Regional Feedback Session: Establishing Behavioral Health Network Adequacy Standards

Washington State Health Care Authority

Desired Outcomes

- Describe the applicable legislation and requirements
- Provide an overview of what network adequacy is
- Describe the progress made to date
- Obtain feedback on areas where community voice is needed
- Identify next steps

Overview of E2SHB 1515

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Engrossed Second Substitute House Bill 1515

- In 2023, legislation passed that focused on three key areas:
  1. Adopting regional BH network standards
  2. Defining priorities and requirements for upcoming procurements
  3. Maximizing medicaid funding for the crisis delivery system and long-term involuntary inpatient treatment

Today's meeting will focus on #1 from the list above.

Regional BH Network Standard Requirements

The legislation requires HCA to:

- Adopt statewide network adequacy standards that are assessed on a regional basis for the behavioral health provider networks
- Adopt standards no later than January 1, 2025
- Provide for participation of counties and Behavioral health providers in the development and subsequent updates
- Design/Implement a process for an annual review of the standards
- Include a structure for monitoring compliance with provider network standards and timely access

1515 Required Standards

At a minimum, these standards must address each behavioral health services type covered by the medicaid integrated managed care contract. This includes, but is not limited to:

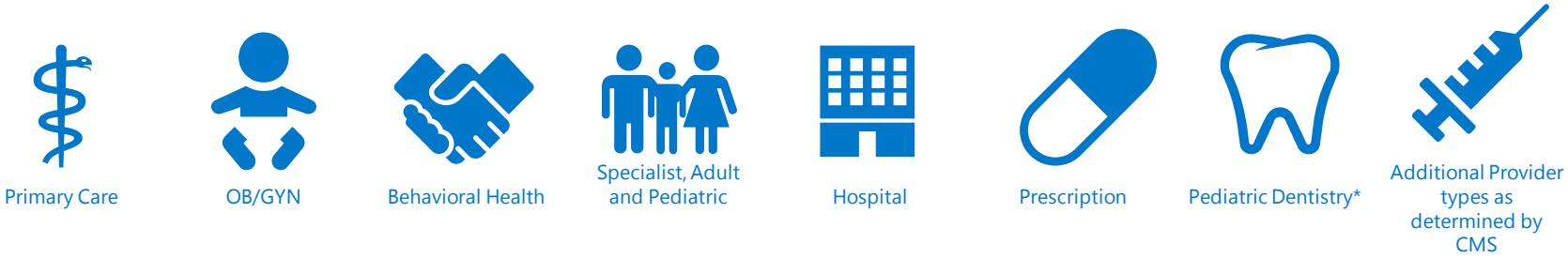
- Outpatient, inpatient, and residential levels of care for adults and youth with a mental health disorder;
- Outpatient, inpatient, and residential levels of care for adults and youth with a substance use disorder;
- Crisis and stabilization services;
- Providers of medication for opioid use disorders;
- Specialty care;
- Other facility-based services; and
- Other providers as determined by the authority through this process.

Overview of Current Network Adequacy

Network Adequacy Federal Requirements

Rules specific to Medicaid:

42 CFR § 438.68 requires states to ensure provider specific network adequacy standards. The state must develop **quantitative** network adequacy standards for the following provider types:



- HCA's Managed Care program does not include pediatric dentistry done outside of a PCPs office
- For Behavioral Health, HCA measures for both individual clinicians and outpatient behavioral health agencies

Network Adequacy in WA

- HCA defines its **quantitative** network adequacy standards using time and distance.
- Networks must have enough providers to ensure access for all enrollees. If a contracted provider is not available, MCO must arrange for a "non-participating" provider to see the enrollee.

