Mercer

Government Human Services Consulting

Proviso 40 — Pilot Programs for Intensive Outpatient Services and Partial Hospitalization Services for Children and Adolescents: Progress Report

Washington State Health Care Authority

October 2022

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Contents

Section 1
Introduction

The State of Washington (State or Washington) Health Care Authority (HCA) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to conduct a program evaluation for the Pilot program providing Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP) services for mental health in response to Proviso 40.[1] Per the Proviso, the final report must provide the following information for two Pilot sites:

- Services provided at each pilot site and identification of any specific gaps the sites were able to fill in the current continuum of care.
- Clinical outcomes and estimated reductions in psychiatric inpatient costs associated with each of the pilot sites.
- Recommendations for whether either or both of the pilot models should be expanded statewide; whether modifications should be made to the models to better address gaps in the continuum identified through the pilot sites, whether the models could be expanded to community behavioral health providers, and whether statewide implementation should be achieved through a state plan amendment or some other mechanism for leveraging federal Medicaid match.
- Actuarial projections on the statewide need for services related to the pilot sites and estimated costs of adding each of the services to the Medicaid behavioral health benefit for children and adolescents and adults.

In July 2022, HCA requested a Proviso 40 report extension from December 2022 to December 2023 to allow for more robust data from all Pilot program locations. As a result, this initial Progress Report provides information on the first two bullets above in an interim evaluation of the current Pilot program sites, limited to a review of clinical data and claims data, and areas for consideration prior to the final report to be issued in December 2023.

At the time of this Progress Report, HCA and a third location are in contract negotiations and therefore, no data is available outside the initial two sites.

Background

Senate Bill (SB) 5092 (2021) Section 215(39)(e) and SB 6168 (2020) Section 215(76)(f), referred to as Proviso 76 required HCA to implement two Pilot sites for IOP and PHP services, for certain children and adolescents, under the age of 21. In coordination with HCA, Mercer developed the fees and fiscal impact for the Pilot PHP and IOP mental health programs effective January 1, 2021.[2] Mercer also outlined considerations for potential

[1] 67th Legislature 2022 Regular Session. Certification of Enrollment Engrossed Substitute Senate Bill 5693. Available at: 5693-S.PL.pdf (wa.gov)

[2] Startup of direct services began in the spring of 2021.

Medicaid coverage of these two programs in the future. HCA established minimum program standards, eligibility criteria, authorization, and utilization review process.

In November 2021, HCA requested Mercer update the Proviso 76 report to align with final program expectations. Mercer utilized Schedule A from of the contracts for the IOP and PHP Programs between HCA and Seattle Children's Hospital (K5190) and between HCA and Providence (K5191). Mercer's rate development approach, six-month revenues of each program, fiscal impact, and per diem rates remained unchanged at the time the report was updated. Eligibility criteria, data collection, and program standards were updated in the December 2021 IOP and PHP report[3] to align with final program expectations.

Pilot Sites

Currently, the Pilot sites are based in psychiatric hospitals serving children and adolescents at two sites:

- Seattle Children's Hospital (west of the Cascade mountains).
- Providence Sacred Heart Medical Center in Spokane (east of the Cascade mountains).

Seattle Children's Hospital developed the following IOPs, which are designed for both in-person and virtual services:

- Obsessive Compulsive Disorder (OCD) for children and young adults aged 11 to 18 who are diagnosed with OCD or an anxiety disorder. The Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS) is utilized by the IOP program.
- Anxiety for youth with severe anxiety and/or school refusal. The program utilizes the Anxiety Disorders Interview Schedule (ADIS) Clinician Severity Rating, Patient-Reported Outcomes Measurement Information System (PROMIS), and the Child Anxiety Life Interference Scale (CALIS).
- Dialectical Behavior Therapy (DBT) for high school ages youth with chronic suicidal ideation and self-injurious behavior. The IOP program utilizes the Strength and Difficulties Questionnaire (SDQ), Conflict Behavior Questionnaire (CBQ), Suicide Ideation Questionnaire-Junior (SIQ-Jr), and the Columbia Suicide Severity Rating Scale (C-SSRS).
- A Disruptive Behavior (DB) Program was added in February 2022. This program is intended to train caregivers in delivering interventions to children ages 5–12 who struggle with unsafe behaviors including aggression and property destruction. The program utilizes the Disruptive Behavior Disorder Rating Scale (DBD-RS), Alabama Parenting Questionnaire-Short Form (APQ-9), Interaction Rating Scale (IRS), Client Satisfaction Questionnaire (CSQ), and PROMIS at admission and discharge.

