# Overview of Commercial and Medicaid Behavioral Health Coverage

Joint Legislative Executive Committee on Behavioral Health

October 25, 2024

OFFICE of the INSURANCE COMMISSIONER WASHINGTON STATE

Washington State Health Care Authority

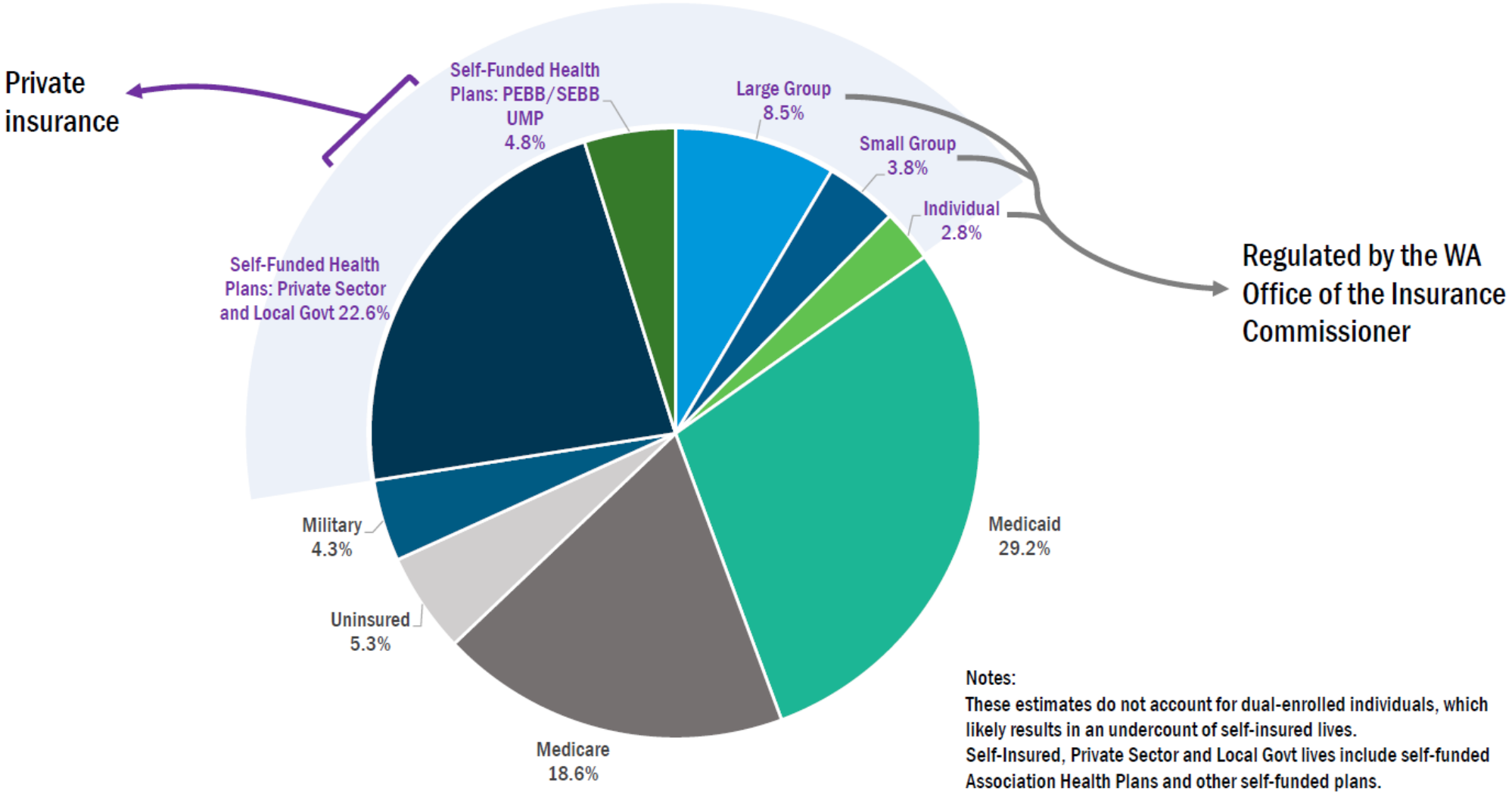
# Presentation Outline

- Who is covered
- What services are covered
- Approach to network adequacy
- Utilization review and medical necessity
- Opportunities and initiatives
- Appendix with additional resources

# Health Care Coverage in Washington

Who is covered?

# Granular Insurance Market Categories in Washington 2022




Notes:
These estimates do not account for dual-enrolled individuals, which likely results in an undercount of self-insured lives.
Self-Insured, Private Sector and Local Govt lives include self-funded Association Health Plans and other self-funded plans.

# Enrollment by Coverage Type

| Broad coverage type | Granular coverage type | Enrolled | Percent |
|---|---|---|---|
| Fully Insured | Large Group | 671,510 | 8.5% |
| Fully Insured | Small Group | 302,558 | 3.8% |
| Fully Insured | Individual | 220,000 | 2.8% |
| Self-Funded Health Plans | Self-Funded Health Plans: Private Sector and Local Govt | 1,780,402 | 22.6% |
| Self-Funded Health Plans | Self-Funded Health Plans: PEBB/SEBB UMP | 379,058 | 4.8% |
| Medicaid | Medicaid | 2,293,404 | 29.2% |
| Medicare | Medicare | 1,459,250 | 18.6% |
| Uninsured | Uninsured | 416,813 | 5.3% |
| Military | Military | 340,062 | 4.3% |

# Washington's Medicaid System

- The Health Care Authority (HCA) is Washington's designated Medicaid authority.
- Nearly two million Washingtonians are enrolled in Apple Health (Medicaid) and approximately 85% enrolled in managed care.
  - Currently, the HCA contracts with five Apple Health Managed Care Organizations (MCO).
  - One MCO also managed a statewide program for children involved in the foster care system.
- Approximately 340,000 Apple Health members receive services via fee-for-service (FFS).
  - Approx. 43% of FFS members are over the age of 65 and are dually eligible (Medicare/Medicaid)
  - Approx. 17% of FFS members are American Indian/Alaska Native
  - HCA contracts directly with health care providers to deliver services to Apple Health fee-for-service members.
  - Note: American Indians or Alaska Natives are automatically enrolled into fee-for-service and have the option to enroll into managed care.

