Washington State
Health Care Authority
Report to the Legislature

Behavioral health outcomes

An overview of metrics for future reporting

Engrossed Substitute Senate Bill 5693; Section 215(39); Chapter 297; Laws of 2022

June 30, 2023

Behavioral health outcomes; an overview of metrics for future reporting

Acknowledgements

The Health Care Authority (HCA) would like to thank Tribal leaders, managed care organizations (MCOs), licensed community behavioral health agencies, and behavioral health administrative service organizations (BH-ASOs) for contributing to this report. Their guidance is essential as efforts to develop and improve behavioral health outcome metrics and data acquisition for Integrated Managed Care (IMC) and beyond continues to evolve at HCA.

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Executive summary

The Health Care Authority (HCA) is submitting this report in response to ESSB 5693; Section 215(39); Chapter 297; Laws of 2022:

> The authority shall seek input from representatives of the managed care organizations (MCOs), licensed community behavioral health agencies, and behavioral health administrative service organizations (BH-ASOs) to develop specific metrics related to behavioral health outcomes under integrated managed care (IMC). These metrics must include, but are not limited to:
>
> > (a) Revenues and expenditures for community behavioral health programs, including Medicaid and non-Medicaid funding;
> > (b) access to services, service denials, and utilization by state plan modality;
> > (c) claims denials and record of timely payment to providers;
> > (d) client demographics; and
> > (e) social and recovery measures and managed care organization performance measures.
>
> The authority must work with managed care organizations and behavioral health administrative service organizations to integrate these metrics into an annual reporting structure designed to evaluate the performance of the behavioral health system in the state over time. The authority must submit a report by June 30, 2023, outlining the specific metrics implemented. Thereafter, the authority shall submit the report for the preceding calendar year to the governor and appropriate committees of the legislature on or before December 30th of each year detailing the implemented metrics and relevant performance outcomes for the prior calendar year.

Identifying behavioral health outcome data points that align with the required metrics outlined in the legislative directive required HCA to collaborate internally and consult Tribal leaders, behavioral health providers, Managed Care Organizations (MCOs), and other external partners, with MCO representatives and behavioral health providers raising concerns about implementing new metrics into already cumbersome reporting requirements.

Beginning December 2023, HCA will submit an annual report to the Legislature containing a comprehensive set of behavioral health outcome data from multiple sources in accordance with the blueprint presented in this report; ultimately, helping readers review the performance of the behavioral health system in Washington over time. While HCA will initially include existing behavioral health data points in alignment with the legislative directive, future reporting may include additional performance metrics as they are developed and implemented by the Performance Measures Coordinating Committee (PMCC).

Background

Legislation

During the 2021-22 biennium, Community Behavioral Health Proviso 38 (ESSB 5092) outlined requirements for HCA to develop a legislative report addressing revenues and expenditures for community behavioral health programs, including data on social and recovery measures and MCO performance measures. After the submission of HCA's initial response, Washington's Legislature clarified their directive in ESSB 5693 (2022); Section 215(39), which states HCA must collaborate with MCOs, BH-ASOs, and licensed community behavioral health agencies to develop specific metrics related to behavioral health outcomes, with the first report presenting data due to the Legislature on or before December 30th of each year forward. The following metrics must be included in the report:

- Revenues and expenditures for community behavioral health programs, including Medicaid and non-Medicaid funding;
- Access to services, service denials, and utilization by state plan modality;
- Claims denials and record of timely payment to providers;
- Client demographics; and
- Social and recovery measures and managed care organization performance measures.

Washington's behavioral health care landscape

In 2014, Washington approved the Affordable Care Act's (ACA) Medicaid expansion, effectively extending coverage to eligible individuals under age 65 with incomes below 138 percent of the federal poverty level and subsidizing coverage through the Health Benefits Exchange for individuals with incomes above 138 percent but below 400 percent of the federal poverty level. During the same year, Washington's Legislature passed SSB 6312 (2014) which directed HCA to integrate the financing and delivery of physical health, mental health, and substance use disorder (SUD) services – or integrated managed care (IMC) – in each region of Washington, with full payment integration occurring across the state by 2020. According to federal law, HCA was required to maintain a behavioral health fee-for-service system for AI/AN to ensure that they have the choice in opting into managed care.

HCA contracts with five managed care plans across Washington State's ten regions and each plan coordinates behavioral and physical health care services for its enrollees. In addition to the five managed care plans, each of the ten regions has a Behavioral Health – Administrative Services Organization (BH-ASO). These BH-ASOs administer and oversee the crisis system, inclusive of regional crisis lines and outreach teams, for all community members regardless of insurance of coverage. BH-ASOs also offer behavioral health services within available resources to non-Medicaid individuals who are either uninsured or underinsured.

Apple Health coverage without a managed care plan is known as fee-for-service (FFS). Under this system, Apple Health pays community behavioral health providers directly rather than via MCOs. While most individuals enroll in Apple Health through an MCO, individuals such as American Indians or Alaska Natives (AI/AN), are automatically enrolled in FFS but have the choice to opt into managed care. Populations who are not automatically enrolled in managed care are served by Apple Health FFS and include: AI/AN individuals, foster care alumni, individuals under 65 years of age who are dually eligible for Medicaid and

Medicare, and children with high health needs or rare diseases. The state considers these individuals to be some of the most vulnerable and underserved populations covered by Medicaid.