Providence developed the following IOP/PHP programs:

- Behavioral and Educational Skills Training (BEST) IOP/PHP for elementary and middle school aged children who struggle with behaviors that affect their social and/or

[3] Health Care Authority, Division of Behavioral Health and Recovery. Intensive Outpatient Services report. Engrossed Substitute Senate Bill 5092, Section 215(39)(e); Chapter 334; Laws of 2021. Available at: Intensive Outpatient Services report (wa.gov)

educational environments. The Ohio Functional Assessment Battery is utilized by the program.

- Resources, Insight, Support, and Empowerment (RISE) IOP/PHP for youth and young adults aged 13–21 who struggle with severe anxiety, chronic suicidal ideations, and self-injurious behaviors. RISE utilizes the Generalized Anxiety Disorder 7 (GAD-7), and the Colombia Suicide Severity Rating Scale (C-SSRS).

Executive Summary

Despite the limited data provided and described in Section 2, all programs appear to be trending towards delivering positive clinical outcomes, but a determination of clinical effectiveness of each program cannot be made at this time.

Similar to the clinical data, claims data evaluated for the Progress Report exhibits limitations related to small sample size, program continuity, and recent program expansion resulting in limited analysis completed at this time.

Sixty-seven youth including transgender, non-binary, females, and males were served by the Pilot programs between March 2021 and February 2022.[4] The Providence BEST and RISE programs provide both PHP and IOP services and the number of days spent in the programs ranges from 3 days to 26 days. The Seattle Children's programs only provide IOP services and the number of days in three of the programs range from 6 days to 33 days. Providence programs self-reported that 100% of their enrolled individuals were diverted from inpatient admissions for at least some period of time while Seattle Children's programs did not self-report the number of inpatient days diverted. Although each program utilized a number of nationally validated assessment tools to track the progress of enrolled individuals and to determine the effectiveness of the program, the majority of the programs did not report consistent or complete screening tool data. All programs showed positive discharge planning and placement outcomes with 50 of the 67 enrolled individuals having a home discharge placement. Complete data on emergency department (ED) utilization and psychiatric admissions pre and post enrollment in the IOP/PHP Pilot programs was not provided. As noted in this report, because complete data was not provided by the programs and without consistent data, a determination of clinical effectiveness of each program cannot be made at this time.

In order to evaluate the impact of the Pilot program on Medicaid service utilization, Mercer proposed a review of Medicaid claims experience restricted to individuals served by the Pilot program. HCA provided Mercer with a client roster of fewer than 100 individuals served by the PHP and IOP programs summarized by program in the table below without any restrictions on dates of admission. HCA relied on the roster to extract claims data from the State's Medicaid Management Information System (MMIS) to support the analysis. Mercer segmented the claims data into meaningful time periods of claims experience prior to admission to a Pilot PHP or IOP program, during participation in the Pilot PHP or IOP program, and after discharge from the Pilot PHP or IOP program. Mercer observed that due to program continuity factors and program expansion, many individuals in the already small sample are participating in the Pilot program in 2022 limiting the available claims experience, especially after discharge from the Pilot program. Mercer anticipates that the final report to

[4] During this time, Providence did not participate in the Pilot program for five months.

be issued in December 2023 will include further analysis stratified by the three time periods once more data is available for the new programs as well as any new sites entering the Pilot program.

Table 1. Enrolled Youth by PHP IOP Pilot Program Without any Restrictions on Dates of Admission

Program	Enrolled Youth
Seattle Children's DBT IOP	13
Seattle Children's Anxiety IOP	11
Seattle Children's OCD IOP	7
Seattle Children's DB IOP	15
Providence RISE	26
Providence BEST	18
All Programs	90

Section 2
Pilot Program Data Evaluation

Clinical Data

Data Overview

The final provider contracts between HCA and the Pilot program sites require Pilot program sites to submit the following data to HCA to help determine the effectiveness of the Pilot program. Data must be submitted for youth within five days of discharge from the program as well as for youth enrolled and actively receiving treatment. Data submitted must include:

- Facility name (tax identification number [Tax ID#] or National Provider Identification [NPI]).
- Client's first and last name.
- Date of admission.
- Admission diagnosis.
- Race/ethnicity.
- Gender at birth.
- Current gender identification.
- Length of treatment (days of treatment).
- Guardianship status (e.g., parent(s), legal guardian, Department of Children, Youth and Families [DCYF] case worker, etc.).
- Insurance type (e.g., Medicaid, private, etc.)
  - How many additional youth were served above what the Pilot program paid for?[5]
- Presence of developmental disability/intellectual disability/ autism spectrum disorder or another co-occurring disorder.
- Number of mental health ED visits in prior 12 months.
- Number of inpatient psychiatric hospitalizations in prior 12 months.
- Assessments completed at admission and discharge using a nationally validated tool.
- Estimated reductions in psychiatric inpatient costs associated with each of the Pilot sites including:

[5] Data was not reported for services provided in addition to the services reimbursed by the Pilot program.