# Two main eligibility pathways

- Modified adjusted gross income (MAGI):
  - Adults up to 133% of federal poverty level (FPL) for a 3-person household (up to $2,969 per month; $20,784 per year for a single person or $43,056 for a family of four)
  - Pregnancy/After-Pregnancy Coverage (APC) up to 193% FPL for a 3-person household (up to $4,260 per month)
  - Children up to 312% FPL for a 3-person household (up to $6,821 per month)
- Non-MAGI:
  - People aged 65 and older, blind, or disabled (by Social Security standards)
  - Are eligible for Medicaid based on income, resources, and their living arrangements
- https://www.hca.wa.gov/assets/free-or-low-cost/22-315.pdf

# Who do we serve in the Behavioral Health Delivery system?

**For FY 2023:**

- **431,852** individuals received Mental Health treatment services.
- **91,774** individuals received SUD treatment services.
- **12,537** individuals received prevention services.

# Covered Services

# Commercial Coverage: Required behavioral health services

| Required behavioral health services | |
|---|---|
| Inpatient hospitalization including state hospitals (w/o prior auth for ITA) (EHB) | Services provided by a licensed behavioral health provider for a covered diagnosis in a skilled nursing facility (EHB) |
| Residential mental health and substance use disorder treatment, including diagnosis and partial hospitalization programs (EHB) | Behavioral treatment for a DSM category diagnosis (EHB) |
| SUD Withdrawal management (EHB) | Prescription medication (EHB) |
| Emergency room and BH crisis (mobile crisis response, crisis stabilization, 23 hour crisis relief center, E&T, medical withdrawal) | Outpatient treatment (individual and group) (EHB) |
| Parity with med/surg required under MHPAEA | |

# Community Behavioral health: Medicaid State Plan section 13d, Rehabilitative Services

- Crisis Intervention
- Crisis Stabilization
- Intake evaluation, assessment, and screenings (Mental Health)
- Intake evaluation, assessment, and screenings (Substance Use or Problem Gambling Disorder)
- Medication Management
- Medication Monitoring
- Mental Health Treatment Interventions
- Peer Support
- Behavioral Health Care Coordination and Community Integration
- Substance Use Disorder Brief Intervention
- Substance Use or Problem Gambling Disorder Treatment Interventions
- Substance Use Disorder Withdrawal Management

Note: Many other services in other sections (like physical health, I/DD, long term care) of the Medicaid state plan that are relevant for behavioral health care

# Network Adequacy

# What is Network Adequacy?

| What network adequacy is | What network adequacy is not |
|---|---|
| Standards to evaluate whether a carrier/MCO has a sufficient number and type of providers and facilities contracted to meet the needs of the people enrolled in their plans. | A requirement that every in-network provider or facility care for any person enrolled in their health plan at any time. |
| Can have both quantitative and/or qualitative components | Dependent upon provider/facility capacity |
| Allows for distinctions between urban and rural areas | A way to measure long appointment wait times |
| Allows for consideration of the role of telehealth | A way to gain insight into whether providers have the resources to meet the needs of a certain populations |

# OIC Network Access standards

# OIC: Why do network access rules exist?

- Health insurers sell health plans that require consumers to use a contracted network of providers to receive benefits.
  - Network types:
    - Participating Provider Organization (PPO)
    - Point of Service (POS)
    - Health Maintenance Organization (HMO)
    - Exclusive Provider Organization (EPO)
- Network standards set Regulatory requirements for insurers.
  - Ensure the delivery of medically necessary services promised to consumers enrolled in their health plans by providing reasonable access to a sufficient number of in-network providers.
- Inadequate networks make it more likely that consumers will have to seek care out of network.
  - Results are higher costs for consumers.

# OIC: General network access standards

- Networks must include sufficient numbers and types of providers and facilities to assure that, to the extent feasible, all health plan services will be accessible in a timely manner appropriate for an enrollee's condition.
- When an insurer has an absence of or an insufficient number or type of provider or facilities to provide a particular covered service, the insurer must ensure the enrollee can obtain the covered service within reasonable proximity and at no greater cost than if the service were obtained from network providers and facilities.

# OIC: Overseeing network access

- Before a health plan is offered or renewed, insurers must submit:
- Insurer/Provider contracts with OIC for approval.
- Health carriers submit reports detailing network development.
  - Network type: PPO, POS, HMO, EPO
  - Market type: Exchange, outside market, small and/or large group
  - Service area, i.e. counties
  - Subcontract relationships: will carrier be utilizing an HCBM for any covered services?
- Health plan documents reviewed to ensure the plan benefits and service area match their provider network.

# OIC: Overseeing network access

- Ongoing oversight
  - Monthly reports from insurers on location of providers, Provider Directory accuracy and access to “next day appointments” per HB 1477carriers:
  - Yearly reports from insurers, including:
  - Health plan enrollee location and demographics,
  - How they are maintaining an adequate network, and
  - Maps showing the geographic location of each contracted provider/facility shown on maps.  Show time and distance to care.
- Insurers must notify OIC if:
  - Defined levels of change occur for specialty providers, primary care providers, hospitals or providers/facilities caring for people with a specific chronic condition or disease; or
  - Increase or decrease of 25% or more number of enrollees in service area

# OIC: What if an insurer cannot meet OIC network access standards?

- When an insurer cannot meet these standards, the carrier may propose an alternate access delivery request (aka "AADR").
- An AADR may be proposed only if:
  - Carrier is unable to contract with sufficient providers or facilities to meet the network standards;
  - Provider or facility type becomes unavailable within a health plan's service area;
  - Insurer serving only a very rural county; or
  - A carrier offering plans on the Washington Health Benefit Exchange cannot meet standards for inclusion of required community providers.
- AADR's also may be used when there is a potential insurer/provider contract termination, or if OIC determines that a network doesn't meet network access standards. OIC can require insurer to submit an AADR.

# OIC: Carrier provider directories

- Insurers must review and update provider directories
  - State law: Monthly
  - Federal law: Quarterly
- OIC rules detail:
  - Required information included for each provider/facility.
  - Whether provider offers telemedicine.
  - How consumers access provider directories.
  - Steps insurers must take to maintain accuracy of directories

# Medicaid Network Adequacy standards

# Medicaid: Network adequacy

**Federal 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:


- For Behavioral Health, HCA measures for both individual clinicians and outpatient behavioral health agencies.