Population Density	Time	distance
Urban	30-minute drive	2 providers in 10 miles
Non-Urban (Suburban/Rural)	30-minute drive	1 provider in 25 miles
Large Rural (Frontier)	90-minute drive	* Distance standards are only broken out by 2 designations

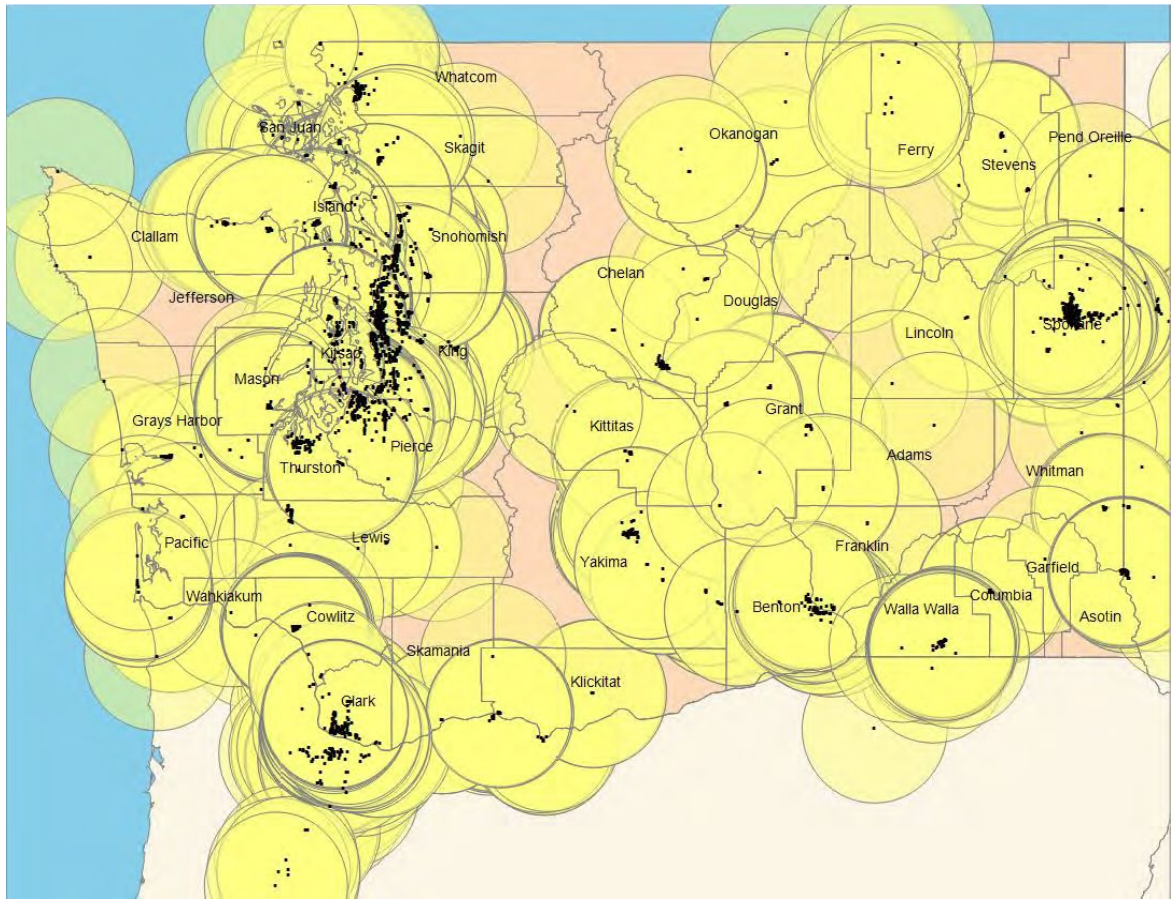
Provider Networks Submissions

- Provider network submissions are assessed for the individual MCO's ability to meet the capacity threshold for critical provider types by county.
- Provider networks are reported quarterly.
  - As of 2020, quarterly network submissions have changed to prospective reporting model. For example, quarterly reports turned in April 15th are for the months of April, May, and June of the same year.
    - This allows us to get a more real-time look at network adequacy.

How Network Adequacy is Measured

- HCA uses geocoding on Network submissions, which include latitude and longitude of the provider servicing location.
- Using QuestAnalytics software, the raw data is overlaid on the proximity file to measure the distance from an enrollees' approximate location to the nearest provider for every provider type reported.
- Each MCO must show an ability to serve 80% of **total** Medicaid enrollees in each county in a region in all seven critical provider types to be considered adequate.