  - Number of days of inpatient stays diverted due to early discharge and treatment in a Pilot program consistent with the language of the Proviso.
  - Number of inpatient admissions diverted due to treatment in the Pilot programs.
  - Services that the Pilot programs replaced at a lower cost for each youth.
- Discharge plan:
  - Discharged placement (e.g., home, foster home, residential treatment, etc.)
  - Treatment after discharge (e.g., individual/group therapy, family therapy, medication management, etc.)

Data Time Period

For purposes of this Pilot program Progress Report, HCA identified a 12-month reporting time period of March 2021 through February 2022. Data utilized in this report is restricted to youth with an admission date between March 1, 2021 and February 28, 2022.

Data Limitations

Between August 2021 and December 2021, Providence Hospital did not participate in the Pilot, and instead provided Pilot program services as an "in-lieu of" service in the fully integrated Medicaid managed care program. Because this period was not under the Pilot program contract, HCA confirmed that Providence did not perform the clinical assessments required under the Pilot. HCA also identified limitations in data collected by managed care organizations (MCOs) of these services as "in-lieu of" services during Providence's absence from the Pilot program. As a result, there is limited data available regarding IOP and/or PHP services at Providence during this non-Pilot period. Beginning in January 2022, Providence resumed delivery of PHP and IOP services through the Pilot as well as completing all required clinical assessments.

Seattle Children's Hospital OCD IOP, Anxiety IOP, and DBT IOP programs participated in the Pilot program for the entire data time period. Seattle Children's Hospital DB IOP program began in February 2022 and some data from this limited time period is included in this Progress Report.

Data Quality

This report serves as a progress report for future report comparison and analysis. While each program provided some clinical information, a final analysis of clinical effectiveness cannot be provided in this report because all Pilot programs provided incomplete data. The following section identifies whether or not a program provided the requested data in each of the subsections. Despite the limited data provided, Mercer completed a thorough review to support development of future reports and evaluation of continued trends. Please note that despite the limited data provided, all programs appear to be trending towards delivering positive clinical outcomes. To complete the final analysis, Mercer recommends that the programs improve oversight of clinically relevant data so that HCA can ensure valid results in the final evaluation.

Youth Served

Two program sites provided clinical data for a total of 75 members. Of those 75 individuals, eight members were served outside of the data analysis time period and will not be used in the analysis. An additional 27 members have either an admission date or discharge date outside of the data analysis time period. The breakdown of the 67 youth served can be found in Table 2.

Table 2: Number of Enrolled Youth between March 2021 and February 2022

Program	Enrolled Youth
Seattle Children's DBT IOP	9
Seattle Children's Anxiety IOP	7
Seattle Children's OCD IOP	6
Seattle Children's DB IOP	7
Providence RISE	26
Providence BEST	12

Demographics

Gender Identity and Transgender Identity

Both Providence and Seattle Children's programs served individuals who identified as transgendered or non-binary youth. Within the Providence programs, 61% of individuals were assigned female at birth while 39% were assigned male. At admission, two individuals identified as non-binary and two identified as transgendered female to male.

Seattle Children's programs did not provide gender identity data for 21% of enrolled individuals. An additional 48% of served individuals were assigned female at birth compared to 31% assigned male at birth while two individuals identified as non-binary at admission.

Race/Ethnicity

Within the Providence programs, 74% of individuals served identified as white or Caucasian. 8% of individuals identified as black/African American, 8% Native American, and 10% identified as Asian, Hispanic, and "other".

Within the Seattle Children's program, 41% of enrolled individuals identified as white/non-Hispanic, 6% identified as Hispanic, and 3% identified as black/African American. 48% of individuals served by Seattle Children's either declined to identify their race/ethnicity or no data was taken.

Co-Occurring Disorders

All programs were asked to provide co-occurring conditions for enrolled individuals. Most of the data received indicated if an individual had a co-occurring condition or diagnosis, including a cognitive disability, however specific diagnoses were not provided. Of the 38 individuals served through the Providence programs, 16% of records reported a co-occurring

diagnosis compared to 17% of individuals in the Seattle Children's program. However, the Seattle Children's programs did not provide data for over half (52%) of their enrolled individuals.

Guardianship Status

All reviewed programs supported diverse levels of parent/guardianship involvement. In the Providence programs, over 80% of enrolled individuals lived with their parents.

In the Seattle Children's programs, there were 29 enrolled youth and 55% of the enrolled individuals lived with their parents. The remaining individuals reported to live with their grandparents, with a legal guardian, or did not report guardianship information.