In 2017, Washington's Section 1115 Medicaid demonstration waiver – otherwise known as Washington's Medicaid Transformation Project (MTP) – was approved by the Center for Medicare and Medicaid Services (CMS). MTP's aim is to focus on implementing whole-person care, or IMC, while moving from an FFS approach to value-based purchasing (VBP) – enhancing how HCA pays for services. The MTP allows HCA and state agency partners to create and continue developing projects, activities, and services that improve Washington's health care system. This is done in part by addressing social determinants of health (SDOH) through VBP – ultimately ensuring health plans and health care providers are accountable for providing high-quality, high-value care and a satisfying patient experience. On June 30, 2023, CMS approved the next 5-year waiver period.

COVID-19 impact

In 2020, as Washington achieved IMC payment implementation across the entire state, the onset of the COVID-19 pandemic and the corresponding public health emergency (PHE) commenced. The PHE declaration enabled the federal government to waive or modify typical Medicaid requirements – allowing HCA to continuously enroll Apple Health beneficiaries without annual eligibility redeterminations. The passage of the federal Consolidated Appropriations Act of 2023 terminated this provision on March 31, 2023. With HCA resuming normal operations on April 1, 2023, Apple Health enrollees will receive a renewal notice before the end of their Apple Health certification period, which will occur sometime over the next 12 months, based on an enrollee's renewal date.

Preexisting behavioral health workforce shortages were exacerbated by the COVID-19 pandemic. Staff turnover across behavioral health agencies (BHAs) in Washington increased, with BHAs reporting an average timeline of five months for filling vacant positions.[1] Some barriers to workforce development include low Medicaid rates, lack of clinical training sites, a low number of trained workers, and other obstacles.

To help grow and bolster Washington's behavioral health workforce during the PHE, HCA launched a recruitment campaign across multiple media platforms with a landing page at www.startyourpath.org. This initiative focuses on increasing awareness of the benefits of working in behavioral health, including pathways to behavioral health professions. HCA also continues to work toward increasing Medicaid provider payment rates. In 2022 there was a 7% increase in payment to service providers for Medicaid services. There was an additional targeted 7% increase to behavioral health providers contracted through managed care organizations effective January 2023. Effective January 2, 2024, there is an additional authorized increase of 15% for the same population of providers.

HCA also disbursed $100 million to behavioral health providers to address workforce challenges and provide workforce technical assistance and continuing education. A portion of the funding will be used to support yearly collaboration and training events. Additionally, HCA convened and oversaw the workgroup to develop recommendations for obtaining rate enhancements for teaching clinics including

[1] Washington Behavioral Health Council. "The State of the Community Behavioral Health System." https://www.thewashingtoncouncil.org/wp-content/uploads/2020/05/COVID-impact-survey_wacouncil.pdf

recommending enhanced rates for behavioral health agencies training and supervising students and those seeking their certification or license.

Collaboratively developing behavioral health outcome metrics

Generating a blueprint for reporting behavioral health outcomes according to the legislative directive required collaboration and coordination among internal and external partners. HCA staff adhered to the following steps to develop HCA's behavioral health outcomes reporting blueprint:

Step 1: Work internally to identify behavioral health outcome data that align with the metric requirements outlined in Proviso 39 that HCA is already receiving to use for future reports.

Step 2: Collaborate with internal workgroup members to detect gaps in metrics and generate strategies to improve HCA's data acquisition and management processes for reporting behavioral health outcomes.

Step 3: Engage external partners and initiate a Tribal engagement process to familiarize them with HCA's new approach to reporting behavioral health outcomes to the Legislature. This step included HCA presenting ideas to relevant partners for metrics that would be included in HCA's report to the Legislature, obtaining feedback from HCA's partners about how this report may impact their administrative processes, and addressing other feedback concerning the submission of HCA's future behavioral health outcomes report.

Step 4: If necessary, implement new metrics via agreements with external partners or amending contracts.

Step 5: Draft and submit a report to the Legislature displaying a format for future reports along with a detailed description of why data will be presented and how HCA aims to improve data acquisition concerning certain metrics.

Ongoing: Meet with the project's steering committee and sponsors for guidance on engagement and report drafting processes.

Metric identification

Before engaging MCOs, BH-ASOs, and licensed community behavioral health agencies to discuss behavioral health metrics to include in the report, HCA staff formed internal workgroups to identify metrics already acquired by HCA under various contracts. A data inventory was developed to help identify the metrics, the reporting mechanism, and their reporting cadence. Once the preexisting metrics were identified, workgroups reviewed the metrics to ensure they sufficiently met the metrics outlined in the legislative directive. Each workgroup determined that the metrics HCA is already acquiring can be used for this report and no new metrics were identified for inclusion in upcoming behavioral health outcomes report submissions.

Working in partnership with MCOs, ASOs, and licensed community behavioral health agencies

After developing a comprehensive inventory of data, HCA staff engaged MCOs, ASOs, and licensed community behavioral health agencies by attending meetings that brought relevant HCA partners together to discuss the legislative directive for this report.

HCA staff attended the following meetings for input from our external partners:

- Behavioral Health System Coordination Committee (BHSCC)
- Association of Addiction Professionals (AAP)
- Washington Behavioral Health Council
- Monthly Tribal Meeting (MTM)
- Monthly BH-ASO and MCO meetings
- Other stakeholder meetings as appropriate to the subject

At these meetings, HCA presented the legislative directive and the agency's approach to fulfilling the mandate. While feedback from HCA's partners regarding the upcoming report was primarily positive, **provider and MCO representatives stressed that implementing new metrics would not be welcome** due to the current administrative burden they experience when obtaining and submitting behavioral health outcome data.