Example of Geocoding
Individual Mental Health Clinicians



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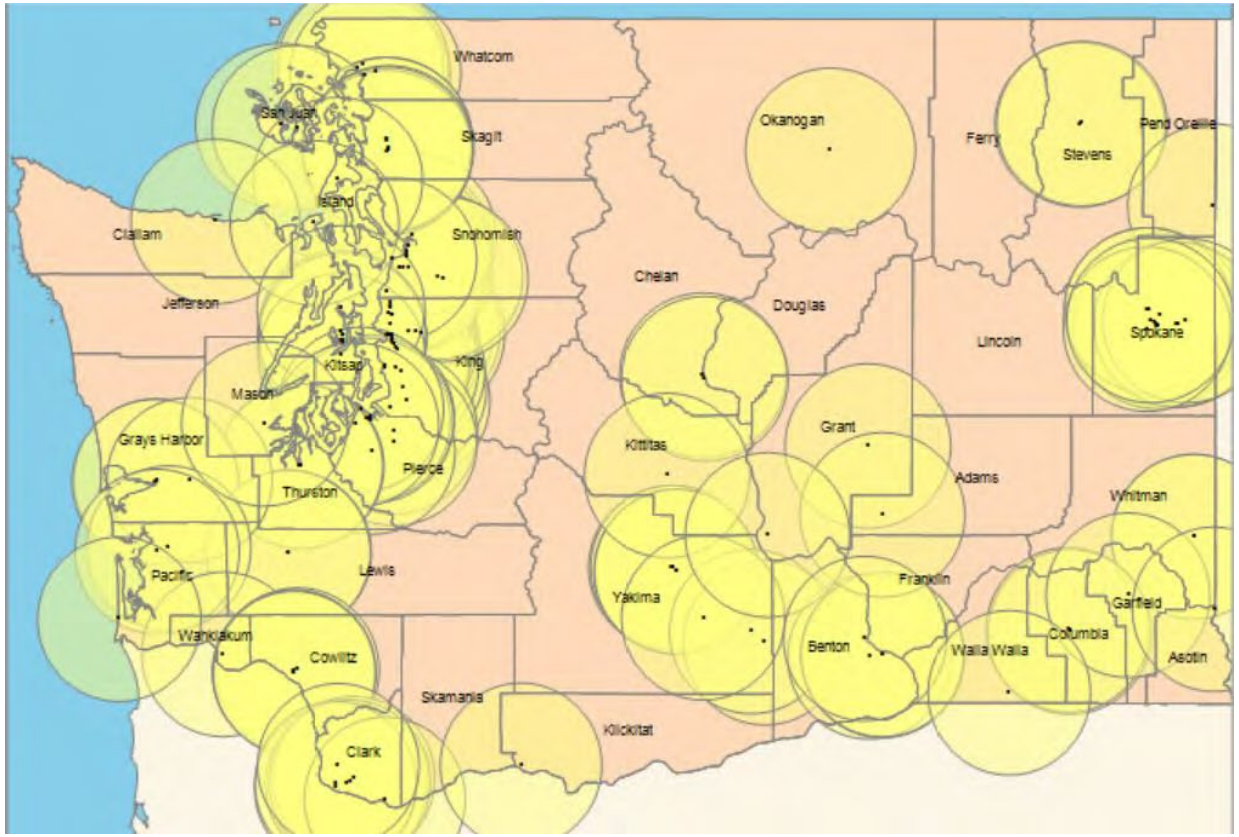
Example of Geocoding
WISe Providers