Service Diagnosis[6]

The Seattle Children's programs reported participant diagnoses according to the following categories:

Program	Diagnosis Code	Description
DBT IOP	F31.2	Bipolar Disorder, current episode, manic severe with psychotic features
DBT IOP	F32.2	Major Depressive Disorder, single episode, severe without psychotic features
DBT IOP	F32.9	Major Depressive Disorder, single episode, unspecified
DBT IOP	F33.1	Major Depressive Disorder, recurrent, moderate
DBT IOP	F33.2	Major Depressive Disorder, recurrent, severe without psychotic features
Anxiety IOP	F40.10	Social Phobia, unspecified
Anxiety IOP	F41.1	Generalized Anxiety Disorder
OCD IOP	F42.2	Obsessive Compulsive Disorder, mixed obsessional thoughts and acts
DB IOP	F91.9	Conduct Disorder, unspecified

Services Provided

The Providence BEST and RISE programs provided phased care for youth through both partial hospitalization and intensive outpatient services. Many enrolled individuals received treatment in both the PHP and IOP phases of their program. Table 3 shows the number of individuals receiving PHP or IOP in each program and the average number of days they received those services. **Table 3: Average Days in Providence Programs**

[6] Admission service diagnosis codes were not provided by Providence in their clinical data submission.

Program	# of Enrolled in PHP	Average Days in PHP	# of Enrolled in IOP	Average Days in IOP
Providence RISE	5	7 days (Range of 4–10 days)	26	15.5 days (Range of 3–26 days)
Providence BEST	11	11.8 days (Range of 5–16 days)	11	6.7 days (Range of 3–17 days)

The Seattle Children's programs only provide intensive outpatient services. Table 4 shows the average number of days individuals participated in each IOP program. The average days of participation were calculated using only data points provided. *Note: complete data was not provided at the time of this report.*

Table 4: Average Days in Seattle Children's Programs

Program	Numbered Enrolled vs. Number of data points provided	Average days in IOP Program
Seattle Children's OCD IOP	6 enrolled, 5 data points provided	17.2 days (Range of 6–31 days)
Seattle Children's Anxiety IOP	7 enrolled, 4 data points provided	20 days (Range of 9–28 days)
Seattle Children's DBT IOP	9 enrolled, 4 data points provided	13.8 days (Range of 3–28 days)
Seattle Children's DB IOP	No clinical data provided	N/A

Impact and Outcomes

As noted above, neither program provided complete data. Without consistent data, a determination of clinical effectiveness of each program cannot be made at this time. To enrich the analysis, Mercer has analyzed other data sources below to assess the clinical soundness of each program. While the interim Progress Report focuses on currently available information, Mercer and HCA expect that more complete data will be available for the final summative evaluation.

Prevented Inpatient Stays

Each program is required by contract to provide the number of inpatient days that were possibly diverted due to participation in the Pilot program. The Providence programs provided the number of diverted inpatient days using self-reported data without specifying the method of calculating the diverted days.

Both Providence programs reported that 100% of their enrolled individuals were diverted from inpatient admission for at least some period of time. The RISE program reported an estimated 136 diverted admission days for the 26 enrolled individuals. The average number of days diverted was 5.25, with the range being between 1.5 days to 13.75 days. The BEST program reported an estimated 145 diverted admissions days for their 12 enrolled individuals. The average number of days diverted was 12.1, with a range of 4 to 17 days.

The Seattle Children's programs did not provide a number of inpatient days diverted. Mercer analyzed the raw data and found inconsistent data reports when the program was asked if a patient was diverted from inpatient admission at all (e.g., when a Yes/No answer was required). As a result, Mercer made the determination that diversion information for Seattle Children's programs will not be included in this report.

Screening Tools

Each program utilized a number of nationally validated assessment tools to track the progress of enrolled individuals and to determine the effectiveness of the program.

The Providence RISE Program provided pre- and post-screening information for all 26 enrolled individuals using the GAD-7, C-SSRS, and PHQ-9.