# Medicaid: How network adequacy is measured

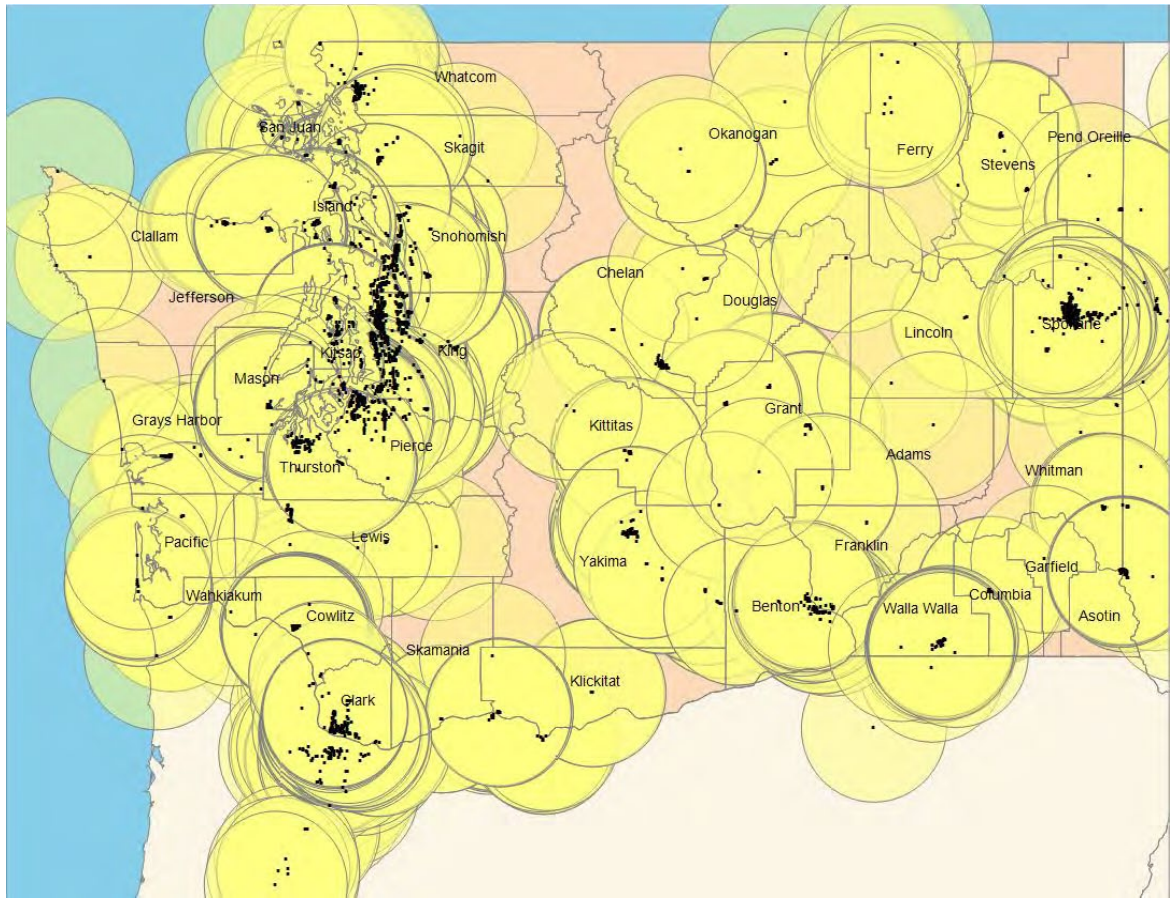
- HCA defines its **quantitative** network adequacy standards using time and distance.
- HCA uses software to analyze network submissions. The exact location of providers is overlaid with population data to measure the distance from enrollees' location to the nearest provider for every provider type reported.

| Population Density | Time | Distance |
|---|---|---|
| Urban | 30-minute drive | 2 providers in 10 miles |
| Non-Urban (Suburban/Rural) | 60-minute drive | 1 provider in 25 miles |

# Medicaid: Network adequacy limitations

- Meeting Medicaid network adequacy standards does not necessarily translate into real "access", such as getting in to see a provider.
  - **Example:** There are enough providers contracted for a particular services in an area for an MCO to meet network adequacy standards, but appointment wait times are so long that patients are unable to access services from those providers timely.
  - **Example:** There is a provider in the area, but they do not have the resources to meet the needs of a certain population. An example of this could be an inpatient level of care is nearby and has open beds, but a person's physical health needs cannot be met at that facility.
- Additional work is underway or will be coming soon, to better address "access", including new federal requirements.

# Example of Geocoding
## Individual Mental Health Clinicians




OFFICE of the INSURANCE COMMISSIONER WASHINGTON STATE

Washington State Health Care Authority

# Engrossed Second Substitute House Bill 1515

Requires Health Care Authority (HCA) to:

- Adopt statewide behavioral health network adequacy standards assessed on a regional basis by January 1, 2025
- Provide for participation of counties and Behavioral Health providers in development
- Design/implement process for annual review of the standards
- Include a structure for monitoring compliance with provider network standards and timely access

At a minimum, these standards must address each behavioral health service type covered by the Apple Health (Medicaid) integrated managed care contract. This includes, but is not limited to (all for adults and youth, with a mental health or substance use disorder):

- Outpatient
- Inpatient
- Residential levels of care
- Also includes:
  - Crisis and stabilization services
  - Providers of medication for opioid use disorders
  - Specialty care;
  - Other facility-based services, etc.

# Developing behavioral health standards

- To date:
  - HCA has been leveraging a sub-committee of the **RCW** 71.24.861 Behavioral Health Systems Coordination Committee (BHSCC) that is specifically focused on network/access 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.
  - The workgroup helped develop an approach for categorizing services to match those found in 1515 and developed materials for regional feedback.
  - The BHSCC subgroup reviewed the regional feedback and on 9/11/2024 agreed upon what standards to use for January 2025.

| Service | Mental Health Adult | Mental Health Youth | SUD Adult | SUD Youth |
|---|---|---|---|---|
| **Outpatient** | 1 in 25 miles | 1 in 25 miles | 1 in 25 miles | 1 in 25 miles |
| **Residential** | Presence of service within the network | N/A | Presence of service within the network by ASAM level of care (3.1, 3.3, 3.5, & 3.7) | Presence of service within the network by ASAM level of care (3.1 & 3.5) |
| **Inpatient** | 1 per region | 1 per region | N/A | N/A |
| **Crisis & Stabilization** | • Facility based: presence of service within network.<br>• In-person response: presence of service in region & by team type. | • Facility based: presence of service within network.<br>• In-person response: presence of service in region & by team type. | N/A | N/A |
| **Providers of Medication for Opioid Use Disorders (MOUD)** | N/A | N/A | • Prescribers of MOUD: Presence of service within network.<br>• BHA Facilities providing MOUD (OTPs): Presence of service within network. | • Prescribers of MOUD: Presence of service within network.<br>• BHA Facilities providing MOUD (OTPs): Presence of service within network. |
| **Specialty Care** | • PACT: 1 per region<br>• New Journeys: Presence of service within network.<br>• BHA Facility providing Medication Management: 1 per region. | • WISe: 1 in-person provider per county<br>• BHA Facility providing Medication Management: 1 per region. | N/A | N/A |
| **Other Facility-based Services** | N/A | N/A | • PPW: Presence of service in network<br>• SWMS: Presence of service in network | N/A |