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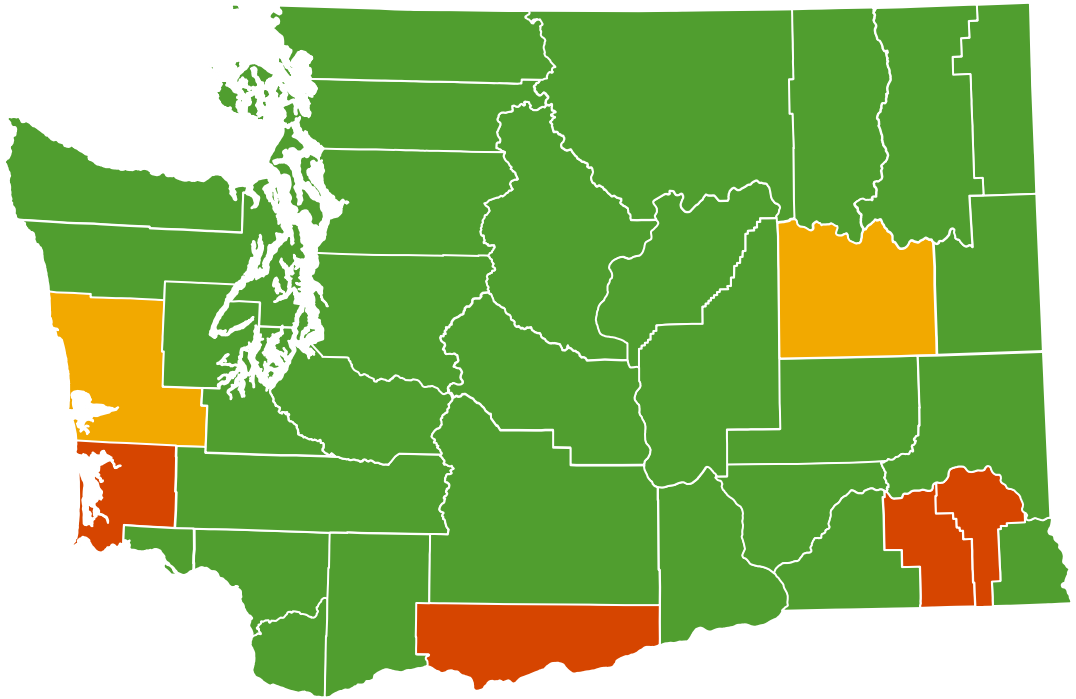
Network Adequacy Monitoring

- When an MCO is between 60-79% HCA may adjust the methodology for when an MCOs receives new clients.
- In general, MCOs that fall below a 60% capacity threshold in any county in a region are given an official notice of our intent to remove them from the region and put on a corrective action plan (CAP). This CAP outlines specific steps the MCO must take to avoid being removed from the region and ensure adequate access to services.
- MCOs are given 2 quarters (6 months) to show proof that they have an adequate network in the county.

HCA Monitoring of Health Plans Networks

Sample Visual



Assignment **80%-100%**	• Demonstrates sufficient provider network to receive all eligible enrollees • Plan name appears on enrollment form • HCA auto-enrolls
Enrollment only **60%-79%**	• Demonstrates a *mostly* sufficient provider network to receive all eligible enrollees, but *lacks sufficiency in one or more categories* • Plan name appears on enrollment form • HCA won't auto-enroll
Inadequate network **0%-59%**	• *Does not demonstrate* a sufficient provider network to receive eligible enrollees. Plan name *will not* appear on enrollment form

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Network Adequacy Exceptions

- If the low-capacity threshold is the result of a provider gap, HCA can grant an exception to that provider type in that county only.
- Exceptions are only granted if it is unlikely that the services will be provided in the county soon (ex. new facilities built, existing providers carrying specialty certifications, etc.)
- To date, there are 6 exception counties for OB, 2 for Mental Health Outpatient (BHA), 3 for Adult SUD Outpatient, and 6 for Youth SUD Outpatient in Washington State.

Presence of Service Standards

- Essential behavioral health providers, other than outpatient BHA services, are not currently held to distance standard. HCA uses a 'presence of service' determination. This allows MCOs to maintain an adequate network in counties or regions where multiple specialty providers are unlikely to be located.
- Presence of service means that the MCO has someone in-network within the county or region that can provide the service.
- Statewide services adhere to the presence of service standard as they are not located in every county.

Current Behavioral Health Provider Types

- Licensed Mental Health Professionals
  - Working within a BHA*
  - Working with youth*
- Peer
- PACT
- WISe
- SUD
  - Opiate Substitution Treatment
  - Adult Outpatient*
  - Adult Intensive Outpatient*
  - Adult Intensive Inpatient
  - Adult Long Term
  - Adult ITA
  - PPW
  - Adult Recovery House

**must meet capacity threshold*

Current Behavioral Health Provider Types (cont.)