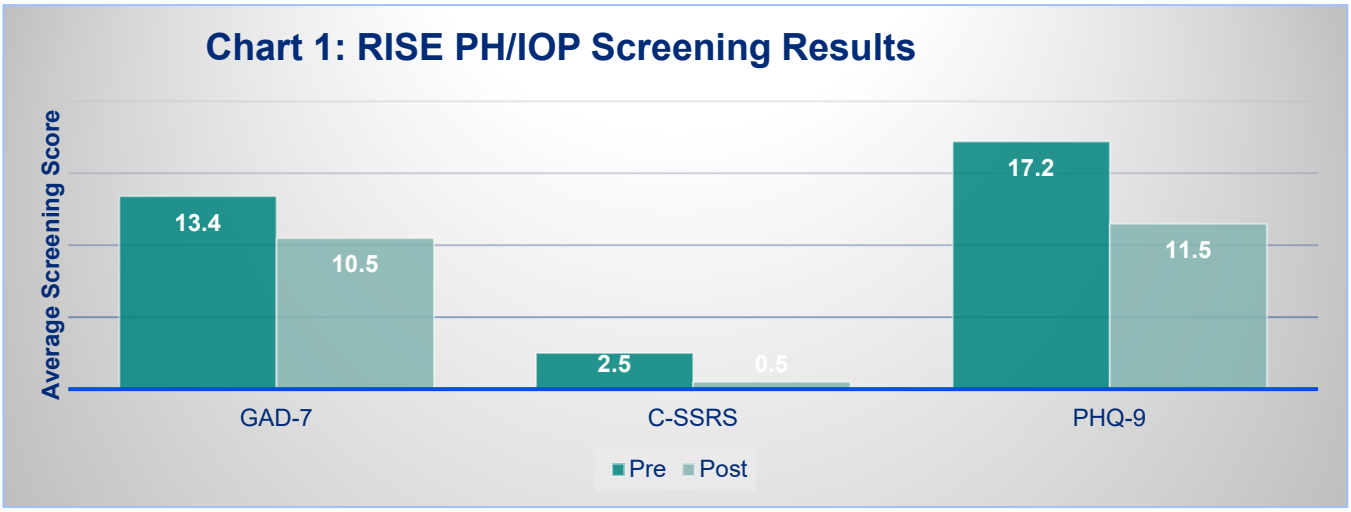
- The GAD-7 is a seven item, self-reporting questionnaire using a Likert scale to indicate feelings of anxiety within the last two weeks. A total score of 5–9 indicates mild anxiety, 10–15 indicates moderate anxiety, and a score greater than 15 indicates severe anxiety.[7]
- The C-SSRS is a six question protocol used to assess current suicide risk.[8] Questions are presented in a yes/no format, with more "yes" answers indicating a greater risk of harm. The RISE program presented their data numerically, with yes=1 and no=0, therefore a higher scores indicates a higher risk of suicide.
- The PHQ-9 is a self-administered, nine item questionnaire that indicates feelings of major depression using a Likert scale. PHQ-9 scores range from 0–27, with the higher the score indicating higher levels of depression.[9]

[7] Spitzer RL, Kroenke K, Williams JBW, Lowe B. A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7. Arch Intern Med. 2006:166(10)1092-1097. Doi:10.1001/archinte.166.10.1092

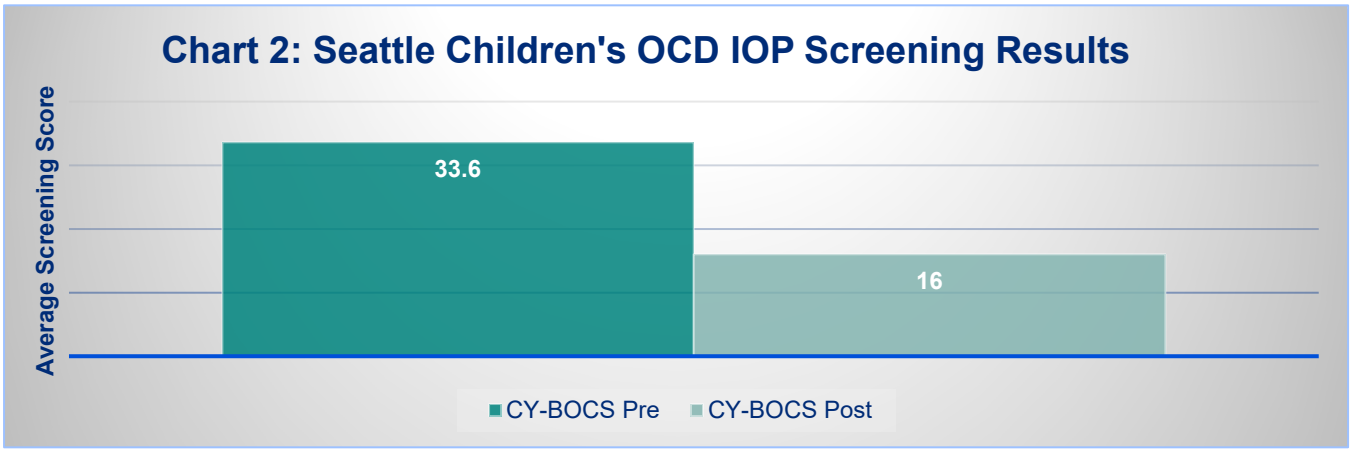
[8] The Columbia Lighthouse Project. (2022). About the Protocol. C-SSRS. Available at: http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/

[9] Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. J Gen Intern Med. 2001. Sep.16 (9):606. Doi:10:1046/j.1525-1497.2001.016009606.x.

All three screening tools indicate an average positive clinical outcome for the program. Chart 1 shows the average pre and post scores for all three screening measurements for the RISE program.