# Next Steps on Network Adequacy

- HCA to develop ways to measure and address cultural barriers to health care for:
  - Communities of color
  - The LGBTQIA+ community
  - Other communities experiencing barriers to care
- Establish an annual process to review and update the standards.
- HCA to develop and implement enhanced monitoring for access.
- HCA to align with new CMS access rules

# Quality: Medical Necessity and Utilization Review

# Commercial health plans: Medical Necessity

- Medical necessity criteria
  - Substance Use Disorder (SUD) treatment:
    - Must use ASAM (RCW 41.05.528 & RCW 48.43.761)
    - "Medically necessary" or "medical necessity" for any SUD benefits not governed by ASAM: a carrier determination as to whether a health service is a covered benefit because the service is consistent with generally recognized standards within a relevant health profession. WAC 284-43-7010
  - Mental health services:
    - "Medically necessary" or "medical necessity" For mental health services: a carrier determination as to whether a health service is a covered benefit because the service is consistent with generally recognized standards within a relevant health profession. WAC 284-43-7010
  - Prescription drugs:
    - "Medically appropriate" – prescription drugs that under the applicable standard of care are appropriate: (a) To improve or preserve health, life, or function; (b) to slow the deterioration of health, life, or function; or (c) for the early screening, prevention, evaluation, diagnosis, or treatment of a disease, condition, illness, or injury. RCW 48.43.400

# Commercial health plans: Utilization review

- Utilization review includes prior authorization, concurrent review and retrospective review
- Utilization review generally: RCW 48.43.520
  - UR criteria based on reasonable medical evidence and updated
  - Criteria available upon request to providers

- Prior Authorization generally: RCW 48.43.830, 48.43.016
  - Prior authorization: Clinical requirements must be based on peer-reviewed clinical criteria. Clinical review criteria must be evidence-based and accommodate new and emerging info re application to minority/gender/etc. Update annually, if necessary.
    - Timeframes for PA determinations and notifications
    - PA requirements described in detail and written in easily understandable language;
    - PA requirements posted & available in electronic format upon request

# Commercial health plans: Utilization review

- Unless limited by statute, insurers choose which services are subject to utilization review
  - Annual OIC report on 10 most commonly required and approved services across medical and behavioral health services
    - Inpatient
    - Outpatient
    - Durable Medical Equipment
    - Diabetes supplies
    - Prescription drugs (beginning in 2024)

# Where has legislature limited Prior Auth for Behavioral Health?

- SUD services: Commercial & Medicaid RCW 48.43.761
  - No prior authorization for withdrawal mgmt. (first 3 days) and residential treatment (first 2 days)
  - Initial authorization for residential treatment– 14 days. Concurrent review – 7 days.
- OUD Medication: Commercial & Medicaid RCW 48.43.760
  - Coverage without prior authorization of at least one federal food and drug administration approved product for the treatment of opioid use disorder in the drug classes opioid agonists, opioid antagonists, and opioid partial agonists.
- Drugs to treat serious mental illness: RCW 48.43.0961
  - Cannot substitute or increase cost-sharing for drug to treat SMI if enrollee is medically stable on current medication. (Effective January 1, 2025)

# Where has the legislature limited Prior Auth?

- Chiropractic, physical therapy, occupational therapy, acupuncture, and Eastern medicine, message therapy, or speech and hearing therapies RCW 48.43.016
- Emergency services (including ambulance): RCW 48.43.093 & RCW 48.43.121
  - Prior authorization prohibited
- HIV Postexposure prophylaxis: Commercial & Medicaid RCW 48.43.440
  - No prior auth or cost-sharing for HIV PEP medication (Effective Jan. 1, 2025)
- Biomarker testing for certain cancers: RCW 48.43.810
  - Prior authorization prohibited

# Medicaid: Medical Necessity

- HCA is the single state agency for administering the Medicaid program
- Federal dollars can only be used to pay for care deemed **medically necessary** through managed care utilization review programs, including prior authorization and program integrity functions
  - "Medically necessary" is a term for describing requested service which is **reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions** in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is **no other equally effective, more conservative or substantially less costly course of treatment available or suitable** for the client requesting the service.
  - WAC 182-500-0070

# Medicaid MCOs: Utilization controls

- Utilization controls encompass prior authorization requests, concurrent review, and retrospective review.
- MCO Utilization Controls 42 C.F.R. § 438.210(a)(4)(ii)
  - Unless otherwise directed by HCA, MCOs may apply Utilization controls to services at their discretion.
  - MCO utilization control measures are not required to be the same as those in the Medicaid FFS program.
  - Utilization control measures must not deny medically necessary contracted services or unduly burden providers or Enrollees
- Prior Authorization WAC 182-500-0085:
  - **"Prior authorization"** means the requirement that a provider must request, on behalf of a client and when required by rule or agency billing instructions, the agency or the agency's designee's approval to provide a health care service before the client receives the health care service, prescribed drug, device, or drug-related supply. The agency or the agency's designee's approval is based on medical necessity. Receipt of prior authorization does not guarantee payment. Expedited prior authorization and limitation extension are types of prior authorization.