- SUD Cont.
  - Youth Outpatient*
  - Youth Intensive Outpatient*
  - Youth Residential
  - Youth Recovery House
- E&T

- Beds
  - Adult Residential
  - Youth Residential
  - ITA IMD
  - Pregnant Women Services
  - Parenting Women Services
  - Adult Detox IMD
  - Adult Detox Non-IMD
  - Youth Detox IMD
  - Youth Detox Non-IMD

**must meet capacity threshold*

Network Adequacy Limitations

- Meeting Medicaid network adequacy standards does not necessarily translate into real “access”, as in can I get in to see a provider.
  - Example: There are enough providers in an area to meet network adequacy standards, but appointment wait times are so long that patients are unable to access services from those providers.
  - Example: There are enough providers in an area, but they do not have the resources to meet the needs of a certain population, such as specialty beds for people with specific diagnoses.
- Additional work is underway or will be coming soon, to better address “access”, including new federal requirements.

Progress Made to Date on 1515

Developing BH Standards

- To date:
  - HCA has been leveraging the BHSCC subgroup on network to assist with planning.
  - Subgroup worked to align the categories within the legislation to what is currently collected and the Medicaid BH state plan services.
  - Came to consensus on continuum of care.
  - Identified current programs/services in each 1515 category.
- Additionally, the subgroup completed a series of focus groups to gather provider feedback on access. The results of the focus groups was brought back to the BHSCC Network Workgroup to be analyzed, however the workgroup's focus has currently shifted to 1515 and work on the focus group data will resume in the future.

Agreed upon Continuum

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MH Services by Category

Youth MH *(up to 21)*	
Outpatient	• Clinic-based or provided by a BHA
Residential	• None currently • ~~CLIP *eating disorder youth residential*~~ • NA
Inpatient ***-Long-term inpatient?***	• E&T • ~~CLIP~~ • Freestanding Psychiatric Inpatient • Community Hospital (i.e. Skagit, Swedish)
Crisis/stabilization (BH including COD)	• Mobile • In home youth stab • ~~*CSUs (up to 14 day)*~~ • 23 hour crisis receiving centers (2024 leg session) (5853)? • DCR?
Other facility-based services	• anything here?
Specialty Care ***-Intensive OP***	• CALocus 3 (IOP) and 4 (WISe, New Journeys PHP) • Future: B-5 • Future: TAY
~~***MOUD***~~	•
Others	• Medication Management? • School-based services?

Adult MH	
Outpatient	• Clinic-based or provided by a BHA
Residential	• Medium-term (up to 3 months) • Long-term (3 months+)
Inpatient **-Long-term inpatient?**	• E&T • Hospital • LTCC
Crisis/stabilization (BH including COD)	• Mobile • In home stab • Facility based Crisis stabilization/23 hour/CSUs (up to 14 day)/receiving centers/ Peer Respite • DCR?
Other facility-based services	• Intensive BH Treatment
Specialty Care **-Intensive OP**	• Locus 3 and 4 -- New Journeys, PACT, ACT, IRT, IOP/PHP
~~**MOUD**~~	•
Others	• Medication Management

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SUD Services by Category

Youth SUD *(up to 18)*	
Outpatient	• BHA Level services (group, individual, peer) (1.0)
Residential	• (Residential Long-term 3.1 and 3.5) • No 3.3 for youth
Inpatient	• ~~Medical WM (4.0 in hospital)~~
Crisis/stabilization (BH including COD)	• ~~Mobile~~ • ~~In home youth stab~~ • ~~Facility based Crisis stabilization/23 hour/CSUs (up to 14 day)/receiving centers/ Peer Respite~~ • ~~DCR?~~
Other facility-based services	•
Specialty Care -Intensive OP	• IOP – BHA level 6 hours (2.1)
Providers of MOUD;	• OTP?
Others	• Neonatal?

Adult SUD	
Outpatient	• BHA Level services (group, individual, peer) (1.0)
Residential	• Residential 3.1 (long-term), ~~3.3~~ and 3.5(more acute but shorter stay) • ~~oxford/recovery housing (medicaid?)~~ • Secure WM/voluntary withdrawal Man. (3.7)
Inpatient	• ~~Medical WM (4.0 in hospital)~~
Crisis/stabilization (BH including COD)	• ~~Mobile~~ • ~~In home youth stab~~ • ~~Facility based Crisis stabilization/23 hour/CSUs (up to 14 day)/receiving centers/ Peer Respite~~ • ~~DCR?~~
Other facility-based services	• Sub-acute detox (3.2)
Specialty Care -Intensive OP	• 2.5 Partial Hospital • IOP – BHA level 9 hours (2.1)
Providers of MOUD;	• OBOT at PC • OBOT/SUD treatment • Opiate Substitution Treatment
Others	• PPW