Seattle Children's OCD IOP reported screening information for five of six enrolled individuals. Chart 2 shows the provided information using the CY-BOCS scale. For reference, the CY-BOCS provides a score between 0–40, with higher scores indicating greater severity of OCD symptoms.[10] This initial data shows an improvement over time with the small number of enrolled individuals, but the data is too small to be generalizable.



Aside from the Providence RISE and Seattle Children's OCD IOP programs, the IOP/PHP programs generally did not report consistent or complete screening tool data. Each program's results are listed below:

- Providence BEST program did not provide any screening tool data.

[10] National Institute of Mental Health. (2007, October). Children's Yale-Brown Obsessive Compulsive Scale (CY-BCOS), The Study Center, Yale University of Medicine

- Seattle Children's Anxiety IOP provided screening information for two individuals using the ADIS-5, CALIS, and the PROMIS. These screenings showed positive clinical outcomes for the two individuals, but due to the already small sample size, specific program outcomes cannot be generalized in this report.
- Seattle Children's DBT IOP provided screening information for two individuals using multiple screenings including the SDQ Adolescent, Difficulties in Emotion Regulation Scale (DERS), and the Parental Stress Scale (PSS). The data provided does show some positive clinical outcomes. However, due to the small sample size, specific program outcomes cannot be generalized in this report.
- Seattle Children's DB IOP provided partial screening tool information for each of their seven enrolled individuals using the DBD-RS, APQ-9 and the IRS. It is unclear if the partial data was due to individuals not being discharged within the allotted data window, the newness of the program which began in February 2022 or if they were never completed. Because Mercer had access to only partial admission screening scores, scores are not included in this report.

Discharge Placement

Discharge planning and placement information can be another important indicator of clinical outcome. All programs showed positive discharge planning and placement outcomes with 50 of the 67 enrolled individuals having a home discharge placement. However, no data was provided for 13 individuals in the Seattle Children's programs. There were three individuals discharged and admitted to an inpatient program or the emergency department for further support (4% of discharges). 49 individuals discharged to their home were referred to some type of outpatient support, such as outpatient therapy, medication management, or Applied Behavior Analysis (ABA).

Emergency Admissions

The Providence and Seattle PHP and IOP programs did not provide complete data on ED utilization and psychiatric admissions pre and post enrollment in the IOP/PHP Pilot programs. As a result, Mercer did not include this analysis in the Progress Report due to the small sample and gap in participation of the Providence program. For the final evaluation and based on data provided, Mercer will include an analysis of ED utilization and/or psychiatric admission pre and post enrollment.

Recommendations

The following recommendations focus on aspects of refining the clinical data collection process to ensure more consistent and reliable data will be received for the next review period. Mercer recommends providing programs a uniform data collection tool with as many drop down menus as possible to standardize data fields and sections including:

- Admission diagnosis
- Race/ethnicity
- Gender at birth
- Gender identification

- Guardianship status
- Insurance type
- Presence of developmental disability (Can either choose yes/no or provide options of common developmental disability diagnosis)
- Co-occurring disorder (Yes/No)
- Was patient diverted from inpatient admission? (Yes/No)
  - Current reporting includes notes explaining “why”, which are not necessary
- Client referred by:
  - Current reporting indicates if client was referred by ED
  - It is recommended that a drop down list is provided with ED being one of the options, others can include psychiatrist, behavioral health case manager, primary care provider (PCP), etc.
- Screening tools
  - Add a column in the data collection tool to indicate what screening tool is being used
  - HCA may want to reduce the amount of nationally validated tools they can choose from
  - Providers should not be able to add notes to the scores, rather just provide a numerical value
  - HCA may want to limit the amount of screening tools used by each program
    - For example, the DB IOP program provided incomplete data for four different tools instead of focusing on the completion of two tools that may be more meaningful.
- Discharge placement
- Discharge Plan
  - Have a drop-down menu (or check box options) for the services being referred to for that individual or services that the individual is enrolled in.
  - It may be beneficial to somehow notate the intensity of services post-enrollment. It may point to clinical outcome if the majority of people are being referred to their PCP (low intensity) compared to the Wraparound with Intensive Services (WISe) program (high intensity).
- Number of inpatient stays diverted
  - It needs to be clearly defined and operationalized how this number is being determined.

Claims Data

Data Overview

In addition to the clinical data, Mercer reviewed Medicaid claims data for individuals served by the Pilot programs to evaluate effectiveness and to provide recommendations for future service expansion required in the final report. Mercer requested claims experience for individuals prior to the individual receiving services under the Pilot program, while an individual is actively receiving services in the Pilot program, and after discharge from the Pilot program from ProviderOne.