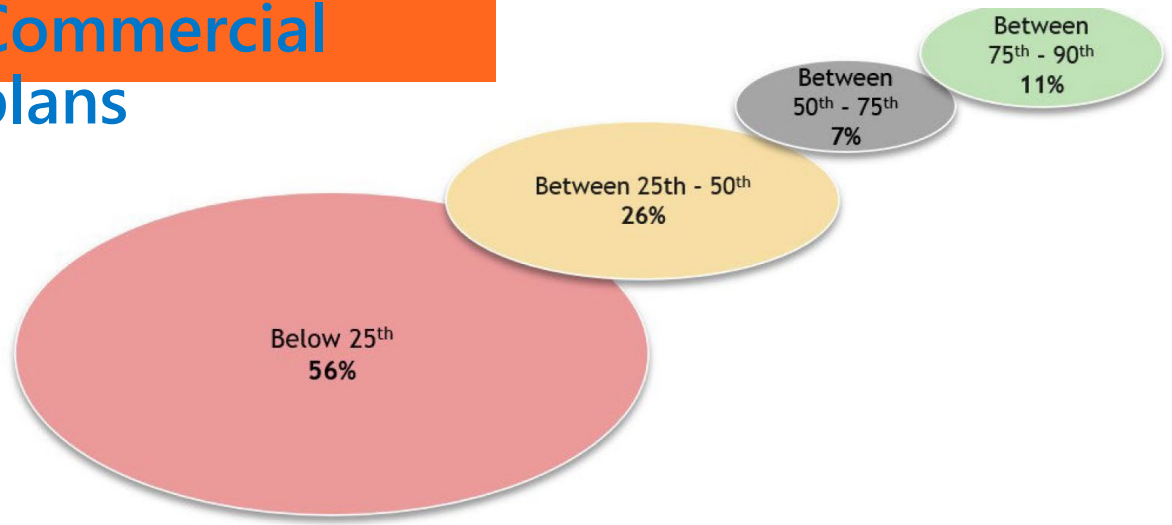
# Medicaid MCOs: Utilization controls

- Prior Authorization General Requirements
  - Clinical decision-making criteria must be evidence based, evaluated annually, and updated as necessary.
  - Criteria must be available to providers and Enrollees upon request
  - All services must be Medically Necessary as defined in WAC 182-500-0070
  - Any decision to deny an authorization request must be made by an individual who has appropriate expertise in addressing the Enrollee's condition 42 CFR 438.210(b)(3)
  - Timeframes for PA determinations are outlined in RCW 74.09.840: Prior authorization.
- Behavioral Health Services
  - MCOs must use ASAM criteria for medical necessity decision for SUD services.
  - Behavioral Health adverse benefit determinations must be peer-to-peer.
- Pharmacy
  - MCOs follow the authorization criteria and limits recommended by the Drug Utilization Review Board or approved by HCA.
  - In the absence of HCA approved criteria or clinical policies, the MCO may use its own drug specific policy

# A note about Quality

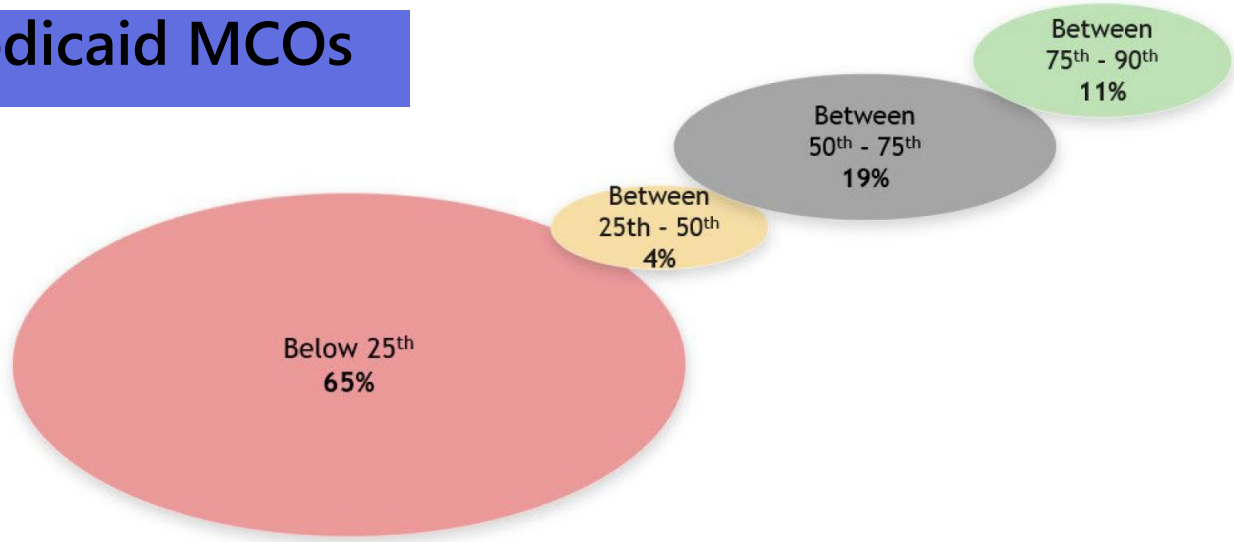
# Medicaid Managed Care competes on quality