Working in partnership with Tribes

AI/AN individuals have two choices for Apple Health coverage:

1) Apple Health coverage without a managed care plan – otherwise known as FFS or,
2) Apple Health Managed Care.

Unless opting into a managed care plan, AI/AN individuals are automatically enrolled into Apple Health FFS for all health care services – including behavioral health. HCA's Office of Tribal Affairs (OTA) provided a critical perspective into HCA's dual system serving Tribal members. Currently, nearly 57 percent of individuals identifying as AI/AN are enrolled in Apple Health FFS, with the remaining opting into managed care.[2] Since AI/AN individuals are served by both billing models – primarily FFS – OTA suggests that HCA develop a strategy to integrate FFS data into HCA's behavioral health outcomes report.

HCA plans to expand the scope of the behavioral health outcomes report to include FFS data in future iterations of the report – strengthening the agency's work to develop an inclusive, holistic services for everyone. Moving forward, HCA plans to internally map the architecture of FFS data to ensure gaps in data acquisition are addressed. This process will include identifying areas where HCA can support the improvement of FFS data systems and reporting mechanisms.

HCA's OTA also serves as a critical connection point for communicating with Tribal health service providers. As part of HCA's approach to receiving Tribal feedback on HCA's response to the legislative directive, OTA offered several engagement recommendations, including:

- Attend monthly Tribal meetings (MTM) to share the legislative directive,

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[2] January 2023 snapshot data concerning AI/AN Apple Health enrollment was acquired from HCA's Office of Tribal Affairs (OTA).

- Notify MTM attendees that HCA is reviewing the Urban Indian Health Institute's Best Practices for American Indian and Alaska Native Data Collection, and
- Send a Dear Tribal Leader Letter (DTLL) with draft report to Tribal Nations and provide up to 30 days for Tribal review.
- By request, hold a formal Consultation or listening session in accordance with our HCA Tribal Consultation Policy.

HCA will continue to work with Tribal partners on refining this report over time so that it accurately includes and reflects behavioral health outcomes including data relating to service provision for Tribal members.[3]

[3] While IMC impacts Washington's crisis system, data concerning crisis system utilization aligns with the legislative directive outlined in Engrossed Substitute Senate Bill 5693; Section 215(99); Chapter 297; Laws of 2022.

Metrics for future reporting

The first report presenting behavioral health outcome data to the Legislature will be submitted by HCA in December, 2023. This report will contain metrics in accordance with the legislative directive for the calendar years 2021 and 2022. The data presented will use existing sources, such as revenue and expenditure reports, service encounter data submitted by the MCOs and BH-ASOs, and performance measure data reported by DSHS Research Data and Analysis (RDA).

All metrics will be reported by calendar year. Providers have up to a year from the date of service to submit claims, thus the most recent calendar year reported may not be fully matured. As this report evolves over time, metrics will need to be annualized once it's matured for inclusion in subsequent reporting. Per the legislation, the report will not include data concerning Apple Health FFS. However, HCA intends to include FFS data in future reporting after HCA internally maps the architecture of FFS data to ensure gaps in acquisition are addressed.

The following provides a description of reports and data elements that will be used to fulfill the requirements outlined in the legislative directive.

Revenues and expenditures for community behavioral health programs

Upon integration, the MCO's revenue and expenditure reports were no longer required to be provided for the managed care portion of the funding provided by HCA. Each MCO in each region must provide reports for General Fund State Wraparound expenditures. These reports are also required to be prepared by the regional BH-ASO. Thus, each quarter results in approximately 80 revenue and expenditure reports with numerous data points to review and compile.

Based on the legislative directive in Community Behavioral Health Proviso 38 (ESSB 5092), HCA created a workgroup to develop a newer, more effective reporting structure in collaboration with MCOs and ASOs. HCA provides regionally specific templates with prepopulated funding levels which are displayed alongside each entity's contracted amounts. These reconfigured reports also include more specific details on expenditures, specifically those expenditure items that have been targeted as potentially needing more funding, such as court costs, involuntary stays, and crisis services costs.

HCA's upcoming behavioral health outcomes report will present data from the following resources:

- **Milliman data book and appendices:** The Milliman Index is a financial data resource that uses Managed Care encounter data to help identify and set service reimbursement rates. Actuarial services and data provided by Milliman help HCA develop actuarially sound capitation rates for Apple Health Managed Care programs. Revenue, expenditure, and behavioral health service utilization metrics are provided in Milliman's data book and appendices.

  When HCA reports Medicaid revenue and expenditure data, utilization data is provided for mental health and substance use disorder (SUD) inpatient admits per 1,000 males ages 19 – 64 and per 1,000 females ages 19 – 64; ultimately, offering readers insight into amounts spent and earned in relation to where services are being used.
- **HCA Quarterly Revenue and Expenditure report:** Reports are submitted by service providers for GF-S non-Medicaid services. For these services, only revenue and expenditure data will be

presented. While no utilization data will be paired with these data points in the upcoming December 2023 report, more detailed utilization data for these services will be presented in the report's *Utilization by State Plan Modality* section.

See Appendix A for sample data reporting tables, which will be used to present data in HCA's upcoming submission of the behavioral health outcomes report.

Access to services

Providing consistent and accurate data on access to behavioral health services continues to be a challenge for HCA due to lack of consistent and accurate recording of data. For this reason, HCA's initial behavioral health outcomes report will likely raise awareness concerning the steps HCA is taking to improve insight into service access across regions.

Currently, data concerning service access is only obtainable for outpatient behavioral health services. HCA anticipates using bed tracking software to support providers and others with identifying available beds on behalf of persons experiencing crises.[4] Use of this software could support the creation of a variety of metrics (e.g., available capacity by specific behavioral health provider type(s) across regions of the state). Until HCA launches this tracking system, HCA is unable to identify service access metrics for these services.

