equivalent dosage for at least 60 consecutive days during the calendar quarter

Source: ProviderOne Medicaid claims/encounter data

Steward: Bree Collaborative

24. Providers Enrolled in Medicaid who Billed for MOUD

Description: Number of providers enrolled in Medicaid that billed for MOUD services during the measurement period

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS (modified)

25. Readmissions Among Beneficiaries with SUD

Formal Name: Readmissions for SUD

Description: The percentage of acute inpatient stays of Medicaid beneficiaries with a SUD, 18 years of age and older, during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

26. Residential and Inpatient Services

Description: The number of Medicaid beneficiaries enrolled for at least one month during the measurement year, who used inpatient or residential services for SUD during the measurement year

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

27. Statewide Deaths due to Drug Overdoses

Formal Name: HIT: Statewide Fatal Drug Overdoses

Description: The number of fatal drug overdoses in the State of Washington, not restricted to Medicaid beneficiaries

Source: WA State death certificates

Steward: WA State Center for Health Statistics

28. Substance Use Disorder Treatment Penetration (Opioid)

Formal Name: HIT: SUD Treatment Penetration Rate

Description: The percentage of Medicaid beneficiaries, 12 years of age and older, with a SUD treatment need identified within the past two years, who received at least one qualifying SUD treatment during the measurement year

Source: ProviderOne Medicaid claims/encounter data

Steward: WA State

29. Withdrawal Management

Description: The number of Medicaid beneficiaries enrolled for at least one month during the measurement year, who used withdrawal management services for SUD during the measurement year

Source: ProviderOne Medicaid claims/encounter data

Steward: CMS

Interview Guide

WA SUD Waiver Key Informant Interview

The questions below are the general topic areas we will explore with interview participants. These questions will be modified in light of what is learned during the study and to fit the expertise of the interviewee.

Introduction

Thank you again for agreeing to talk with us. I'm _____ from Oregon Health and Science University. [If present: My colleague _____ is also on the line to help ask questions and take notes.]

I am/we are with the Center for Health Systems Effectiveness at Oregon Health and Science University. We are the external evaluator for the substance use disorder (SUD) component of the state's Medicaid waiver program. We'd like to get your experience and perspective as someone involved in SUD treatment services in Washington State.

We sent information about this interview a few days ago by email. Did you receive this information and have a chance to review it?

[If yes:] Great, let's continue.

[If no:] In that case, let me review the information with you by phone now. [Read information sheet.]

As we mentioned, we would like to make an audio recording of this call. Are you willing to have us record this interview?

[If no:] We will continue with the interview without recording it.

[If yes:] Do you have any additional questions before we turn on the audio recorder?

Respondent background

1. To start, can you briefly describe your professional background and how you are involved in providing substance use treatment to Washington Medicaid members?

About the SUD IMD waiver

2. How did you learn about changes to the Medicaid program that are part of the new substance use disorder IMD waiver?
3. How, so far, has the waiver program (or new Medicaid rules) affected service delivery by your organization?

Probes (depending on the position of key informant):

- » What changes has your organization made in response to the waiver?

- » What are other changes you see resulting from the waiver so far?
 - » What challenges have you encountered making changes you wanted to make because of the waiver?
 - » How has the waiver affected your capacity or plans for additional capacity?
 - » How has the waiver affected the stability or sustainability of your organization?
4. In general, how do you expect to see the waiver affect substance use disorder treatment across the state, if at all?

Probes:

- » How is it affecting existing providers and how they offer services?
 - » How is it changing who provides services – for example, has it brought new or different kinds of providers into the market?
 - » How is it affecting Medicaid beneficiaries' access to services?
5. What factors do you think will affect progress toward meeting the state's SUD milestones?

Probes

- » Are there particular milestones on which you think it will be more challenging to make progress than others? If so, why?
 - » What (if anything) could the state do to support improvement on these milestones?
6. What kinds of measurements or changes do you see as being most important in assessing the impact of the waiver?
7. We sent you a list of the metrics the state is using to evaluate waiver effects. Do you have that list handy?

[If yes:] Can you think of factors that would contribute to changes or lack of changes in these metrics?

[If no:] Skip this question.

8. Is there anybody else you think we should talk to?

Wrap-up

Thank you for your time and for sharing your perspectives. The assessment team will be back in touch with you to share findings when our report is completed.