## Commercial plans



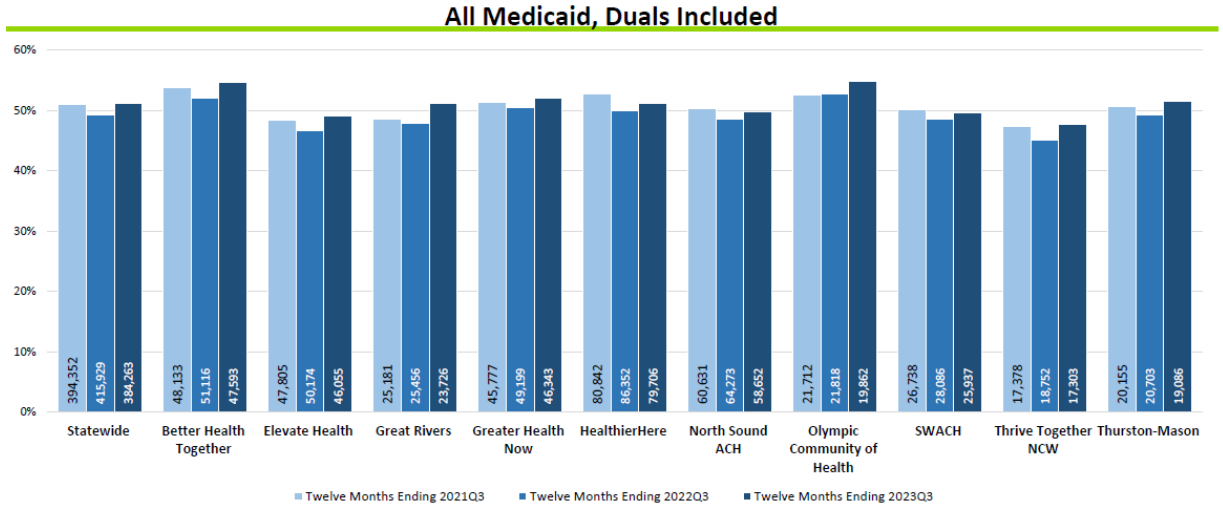

Washington State Results
Comparison to NCQA HEDIS National Benchmarks

## Medicaid MCOs

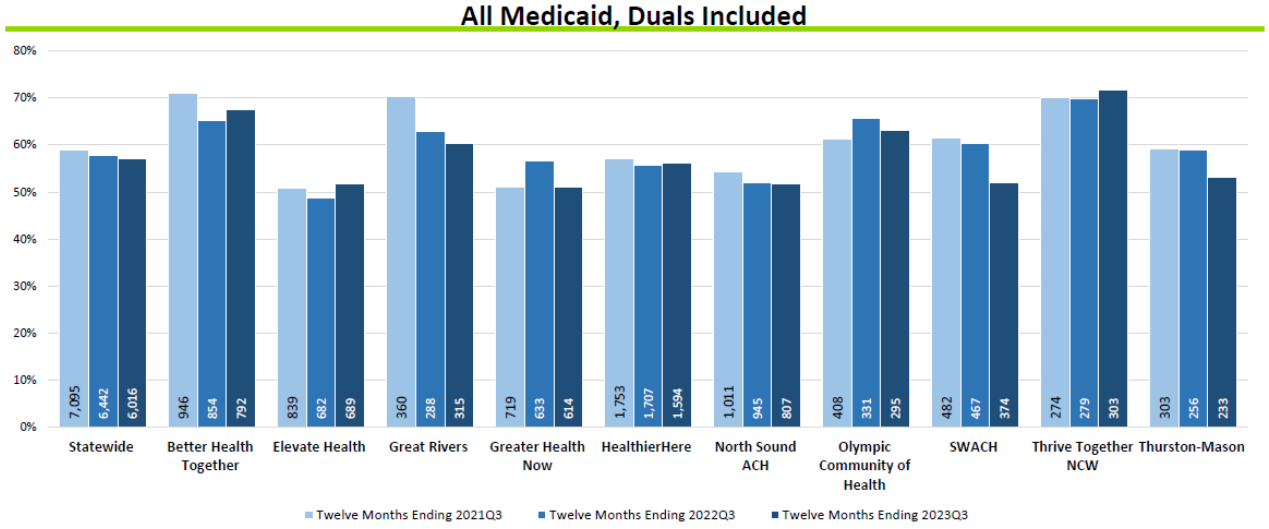



Community Checkup (wacommunitycheckup.org)

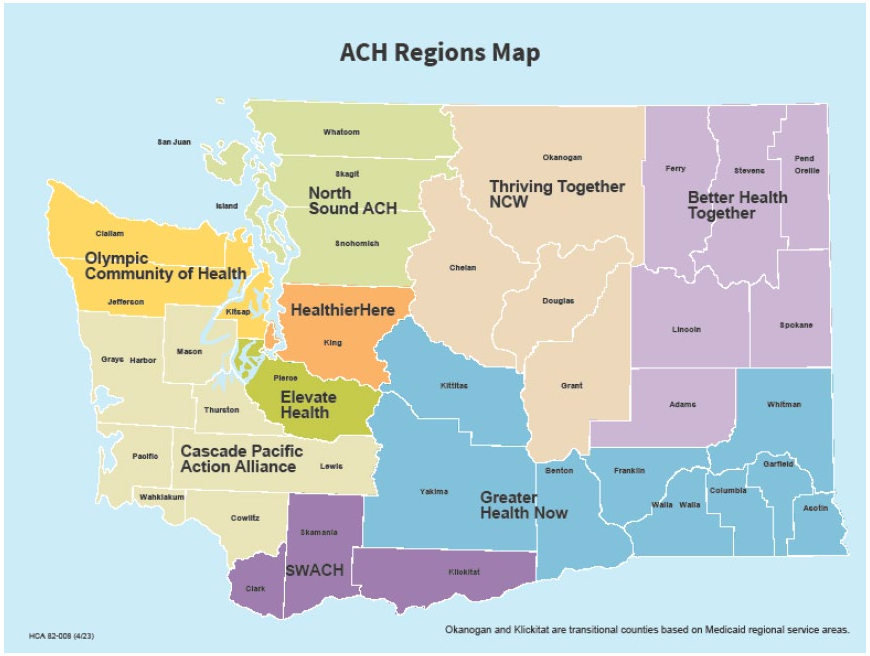
# Mental Health Treatment Rate, Adults 18-64