HCA continues to refine reporting on access to services. HCA plans to present these metrics in an upcoming submission of the behavioral health outcomes report once HCA's new BHDS Tableau Dashboard has been authorized. HCA will use data from the following resources for the upcoming behavioral health outcomes report:

- **Behavioral Health Access Survey:** This report provides a snapshot of current appointment access and service availability to help inform referral patterns for members while identifying needs and gaps. The report is compiled by all MCOs using behavioral health provider survey responses pertaining to the availability of behavioral health services across the state with a focus on access to outpatient services.
- **Access to outpatient services:** Per the encounter reporting guide, outpatient behavioral health providers are to submit "request for service" encounters each time an individual requests services. Using this request for service data point, HCA can measure median and average wait times to the first intake appointment. Due to lack of data completeness, HCA has been unable to use this method with confidence and is developing strategies to improve reliable acquisition of access to service data.
- **Behavioral Health Data Set (BHDS) Tableau dashboard:** This new dashboard, which is discussed in further detail in the *Utilization by State Plan Modality* section of the report, will incorporate access to service data in the future. HCA is currently working internally to identify and define the appropriate service access index events to collect via the dashboard.

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[4] For more information on the 988 system's upcoming bed tracking system, please review HCA's Final Technical and Operational Plan: https://www.hca.wa.gov/assets/program/final-technical-and-operational-plan-988.pdf

- **Network Adequacy Reports:** HCA's current monitoring efforts provide MCOs with a template that enables HCA to drill down on youth and adult service access, including which providers are accepting new patients, and detailed descriptions of the types of services offered within behavioral health agencies. MCOs are also required to provide an in-depth narrative with the quarterly network submission where challenges that are not represented on the template can be reported.

  MCOs must show a capacity to serve 80% of the county's Medicaid population to be considered adequate and remain a plan option for that area. While this report only presents data on provider availability across regions, the upcoming behavioral health outcomes report will use network adequacy data to show where there is a service presence to help inform access to service data across regions.

Service denials

MCOs

Service denials: "Adverse Benefit Determination", "Appeal", "Grievance", and "Grievance and appeal system" are defined within 42 C.F.R. § 438.400(b) and the Apple Health - Integrated Managed Care (IMC) contract.

For MCOs, a service may only be denied, or determined to be an adverse benefit (42 C.F.R. § 438.400(b)), if the MCO or HCA has determined that the service does not meet medical necessity per clinical criteria or is not a covered benefit. At the time of any adverse determination, an individual, provider, and facility seeking services must be notified of the adverse benefit determination in writing. If the service is non-contracted, but covered by HCA, directions for obtaining services through HCA must be provided by an MCO to an individual so they can coordinate and receive those services. Service authorization determinations are to be made and notices provided as expeditiously as the enrollee's health condition requires.

MCOs must decide to approve, deny, or request additional information from a service provider within five calendar days of the original receipt of the request. If additional information is required and requested, MCOs must give the provider five calendar days to submit the information, and then approve or deny the request within four calendar days of the receipt of the additional information. Under certain circumstances, 14 additional calendar days but no more than 28 is allowed (42 C.F.R. § 438.210(d)). For service authorizations decisions not reached during this amount of time, Notices of Adverse Benefit Determinations must be provided no later than the date that the timeframes expire.

Appeals: Individuals can appeal an adverse benefit determination either orally or in writing (42 C.F.R. § 438.402(b)(1)(ii)). With an individual's authorization, the provider can represent the individual and submit chart notes and other clinical documents supporting the individual's need for that service. The MCO must make a determination on the appeal within 14 calendar days. If the MCO needs more time, the individual must be notified, and then the MCO must make their determination no later than 28 days from the receipt of the appeal request (42 CFR 438.408).

Expedited appeal process: The MCO shall establish and maintain an expedited Appeal review process for Appeals when the Contractor determines or a provider indicates that taking the time for a standard

resolution could seriously jeopardize the Enrollee's life, physical or mental health or ability to attain, maintain, or regain maximum function (42 C.F.R. § 438.410(a)).

TEAMonitor: The HCA Medicaid Compliance Review Unit conducts the oversight of Apple Health Managed Care Organization (MCO) and Behavioral Health Services Only (BHSO) (Medicaid) managed care and the Behavioral Health Administrative Service Organization (non-Medicaid) contracts in partnership with other subject matter experts within HCA and the Department of Social and Health Services. The formal review process lasts throughout the year and is performed by a team of clinical and program staff (TEAMonitor). Federal Medicaid managed care regulations require states to conduct compliance, monitoring, and oversight of Medicaid Managed Care Organizations (MCO).

MCO service denial data will be used from the following report:

- **Grievance, Appeals, and Independent Review Report (Medicaid):** MCOs submit quarterly reports to HCA displaying grievances, adverse benefit determinations, and appeals. Adverse benefit determinations are service denials. Data elements pertaining to number of claims processed and paid, completely denied claims, partially denied claims, and rejected claims will be shown in HCA's behavioral health outcomes report.

See Appendix B for sample report tables.