Data Tables Reproduced from Washington's Assessment of SUD Provider Availability (July 2019)

Table #1. Licensed SUD Facilities Statewide and by Region as of June 2018

Region	Outpatient	Inpatient	Withdrawal Management
Better Health Together	57	15	4
Cascade Pacific Action Alliance	77	9	4
Greater Columbia	48	5	3
Healthier Here	146	8	7
North Central	8	2	1
North Sound	78	8	8
Olympic Community of Health	35	4	3
Elevate Health	52	4	4
SWACH	26	2	2
Statewide	449	49	28

Figure #2. Licensed SUD Outpatient Facilities Per 1,000 Individuals with SUD

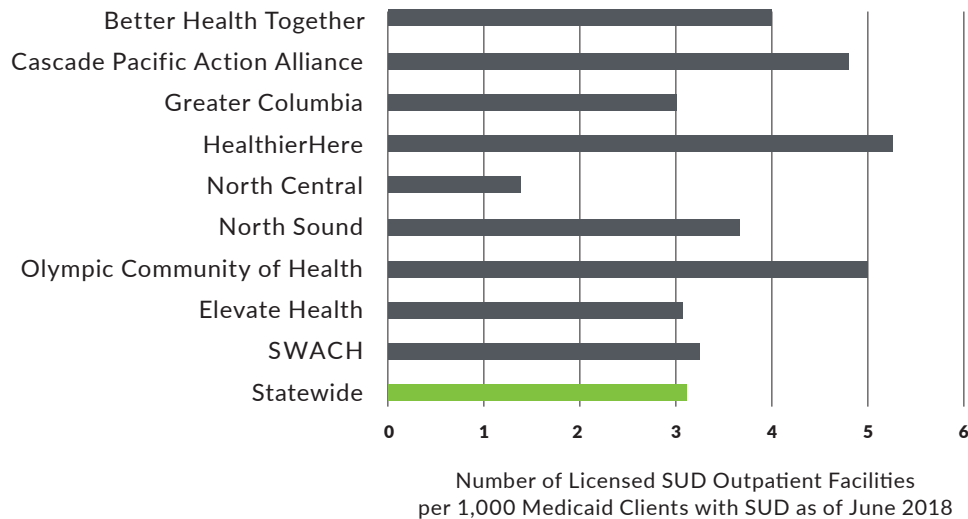


Table #3. Number of Prescribers Submitting Claims for non-Methadone MOUD

Region	Claims Submitted Between			Change Over Time (Jan 2016 to June 2018)	
	Jan 2016 - Dec 2016	Jan 2017 - Dec 2017	July 2017 - June 2018	Number	Percent
Better Health Together	37	50	66	+29	+78%
Cascade Pacific Action Alliance	45	66	78	+33	+73%
Greater Columbia	35	56	63	+28	+80%
Healthier Here	310	441	497	+187	+60%
North Central	33	46	54	+21	+64%
North Sound	101	123	136	+35	+35%
Olympic Community of Health	45	66	74	+29	+64%
Elevate Health	56	67	74	+18	+32%
SWACH	22	29	33	+11	+50%
Statewide	673	931	1060	+387	+58%

Table #5. SUD Treatment Penetration Rate by Region Over Time

Region	Jan 2016 - Dec 2016	Jan 2016 - Dec 2017	Oct 2017 - Sept 2018
Better Health Together	24.25%	27.72%	30.27%
Cascade Pacific Action Alliance	26.67%	31.15%	35.06%
Greater Columbia	22.59%	24.53%	27.16%
Healthier Here	28.48%	31.03%	32.16%
North Central	21.57%	22.81%	24.41%
North Sound	32.34%	35.13%	38.06%
Olympic Community of Health	28.86%	32.12%	34.87%
Elevate Health	21.96%	25.30%	27.80%
SWACH	28.50%	32.55%	36.23%
Statewide	27.09%	30.06%	32.58%

Table #7. Percentage of Individuals with OUD Receiving Any Form of OTP Over Time

Region	Jan 2016 - Dec 2016	Jan 2016 - Dec 2017	Oct 2017 - Sept 2018
Better Health Together	31%	40%	48%
Cascade Pacific Action Alliance	28%	35%	48%
Greater Columbia	25%	33%	41%
Healthier Here	41%	48%	53%
North Central	22%	37%	44%
North Sound	38%	46%	52%
Olympic Community of Health	25%	34%	42%
Elevate Health	33%	39%	44%
SWACH	26%	35%	50%
Statewide	33%	41%	48%

References

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- 2 Centers for Medicare & Medicaid Services. (2018; pp. 305-324).
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