# Follow-up after ED Visit for Mental Illness, 7 D Adults 18-64



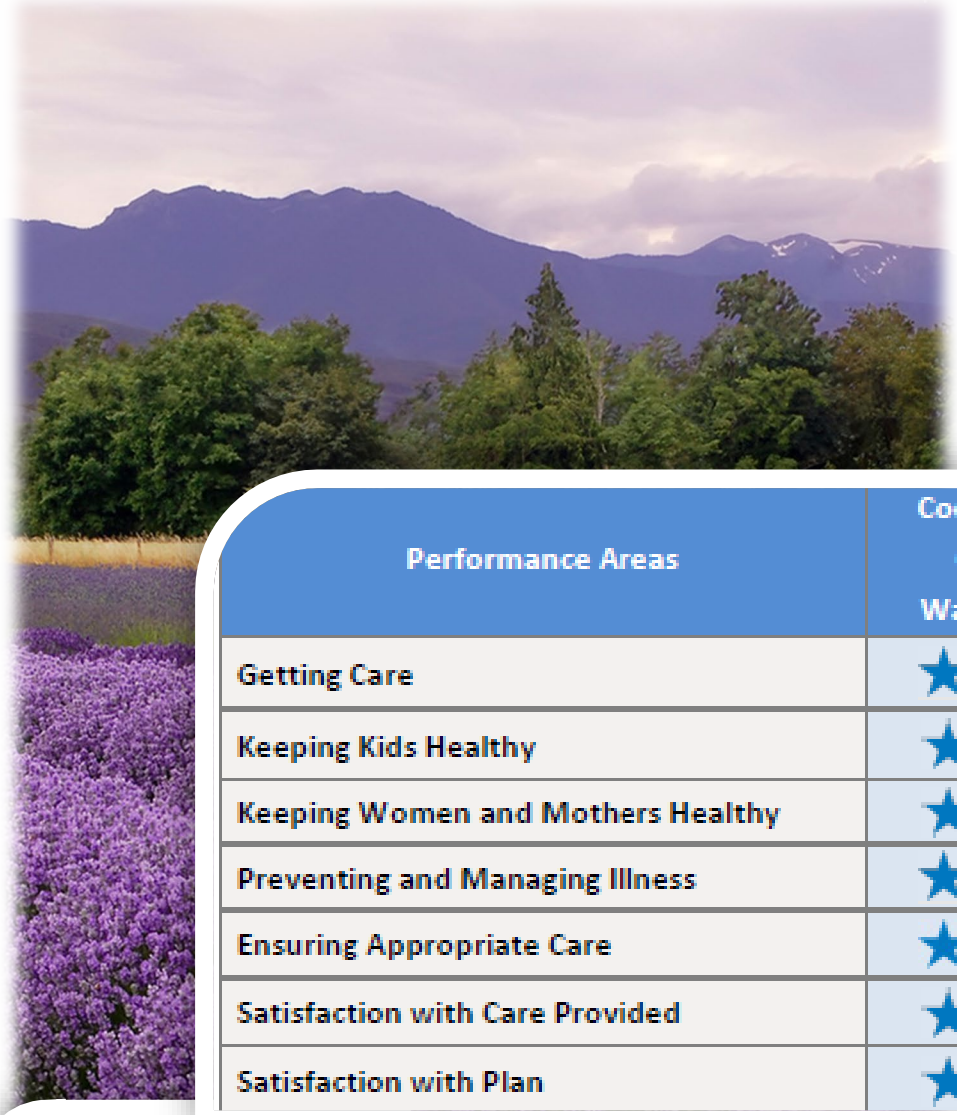

# Behavioral Health Measures: Three Years ending 2023 Q3, by region




[Apple Health (Medicaid) and managed care reports | Washington State Health Care Authority]

Medicaid quarterly from RDA:
https://www.dshs.wa.gov/ffa/research-and-data-analysis/cross-system-outcome-measures-adults-enrolled-medicaid

Washington State Health Care Authority



# Apple Health Plan Report Card 2024

| Performance Areas | Coordinated Care of Washington | Community Health Plan of Washington | Molina Healthcare of Washington | UnitedHealthcare Community Plan | Wellpoint (formerly Amerigroup Washington) |
|---|---|---|---|---|---|
| Getting Care | ★☆☆ | ★★☆ | ★★☆ | ★★☆ | ★☆☆ |
| Keeping Kids Healthy | ★★☆ | ★★☆ | ★★☆ | ★☆☆ | ★☆☆ |
| Keeping Women and Mothers Healthy | ★★☆ | ★★☆ | ★★★ | ★☆☆ | ★☆☆ |
| Preventing and Managing Illness | ★☆☆ | ★☆☆ | ★★☆ | ★★☆ | ★★☆ |
| Ensuring Appropriate Care | ★★★ | ★★☆ | ★☆☆ | ★☆☆ | ★☆☆ |
| Satisfaction with Care Provided | ★★☆ | ★★☆ | ★★☆ | ★★☆ | ★★☆ |
| Satisfaction with Plan | ★★☆ | ★★☆ | ★★☆ | ★★☆ | ★★☆ |

| KEY: Performance compared to all Apple Health plans | |
|---|---|
| Above average | ★★★ |
| Average | ★★★ |
| Below average | ★★★ |

https://www.hca.wa.gov/about-hca/apple-health-medicaid-and-managed-care-reports

Washington State Health Care Authority

# Duals/DSNP Plan Behavioral Health Measures Statewide Rate

| Measure | CY 2022 | CY 2023 |
|---|---|---|
| Mental Health Treatment | 36.3% | 35.9% |
| Follow-Up After Hosp. for Mental Illness - Within 7 Days | 42.3% | 51.1% |
| Follow-up after ED Visit for Mental Illness - Within 7 Days | 54.1% | 66.3% |
| Substance Use Disorder Treatment Rate | 20.1% | 19.8% |
| Opiate Use Disorder Treatment Rates | 30.8% | 29.9% |
| Follow-up after ED Visit for Substance Use-Within 7 Days | 33.3% | 38.4% |

# Addressing Barriers and Opportunities

Parity

Joint Initiatives

Medicaid-Specific Initiatives

# Behavioral Health Parity

- Federal Law : Mental Health Parity and Addiction Equity Act (MHPAEA): If Behavioral Health Benefits offered, then there must be parity with medical / surgical benefits.
- State Law: Behavioral Health benefits must be offered in commercial health plans, and must be parity with medical / surgical benefits
- What do parity laws require?
  - Quantitative treatment limitations (QTLs):
    - Insurers cannot impose dollar or visit limits on behavioral health benefits that are less favorable than those for medical / surgical benefits
  - Nonquantitative treatment limitations (NQTLs):
    - Medical necessity criteria, prior authorization process, formulary design, step therapy protocols, network adequacy standards
    - Must be comparable and no more stringent than policies for medical / surgical

# Behavioral Health Parity Compliance

- OIC received federal grants for the commercial health insurance market
  - 2018-2021
  - 2021-2024
- OIC Mental Health and Substance Use Disorder webpage updates
  - Consumer and provider webpages will "how to" on appeals
  - OIC consumer advocacy staff trained
- OIC Compliance and enforcement
  - Ongoing – confidential under state law (RCW 48.37.080)
  - Consent order with united healthcare
- WA Medicaid is up to date and compliant with the reporting requirements of MHPAEA.
  - Parity analyses from 2017, 2019 and 2023 are available on the Apple Health (Medicaid) and managed care reports webpage.
  - Managed Care Organizations submit annual parity self-assessments each November which are reviewed by an internal committee.
  - As per last analysis, all MCOs meet parity requirements.
  - CMS has proposed to add an annual reporting component regarding parity

# Joint OIC/HCA Initiatives

HCA and OIC are partnering on a number of initiatives and efforts to reduce barriers and improve access to services. These efforts include but are not limited to:

- Crisis Delivery System work:
  - 988 line response
  - commercial health plans covering behavioral health crisis services as “emergency services”
  - 2023 SB 5187 sec 215(19)(b) report on addressing crisis services funding gaps
- 19-20 HB 2642 Removing health coverage barriers to accessing substance use disorder treatment services.
- 23-24 SB 6228 Concerning treatment of substance use disorders
- ASAM 4 Criteria Changes

# Opportunities and Initiatives: Work Underway

- Integration efforts
  - HB 1515- Contracting Network requirements for Medicaid
  - Certified Community Behavioral Health Clinics
  - 13d State Plan Amendment
- Rates
  - Increases
  - HB 2584- Transparency work
  - Benchmarking/minimum fee schedule
- Medication for Opioid use Disorder MOUD Related Efforts:
  - Opioid settlement
  - ASAM 4 Updates
- Eligibility and Coverage Expansion:
  - 1115 waiver Reentry and HRSN services
  - Post-partum
- Children and Youth:
  - Children and Youth Behavioral Health Work Group Initiatives
  - School based services
  - ABA
  - 1580 Complex Discharge
- Capacity Building Efforts:
  - 23-hour facilities
  - Assisted Outpatient and Intensive Outpatient
  - New community facilities

# We're working toward:

## Getting from here to there

- Protecting and expanding workforce capacity to respond to workforce changes
- Ensuring low barrier access to behavioral health care.
- Investing in prevention, health equity, and public health
- Improving health outcomes for complex, high-cost Medicaid populations that live with multiple chronic health conditions including behavioral health disorders
- Expanding and ensuring access to comprehensive, integrated behavioral health treatment and recovery supports.
- Payment model tied to value and based on the cost of providing essential safety net services.
- Children and Youth Behavioral Health Work Group coordination with 2025 priorities
- Continued parity work, improved network, financing, movement to CCBHC, prep for re-entry waiver, and forward movement to the future state!