BH-ASO non-Medicaid

Service denials: For standard authorizations for planned or elective service determinations, the authorization decisions are to be made and notices of Adverse Authorization Determinations are to be provided as expeditiously as the individual's condition requires. BH-ASOs must decide to approve, deny, or request additional information from the Provider within five (5) calendar days of the original receipt of the request. If additional information is required and requested, the BH-ASO must give the provider five (5) calendar days to submit the information and then approve or deny the request within four (4) calendar days of the receipt of the additional information. An extension of up to fourteen (14) additional calendar days (not to exceed twenty-eight [28] calendar days total) is allowed under the following circumstances: the individual or the provider requests the extension; or the BH-ASO justifies and documents a need for additional information and how the extension is in the individual's interest.

BH-ASO's must collect all information necessary to make medical necessity determinations. The BH-ASO's determines which contracted services are medically necessary. The BH-ASO's provide education and ongoing guidance and training to Individuals and Providers about its Utilization Management (UM) protocols and UM criteria, including American Society of Addiction Medicine Criteria for Substance Use Disorder services for admission, continued stay, and discharge criteria. The BH-ASOs must have in effect mechanisms to ensure consistent application of UM review criteria for authorization decisions. The BH-ASOs must have mechanisms for at least annual assessment of interrater reliability of all clinical professionals and non-clinical staff involved in UM determinations. The BH-ASOs must consult with the requesting Provider when appropriate, prior to issuing an authorization determination. When Available Resources are exhausted, any Appeals or Administrative Hearings related to a request for authorization of a non-crisis contracted service will be terminated since non-crisis services cannot be authorized without funding regardless of medical necessity.

Appeals: For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services a decision must be made within fourteen (14) calendar days after receipt of the appeal, unless the BH-ASO notifies the Individual that an extension is necessary to complete the appeal; however, the extension cannot delay the decision beyond twenty-eight (28) calendar days of the request for appeal. For any extension not requested by an Individual, the BH-ASO must give the Individual written notice of the reason for the delay.

Expedited appeal process: The Individual may submit an expedited appeal either orally or in writing. The BH-ASO must decide on the Individual's request for expedited appeal and provide written notice, as expeditiously as the Individual's health condition requires, no later than three (3) calendar days after the BH-ASO receives the appeal. The BH-ASO must also make reasonable efforts to provide oral notice. The BH-ASO may extend the timeframes by up to fourteen (14) calendar days if the Individual requests the extension; or the BH-ASO shows there is a need for additional information and how the delay is in the Individual's interest. For any extension not requested by an Individual, the BH-ASO must give the Individual written notice of the reason for the extension. The BH-ASO must ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports an Individual's appeal. If the BH-ASO denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the Individual prompt oral notice of the denial and follow up within two (2) calendar days with a written notice of denial.[5]

BH-ASO service denial data will be used from the following report:

- **Grievance, Adverse Determination, and Appeals Report (non-Medicaid):** BH-ASOs submit quarterly reports to HCA displaying grievances, adverse determinations, and appeals for non-Medicaid services. Adverse authorization determinations are considered service denials in this report. Data elements pertaining to number of claims processed and paid, completely denied claims, partially denied claims, and rejected claims for non-Medicaid services will be shown in HCA's behavioral health outcomes report.

See Appendix B for sample report tables.

Utilization by state plan modality

Behavioral health service utilization data offers insight into who is using services across Washington's regions. While pairing utilization data with revenue and expenditure data earlier in the report offers HCA an opportunity to display amounts spent with service utilization data, pairing client demographic data with utilization data will highlight disparities or gaps in service utilization across Washington's 10 regions.

HCA continues to refine utilization reporting. HCA plans to incorporate utilization data from the BHDS Tableau Dashboard and Executive Management Information System (EMIS) into an upcoming behavioral health outcomes report.

- **Milliman data book and appendices:** The Milliman Index is a financial data resource that uses Managed Care encounter data to help identify and set service reimbursement rates. Actuarial services and data provided by Milliman help HCA develop actuarially sound capitation rates for

[5] For more information regarding the BH-ASO grievance and appeal system, please review WAC 182-538C-110.

Apple Health Managed Care programs. Revenue, expenditure, and behavioral health service utilization metrics are provided in Milliman's data book and appendices, which may be used for HCA's future report on behavioral health outcomes.

For more information about HCA's approach to using the Milliman data book and appendices to report behavioral health outcome utilization in relation to revenues and expenditures, please review the Revenues and Expenditures section of this report.

- **Report template for EMIS:** ESSB 5693 (2022); Section 215(99) directs HCA to collaborate with RDA to implement community behavioral health service data into the existing EMIS system. Data points are to be incorporated into the monthly EMIS reports on a phased-in basis. HCA and RDA are to ensure data elements are clearly defined and include requirements in MCO and BH-ASO contracts so that data is consistent and timely. Wherever possible and practical, data must include historical monthly counts and shall be broken out to distinguish services to Medicaid and non-Medicaid individuals, and children and adults.

  For the EMIS, DSHS uses the One Department Data Repository (1DDR) – a centralized, automated, and highly structured repository system for aggregate performance measure data. 1DDR was built primarily to support the EMIS reports, which include regularly reported budget, caseload, and utilization data. The goal is reliable, easily accessible, consistently reported and thoroughly documented data. Because of 1DDR's success in meeting these goals, it has expanded to include other data sets from the Department that require similar easy data access, custom reporting, and consistent documentation.

  The system currently houses time series data for 8,017 measures, dating back as far as July 1979. These measures include performance indicators, targets, projections, and sub-program or geographic drilldowns for hundreds of DSHS program areas.

  Visit the EMIS platform by clicking here.
- **BHDS Tableau Dashboard:** This dashboard provides insight into client demographic data and will supply behavioral health service utilization data for persons receiving mental health and substance use disorder services in the future. Data concerning mental health services and SUD services most likely won't be available until 2024 at the earliest.