Mercer relied on the following data sources to complete the claims data evaluation of the Pilot program:

1. Claims data provided by HCA
    a. Claims data, pulled from ProviderOne Operational Data Store (ODS), for Medicaid eligible individuals served by the Pilot program with service dates between March 1, 2020 and July 14, 2022. Claims data is restricted to paid and accepted records. Claims data is inclusive of managed care and fee-for-service (FFS) experience. Paid amounts derived from detailed claim line information relying on the managed care or FFS indicator field.
2. Medicaid eligibility data provided by HCA
    a. Eligibility data, pulled from ProviderOne ODS for Medicaid eligible individuals served by the Pilot program as of July 14, 2022.
3. Program roster data provided by HCA
    a. List of Medicaid eligible individuals served by the Pilot program including start and discharge dates available as of July 14, 2022.

Programs

The six PHP and IOP programs in this data evaluation included programs from both Seattle Children's and Providence hospitals. No programs were excluded from the evaluation.

Time Period

Mercer requested claims data from HCA for months of service from March 2020, representing 12 months prior to the earliest admission into the Pilot program, to the most recent available cutoff date (July 14, 2022).

Data Quality

Mercer reviewed the data and information for internal consistency and reasonableness, but did not audit it. The data was adjusted to remove duplicate program spans and to remove participants who had multiple spans at any of the PHP or IOP programs.

Data Limitations

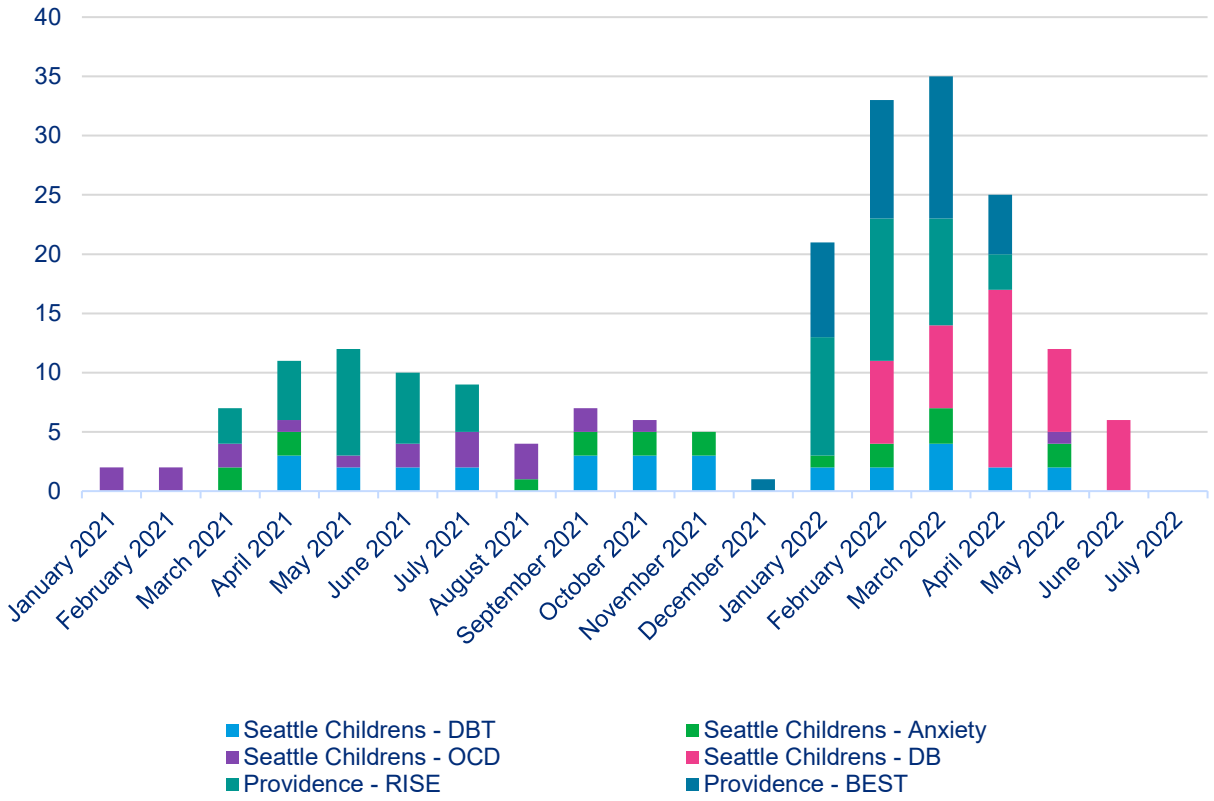
The claims data evaluated for the Progress Report has significant limitations that should be considered when assessing the results summarized in this section. The most impactful limitations are the small sample size, program continuity, and recent program expansion.

The program roster provided by HCA identified fewer than 100 individuals served through the Pilot programs. Any results or conclusions made as a result of the data evaluated are not guaranteed to be replicable is a larger sample and may not be extrapolated beyond the sample analyzed.