Timeline

- June-July – Engage Stakeholders
- July-Sept – Group to make decisions for 2025 standards and draft MCO contract language
- Mid-October – Draft data definitions & template to MCOs
- Mid-November – MCO comments due & draft documents finalized
- Late November – Template to QuestAnalytics
- January 2025 – First submission received using new standards/new template
- **Beyond** –
  - Develop a method for Providers to submit all information necessary for the standards developed.
  - Establish an annual process to review and update the standards
  - HCA to align with new CFR requirements
  - HCA develop and implement enhance monitoring for access

Feedback and Community Voice: Remaining Questions

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Standards for January 2025

What timeframes do we want to consider for January 2025 vs future years?

Current	
Outpatient	1 in 25 (all)
Residential	Presence of service (all)
Inpatient	Presence of service (all)
Crisis and Stabilization	Presence of service in every county
MOUD	No current standard
Specialty Service	WISe –every county; PACT/Act- every region;
Other Facility	
Other	

Feedback Needed: Residential

Should residential services be grouped together or separately?

	Pro	Con
Separate	Provides more specific data about the level of service within residential. This could be helpful information for determining community needs.	Breaking out too far can result in inadequacies or gaps, and trigger exceptions or create potential unintended consequences.
Separate		Provider burden due to reporting the provider must give to the MCO quarterly
Together	Decreases administrative burden	Groups various levels of care into a single field which could create skewed reporting for specific levels of care.
Together	Describes the service not facility type	

Feedback Needed: Residential (cont.)

What standard shall we set for residential services?

Standard	Pro	Con
Presence of Service (e.g. one per state, region, county, etc.)	Better aligns with how our system works, in that these are statewide resources	Difficult to measure gaps/needs.
Specific Distance (e.g. one in 50 miles- vary by urban/rural)	Measurable and aligned with current processes.	• Multiple standards throughout the state. • If there is not a provider type within the region, exceptions would be needed.
Population Based (e.g. one bed per 10,000 people)		The current software does not allow calculations to be made.
Provider Patient Ratio (e.g. one provider per 1,200 people)		Measuring would be difficult. No standard exists, so the number would be arbitrary. This also creates a heavy burden on providers to supply and report and is not reporting we require of physical health providers.

Feedback Needed: Inpatient

Should inpatient services be grouped together or separately?

	Pro	Con
Separate	Provides more specific data about the level of service within residential. This could be helpful information for determining community needs.	Breaking out too far can result in inadequacies or gaps, and trigger exceptions or create potential unintended consequences.
Together	Decreases administrative burden	Harder to determine gaps for sub-populations
Together	Describes the service not facility type	

Feedback Needed: Inpatient (cont.)

What standard shall we set for inpatient services?

Standard	Pro	Con
Presence of Service (e.g. one per region)	Better aligns with how our system works, in that these are statewide resources	Difficult to measure gaps/needs.
Specific Distance (e.g. one in 50 miles- vary by urban/rural)	Measurable and aligned with current processes.	• Multiple standards throughout the state. • If there is not a provider type within the region, exceptions would be needed.
Population Based (e.g. one bed per 10,000 people)		The current software does not allow calculations to be made. This process would need to be manual. No standard exists, so the number would be arbitrary.
Provider Patient Ratio (e.g. one provider per 1,200 people)		Measuring would be difficult. No standard exists, so the number would be arbitrary. This also creates a heavy burden on providers to supply and report and is not reporting we require of physical health providers.

Feedback Needed: Crisis and Stabilization

Should Crisis and Stabilization services be grouped together or separately?

	Pro	Con
Separate	Provides more specific data about various types of crisis services. This could be helpful information for determining community needs.	Breaking out too far can result in inadequacies or gaps, and trigger exceptions or create potential unintended consequences.
Together	Decreases administrative burden	Groups various services into a single field which could create skewed reporting for specific services within this category.

MH Adult	MH Youth	SUD Adult	SUD Youth
		N/A	N/A

Feedback Needed: Crisis and Stabilization

What standard shall we set for crisis and stabilization services?