Claims denials and record of timely payment to providers

To be compliant with federal and state timeliness payment standards, Contractors must pay or deny, and must require subcontractors to pay or deny, 95 percent of clean claims within thirty (30) calendar days of receipt, 95 percent of all claims within sixty (60) calendar days of receipt and 99 percent of clean claims within ninety (90) calendar days of receipt. The Contractor and its providers may agree to a different payment requirement in writing on an individual claim.

Upon submission of a claim, it is determined to be clean, rejected, or denied. A clean claim can result in a paid claim based on the information submitted, or it can be denied after adjudication.

- A "clean claim" is a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

- A "rejected claim" is a claim that was rejected by a payor or clearinghouse due to an incomplete submission.
- A "denied claim" is a claim initially accepted as clean, adjudicated, then payment was denied due to missing or incorrect information, no prior authorization, duplicate claims submission, or other considerations.

Denied claims are not rejected claims – rather they are "punted" due to uncleanliness. Claims are only punted, or determined to be unclean, because additional information is needed from the provider before the claim can be fully re-processed or submitted for payment (i.e., a submitted claim's place of service does not match the recorded place of service). MCOs allow providers 365 calendar days to submit claims for services provided under the Integrated Managed Care contract unless the provider has agreed to a shorter timely filing period.

When an MCO experiences a high percentage of denials, they are required to implement an action plan to address how they will: communicate with the provider and respond to all inquiries within five (5) business days, explain the reason for the denial or rejection within thirty (30) calendar days, provide administrative guidance to help ensure that future claims are billed correctly, and provide education to the five network billing providers with the highest number of total denied claims. HCA provides oversight and may intervene when a provider's denial rate remains above 10 percent for a period of three months or longer. HCA may require a corrective action plan to address a pattern of incorrectly denied or delayed provider payments when a pattern has been determined to exist.

See Appendix C for sample report tables.

- **Claims denial analysis reports:** Claims denial analysis reports are submitted on a quarterly basis by MCOs for Managed Care claims and monthly for claims related to Indian Health care Providers (IHCPs). MCOs must meet the Code of Federal Regulations (CFR) for 90 percent of claim acceptance within 30 days of submission. While submission date is not captured for each unique claim, the 2023 claims denial template may include the number of unclean claims at 30, 60, and 90 days from submission.

Client demographics

The inclusion of client demographics offers HCA an opportunity to perform a variety of disparity analyses concerning behavioral health service outcomes. HCA continues to refine utilization data acquisition and reporting and plans to incorporate utilization data from the BHDS Tableau Dashboard and Executive Management Information System (EMIS) that can be paired with demographic information in future iterations of the behavioral health outcomes report.

Until then, ProviderOne encounter data will be used to report demographic data. ProviderOne encounter data offers the following demographic data:

- Race,
- Ethnicity,
- Age by range, and
- Gender.

To review current demographic data on Apple Health enrollees, please visit HCA's Apple Health Client Dashboard.

Performance measures

Social and recovery metrics

The Substance Abuse and Mental Health Service Administration (SAMHSA) definition of recovery from behavioral health conditions is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." SAMHSA identifies the following attributes of recovery:

- Health: Overcoming or managing one's disease(s) or symptoms,
- Home: A stable and safe place to live,
- Purpose: Meaningful daily activities, and
- Community: Relationships and social networks.[6]

HCA has a broad data-sharing agreement with DSHS/RDA, which allows HCA to access data concerning certain social determinants of health and recovery. Some social determinants of health and aspects of recovery can be directly or indirectly measured with RDA's current set of metrics concerning employment, arrest, homelessness, client satisfaction, measures of treatment adherence, and use of preventative vs. acute and long-term services.

Initially, the following social and recovery metrics will be shown in HCA's behavioral health outcomes report:[7]

- Enrollee employment: employment rate (EMP)
- Living arrangement: homeless broad (HOME-B); homeless narrow (HOME-N)
- Criminal justice involvement: Arrest (ARREST)

The current measures tend to track processes of care. While important, HCA recognizes better measures are needed in order to understand the effectiveness of an intervention on improving health outcomes.

Future opportunities

Substitute Senate Bill 5157 (2021) directs the Performance Measures Coordinating Committee (PMCC)[8] to establish performance measures to be integrated into the Washington State Common Measure Set (WSCMS) that track rates of criminal justice system involvement among Washington Apple Health (Medicaid) clients with an identified behavioral health need including, but not limited to, rates of arrest and incarceration. 2SHB 1860 (2022) also directs the PMCC to establish performance measures to be integrated into the WSCMS for tracking rates of homelessness and housing instability among Apple Health clients.

In 2023, the PMCC added the following new measures to the WSCMS to meet legislative requirements:

- Arrest Rate for Medicaid Beneficiaries with an Identified Behavioral Health Need

[6] For more information regarding SAMHSA's definition of recovery, visit https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf

[7] For more information about these RDA metrics, explore the corresponding links in the text.

[8] HCA facilitates the work of the PMCC.

- Timely Receipt of Substance Use Disorder Treatment for Medicaid Beneficiaries Released from a Correctional Facility
- Timely Receipt of Mental Health Treatment for Medicaid Beneficiaries Released from a Correctional Facility
- Homelessness Broad and Narrow (this measure was modified from the existing Homelessness measure referenced above)

These new measures developed by DSHS-RDA are in the process of being implemented in MCO contracts, and will be integrated into the behavioral health outcomes report in the future.