Another limitation of the data is program continuity and the recent program expansion observed for the Providence BEST and RISE programs as they rejoined the Pilot program. Additionally, a new Seattle Children's DB IOP began operating in the Pilot program in 2022. Additional data is needed to evaluate the programs.

Due to recent growth of programs, a complete longitudinal view of the claims data is not available. As seen in Chart 3 below, the data skews towards increased Pilot program months, defined as months with a Medicaid claim overlapping with an individual's admit and discharge date, in more recent months which creates a natural limitation in the available claims data post discharge from the program. In addition, Mercer observed decreases in the program months for the most recent months, likely due to the completeness considerations with the timing of the data pull.

Chart 3: PHP IOP Pilot Program Months by Program



Methodology

Mercer split the data into three distinct time periods to evaluate Medicaid claims experience: calendar months prior to an individual being admitted to one of the PHP or IOP Pilot programs, calendar months during an individual's time in one of the PHP or IOP Pilot programs, and calendar months after an individual is discharged from one of the PHP or IOP Pilot programs.

For each member, Mercer identified a span of months going back up to 12 months before admission to the program and up to 12 months following discharge from a PHP or IOP program. These spans were linked to the claims data by an individual's Medicaid eligibility identification number to summarize dollars and user months in order to calculate average cost per user per month by span month and Pilot program.

Due to the limitations identified above (especially because there is not a 12-month period available following most discharges), a complete analysis of cost experience by the three distinct time periods is not completed at this time. Mercer anticipates that the final report to be issued in December 2023 will include further analysis stratified by the three time periods once more data is available for the new programs as well as any new sites entering the Pilot program.

For this Progress Report, high level summaries of overall program utilization are described in the results section below.

Results

Enrolled Youth

In aggregate, data was provided for a total of 90 members across the six programs with start dates as early as November 4, 2020 and discharge dates as late as June 2, 2022. As seen above in Chart 3, program months are split unevenly across the period with an increase in recent months in individuals served by the program due to Providence's reentry into the program and the start of the new Seattle Children's DB IOP.

Table 1. Enrolled Youth by PHP IOP Pilot Program

Program	Enrolled Youth
Seattle Children's DBT IOP	13
Seattle Children's Anxiety IOP	11
Seattle Children's OCD IOP	7
Seattle Children's DB IOP	15
Providence RISE	26

Program	Enrolled Youth
Providence BEST	18
All Programs	90

Utilization during Program Months

Medicaid claims experience is summarized below for all calendar months during which an individual was enrolled in one of the PHP or IOP Pilot programs. User months represent months in which an individual was enrolled in one of the PHP or IOP Pilot programs and had a claim in the encounter data. The costs shown below do not include the state-funded per diem rate component for Medicaid and non-Medicaid eligible individuals served by the Pilot program. These costs are tracked separately through a manual billing process established by HCA.

Table 5. Medicaid cost per user per month during admission in a PHP or IOP Pilot program

Program	Total Dollars	User Months	Cost Per User Per Month
Seattle Children's DBT IOP	$ 65,909	30	$ 2,197
Seattle Children's Anxiety IOP	$ 17,362	19	$ 914
Seattle Children's OCD IOP	$ 26,098	20	$ 1,305
Seattle Children's DB IOP	$ 133,888	42	$ 3,188
Providence RISE	$ 307,656	61	$ 5,044
Providence BEST	$ 81,839	36	$ 2,273
All Programs	$ 632,753	208	$ 3,042

Table 6. Medicaid user months prior to and during admission in a PHP or IOP Pilot program

Duration	Seattle Children's DBT IOP	Seattle Children's Anxiety IOP	Seattle Children's OCD IOP	Seattle Children's DB IOP	Providence RISE	Providence BEST	All Programs
12 Months Before	9	6	3	14	19	14	65
11 Months Before	10	5	3	14	19	16	67
10 Months Before	11	7	4	13	22	15	72
9 Months Before	12	7	3	14	21	16	73
8 Months Before	11	10	5	14	20	16	76
7 Months Before	11	10	4	14	21	14	74
6 Months Before	11	10	5	14	18	13	71
5 Months Before	9	9	6	14	20	13	71

Duration	Seattle Children's DBT IOP	Seattle Children's Anxiety IOP	Seattle Children's OCD IOP	Seattle Children's DB IOP	Providence RISE	Providence BEST	All Programs
4 Months Before	10	10	5	14	23	15	77
3 Months Before	10	11	6	13	25	14	79
2 Months Before	13	10	6	14	25	15	83
1 Month Before	13	10	6	15	25	16	85
During Program	**30**	**19**	**20**	**42**	**61**	**36**	**208**

Section 3

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