Standard	Pro	Con
Presence of Service (e.g. one per region)	Allows MCO participation in regions where there is not a specific service type.	Difficult to measure.
Specific Distance (e.g. one in 50 miles)	Measurable and aligned with current processes.	• Multiple standards throughout the state. • If there is not a provider type within the region, exceptions would be needed.
Provider Patient Ratio (e.g. one provider per 1,200 people)		Measuring would be difficult. No standard exists, so the number would be arbitrary. This also creates a heavy burden on providers to supply and report and is not reporting we require of physical health providers.

Feedback Needed: "Other facilities"

1. **Are there facilities that should be monitored that would fall under the "other facility" category?**
2. **If so, what standard shall we set for these services?**

Standard	Pro	Con
Presence of Service (e.g. one per region)	Allows MCO participation in regions where there is not a specific service type.	Difficult to measure.
Specific Distance (e.g. one in 50 miles)	Measurable and aligned with current processes.	• Multiple standards throughout the state. • If there is not a provider type within the region, exceptions would be needed.
Population Based (e.g. one bed per 10,000 people)		The current software does not allow calculations to be made.
Provider Patient Ratio (e.g. one provider per 1,200 people)		Measuring would be difficult. No standard exists, so the number would be arbitrary. This also creates a heavy burden on providers to supply and report and is not reporting we require of physical health providers.

MH Adult	MH Youth	SUD Adult	SUD Youth
N/A	N/A		

Feedback Needed: Providers of MOUD

1. **What should be monitored under the "Providers of MOUD" category?**
2. **What standard(s) shall we set for these services?**

Standard	Pro	Con
Presence of Service (e.g. one per region)	Allows MCO participation in regions where there is not a specific service type.	Difficult to measure.
Specific Distance (e.g. one in 50 miles)	Measurable and aligned with current processes.	• Multiple standards throughout the state. • If there is not a provider type within the region, exceptions would be needed.
Provider Patient Ratio (e.g. one provider per 1,200 people)		Measuring would be difficult. No standard exists, so the number would be arbitrary. This also creates a heavy burden on providers to supply and report and is not reporting we require of physical health providers.

Feedback Needed: Specialty Services

1. **Are there programs/services that we should monitor that would fall under the "specialty services" category?**
2. **If so, what standard shall we set for these services?**

Standard	Pro	Con
Presence of Service (e.g. one per region)	Allows MCO participation in regions where there is not a specific service type.	Difficult to measure.
Specific Distance (e.g. one in 50 miles)	Measurable and aligned with current processes.	• Multiple standards throughout the state. • If there is not a provider type within the region, exceptions would be needed.
Provider Patient Ratio (e.g. one provider per 1,200 people)		Measuring would be difficult. No standard exists, so the number would be arbitrary. This also creates a heavy burden on providers to supply and report and is not reporting we require of physical health providers.

Feedback Needed: Other

1. **Are there programs/services that we should monitor that would fall under the "other" category?**
2. **If so, what standard shall we set for these services?**

Standard	Pro	Con
Presence of Service (e.g. one per region)	Allows MCO participation in regions where there is not a specific service type.	Difficult to measure.
Specific Distance (e.g. one in 50 miles)	Measurable and aligned with current processes.	• Multiple standards throughout the state. • If there is not a provider type within the region, exceptions would be needed.
Provider Patient Ratio (e.g. one provider per 1,200 people)		Measuring would be difficult. No standard exists, so the number would be arbitrary. This also creates a heavy burden on providers to supply and report and is not reporting we require of physical health providers.

Determining Critical Providers

Currently, outpatient MH Adult, MH Youth, SUD Adult, and SUD Youth are critical provider types. What, if any, additional critical provider types does the group recommend:

	MH Adult	MH Youth	SUD Adult	SUD Youth
Outpatient	YES	YES	YES	YES
Residential				
Inpatient				
Crisis Stabilization				
Other Facilities				
Providers of MOUD				
Specialty Services				

Reminder: Not meeting a critical provider type could have significant adverse action of clients, across they health delivery system.

Next Steps

THANK YOU and Next Steps

- July-August – Engage Stakeholders
  - Meetings with provider groups in every region
  - Meeting with Behavioral Health Advisory Committee
- September – 1515 workgroup review feedback from all stakeholders and finalize the 2025 standards
- January 2025 – Implement new standards/new template
- Annual review and enhanced monitoring and access work as described above

Questions?

Managed Care Programs

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