Additional opportunities to improve reporting on health outcomes are on the horizon as the National Committee for Quality Assurance (NCQA) begins implementing new behavioral health measures. These new measures require healthcare providers to complete screenings that identify behavioral health needs *and* ensure appropriate follow-up services are received that lead to improved outcomes. Currently, providers are completing screenings but lack the information technology infrastructure to track and report results. While HCA acknowledges new measures require substantive efforts such as training, data infrastructure development, and provider buy-in, they can help develop a more comprehensive system that tracks provider and client behavioral health outcomes over time.

Furthermore, Washington could mirror other states that have implemented data collection systems that track the level of care utilization scores for Medicaid enrollees engaged in behavioral health services. Under these systems, clinicians use standardized tools to input scores at intake, every six months, and at discharge to monitor the process, assess for appropriateness of services, and help shape treatment planning. State Medicaid systems are then able to assess provider compliance, efficacy, and client outcome trends.

Finally, routine surveys of quality of life are essential to measure the holistic view of recovery. They have not been funded, although mandated several years ago under HB1519 (2013) and SB 5732 (2013).

MCO performance measures

Health Effectiveness Data and Information Set (HEDIS) measures are developed and maintained by the National Committee for Quality Assurance (NCQA), which reflect the levels of quality, timeliness, and accessibility of health care services MCOs should furnish to the state's Medicaid enrollees. In addition to HEDIS metrics, DSHS-RDA monitors and calculates two non-HEDIS behavioral health measures:

1) Mental Health Service Penetration – Broad Definition (MH-B)
2) Substance Use Disorder Treatment Penetration (SUD)

ESHB 1109 (2019) requires HCA's contracted External Quality Review Organization (EQRO) to annually analyze the performance of Apple Health MCOs providing services to Medicaid enrollees according to specific criteria reflecting the state's quality and value priorities to balance cost and utilization. Comagine Health – Washington's EQRO – is contracted to assess MCO performance on measures reported by each plan and to recommend a set of priority measures that meet specific criteria outlined in ESHB 1109, and best reflects the state's quality and value priorities — balancing cost and utilization — while ensuring quality care to enrollees. This legislation directed HCA to implement seven MCO performance measures, including four common measures across MCOs that are included in the WSCMS, and three measures specific to each MCO that reflect poor performance, ultimately supporting the implementation and evolution of HCA's VBP strategies and other quality improvement strategies.

HCA will use the following reports for MCO performance metrics:

- **Comparative Analysis Report**: HCA contracts with Comagine Health to assess MCO performance on the measures reported by each plan via MCO contracts. The data comprises audited performance rates and associated benchmarks for the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set ("HEDIS®") measures, as well as the two RDA homegrown measures listed above.

For more information about MCO performance measure data points, please see **Appendix D.**

Conclusion

HCA plans to submit the first annual report in December, 2023. The report will contain data collected from numerous reports coming from MCOs, BH-ASOs, and licensed community behavioral health providers in accordance with metric requirements outlined in the legislative directive. While no new behavioral health outcome metrics were implemented, HCA is committed to generating an annual report that offers the Legislature and the agency's external partners insightful behavioral health outcome data.

As HCA continues to improve acquisition of utilization, service access, social and recovery measures, MCO performance measures, and others – agency staff will continue collaborating with MCOs, BH-ASOs, Tribes, and licensed community providers in aim of improving HCA's annual behavioral health outcomes report so that it offers a holistic view of behavioral health outcomes across all Apple Health enrollees.

Appendix A: Revenues and expenditures report tables

Medicaid

CY		Total	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Southwest	Spokane	Thurston Mason
2021	Revenue	-	-	-	-	-	-	-	-	-	-	-
	Expenses	-	-	-	-	-	-	-	-	-	-	-
2022	Revenue	-	-	-	-	-	-	-	-	-	-	-
	Expenses	-	-	-	-	-	-	-	-	-	-	-

Inpatient Admit per 1,000	Average	Great Rivers	Greater Columbia	King County	North Central	North Sound	Pierce	Salish	Southwest Washington	Spokane	Thurston-Mason
Female 2021 MH	-	-	-	-	-	-	-	-	-	-	-
Female 2021 SUD	-	-	-	-	-	-	-	-	-	-	-
Male 2021 MH	-	-	-	-	-	-	-	-	-	-	-
Male 2021 SUD	-	-	-	-	-	-	-	-	-	-	-

Utilizations per 1,000	Average	Great Rivers	Greater Columbia	King County	North Central	North Sound	Pierce	Salish	Southwest Washington	Spokane	Thurston-Mason
Female 2021	-	-	-	-	-	-	-	-	-	-	-
Male 2021	-	-	-	-	-	-	-	-	-	-	-

Age range for both genders is 19-64

Date range is Calendar Year (CY)

Inpatient Admit per 1,000	Average	Great Rivers	Greater Columbia	King County	North Central	North Sound	Pierce	Salish	Southwest Washington	Spokane	Thurston-Mason
Female 2022 MH	-	-	-	-	-	-	-	-	-	-	-
Female 2022 SUD	-	-	-	-	-	-	-	-	-	-	-
Male 2022 MH	-	-	-	-	-	-	-	-	-	-	-
Male 2022 SUD	-	-	-	-	-	-	-	-	-	-	-

Utilizations per 1,000	Average	Great Rivers	Greater Columbia	King County	North Central	North Sound	Pierce	Salish	Southwest Washington	Spokane	Thurston-Mason
Female 2022	-	-	-	-	-	-	-	-	-	-	-
Male 2022	-	-	-	-	-	-	-	-	-	-	-

Age range for both genders is 19-64

Date range is Calendar Year (CY)

BH-ASO non-Medicaid

CY	Total of All Sources	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Southwest	Spokane	Thurston Mason
2021 Revenue	-	-	-	-	-	-	-	-	-	-	-
2021 Expenses	-	-	-	-	-	-	-	-	-	-	-
2022 Revenue	-	-	-	-	-	-	-	-	-	-	-
2022 Expenses	-	-	-	-	-	-	-	-	-	-	-

Dedicated Cannabis Account and Criminal Justice Treatment Account

CY	DCA & CJTA Total	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Southwest	Spokane	Thurston Mason
2021 Revenue	-	-	-	-	-	-	-	-	-	-	-
2021 Expenses	-	-	-	-	-	-	-	-	-	-	-
2022 Revenue	-	-	-	-	-	-	-	-	-	-	-
2022 Expenses	-	-	-	-	-	-	-	-	-	-	-

CY	Block GrantTotal	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Southwest	Spokane	Thurston Mason
2021 Revenue	-	-	-	-	-	-	-	-	-	-	-
2021 Expenses	-	-	-	-	-	-	-	-	-	-	-
2022 Revenue	-	-	-	-	-	-	-	-	-	-	-
2022 Expenses	-	-	-	-	-	-	-	-	-	-	-

Appendix B: Service denials

Medicaid

Managed Care Organization	# of adverse behavioral health benefit determinations		# of adverse behavioral health benefit determinations related to GF-S service	
	2021	2022	2021	2022
Amerigroup				
Community Health Plan of Washington				
Coordinated Care of Washington				
Molina Healthcare of Washington				
UnitedHealthcare Community Plan				

Managed Care Organization	# of adverse MH IP benefit determinations		# of adverse MH OP benefit determinations		# of adverse SUD IP benefit determinations		# of adverse SUD OP benefit determinations	
	2021	2022	2021	2022	2021	2022	2021	2022
Amerigroup								
Community Health Plan of Washington								
Coordinated Care of Washington								
Molina Healthcare of Washington								
UnitedHealthcare Community Plan								

BH-ASO non-Medicaid

BH-ASO	# of adverse behavioral health benefit determinations	
	2021	2022
Great Rivers		
Greater Columbia		
King County		
North Central (Carelon)		
North Sound		
Pierce (Carelon)		
Salish		
Southwest Washington (Carelon)		
Spokane		
Thurston-Mason		

BH-ASO	# of adverse MH IP benefit determinations		# of adverse MH OP benefit determinations		# of adverse SUD IP benefit determinations		# of adverse SUD OP benefit determinations	
	2021	2022	2021	2022	2021	2022	2021	2022
Great Rivers								
Greater Columbia								
King County								
North Central (Carelon)								
North Sound								
Pierce (Carelon)								
Salish								
Southwest Washington (Carelon)								
Spokane								

Thurston-Mason								

Appendix C: Claims denials and record of timely payment to providers

Medicaid

Managed Care Organization	Total # of claims processed		Total # of claims paid		Total # completely denied claims		% Total denied claims	
	2021	2022	2021	2022	2021	2022	2021	2022
Amerigroup								
Community Health Plan of Washington								
Coordinated Care of Washington								
Molina Healthcare of Washington								
UnitedHealthcare Community Plan								

Managed Care Organization	Total # partial denied claims		% denied claims		Total # rejected claims		% rejected claims	
	2021	2022	2021	2022	2021	2022	2021	2022
Amerigroup								
Community Health Plan of Washington								

Coordinated Care of Washington								
Molina Healthcare of Washington								
UnitedHealthcare Community Plan								

BH-ASO non-Medicaid

Region	Total # claims processed		Total # claims paid		Total # completely denied claims		% denied claims	
	2021	2022	2021	2022	2021	2022	2021	2022
Great Rivers								
Greater Columbia								
King County								
North Central								
North Sound								
Pierce								
Salish								
Southwest Washington								
Spokane								
Thurston-Mason								

Region	Total # partial denied claims		% denied claims		Total # rejected claims		% rejected claims	
	2021	2022	2021	2022	2021	2022	2021	2022
Great Rivers								
Greater Columbia								
King County								
North Central (Carelon)								
North Sound								
Pierce (Carelon)								
Salish								
Southwest Washington (Carelon)								
Spokane								
Thurston-Mason								

Appendix D: MCO performance measures

MCO Performance Measure	Report leveraged for data	Measure steward	Current value-based purchasing metric
Antidepressant Medication Management (AMM): **1. Effective Acute Phase Treatment;** **2. Effective Continuous Phase Treatment**	Comparative Analysis Report	NCQA/HEDIS	x
Follow-Up After ED Visit for Substance Use (FUA)	Comparative Analysis Report	NCQA/HEDIS	
Follow-up After Emergency Department Visit for Mental Health Illness (FUM)	Comparative Analysis Report	NCQA/HEDIS	
Follow-up After Hospitalization for Mental Illness (FUH)	Comparative Analysis Report	NCQA/HEDIS	
Follow-up Care for Children Prescribed ADHD Medication (ADD) (Initiation & Continuation)	Comparative Analysis Report	NCQA/HEDIS	x
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Comparative Analysis Report	NCQA/HEDIS	
Mental Health Treatment (Services) Penetration – Broad	Comparative Analysis Report	DSHS-RDA	x
Substance Use Disorder Treatment Penetration (Medicaid only)	Comparative Analysis Report	DSHS-RDA	
Psychiatric Hospitalization Readmission Rate	Service Coordination Organization Performance Measure Report	DSHS-RDA	x