# Questions? Contact us.

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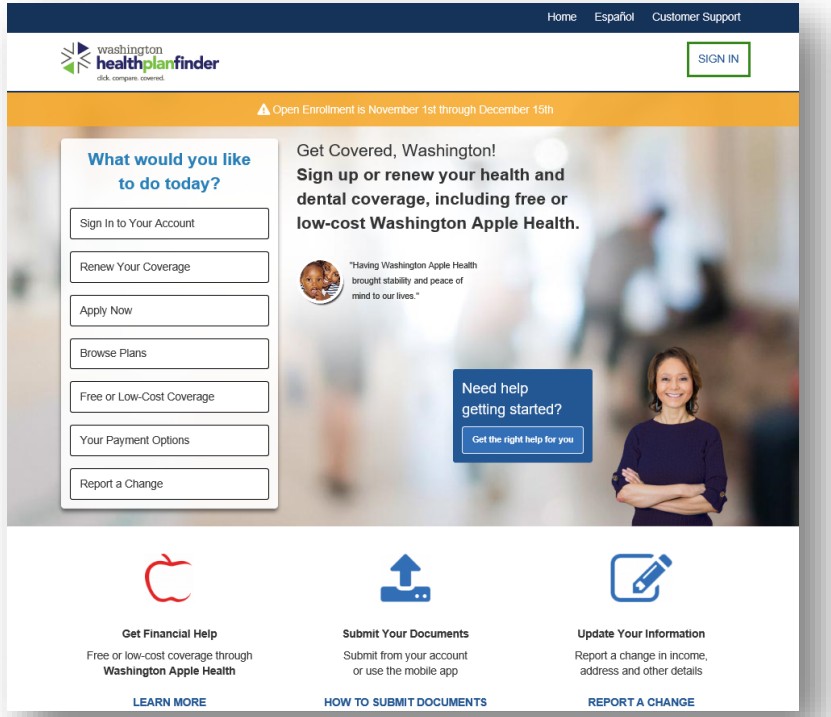
# Appendices

# Apple Health enrollment options

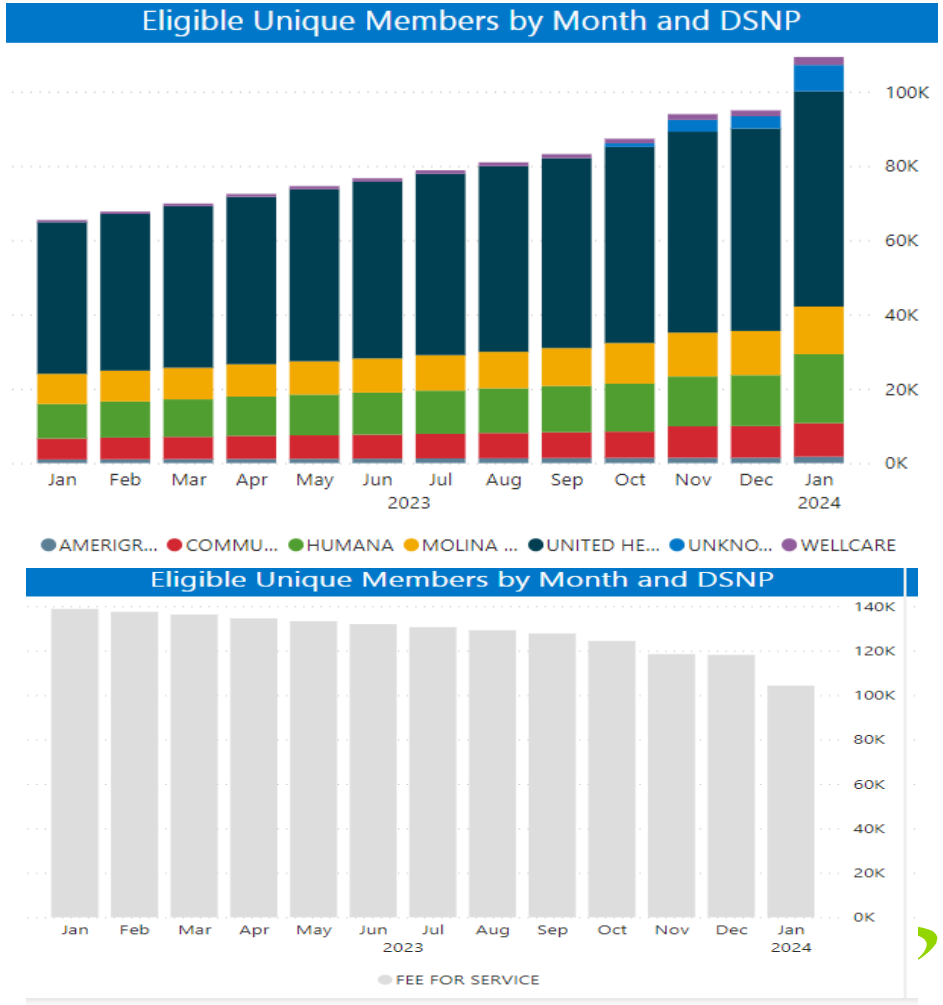
- Apply for or renew if you are:
  - Adults age 19 to 64 years old
  - Children
  - Parent or caretaker with children
  - Pregnant or applying for someone who is pregnant
- **Online**: Go to **Washington Healthplanfinder** - log in and select "Report a change in income or household" under Quick Links.
- **Mobile app:** Download the **WAPlanfinder app** – select “sign in” or “create an account”
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633.
- **Paper**: Submit an **Application for health care coverage (18-001P)**.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage.
  - **Local enrollment assistance** | **Map**



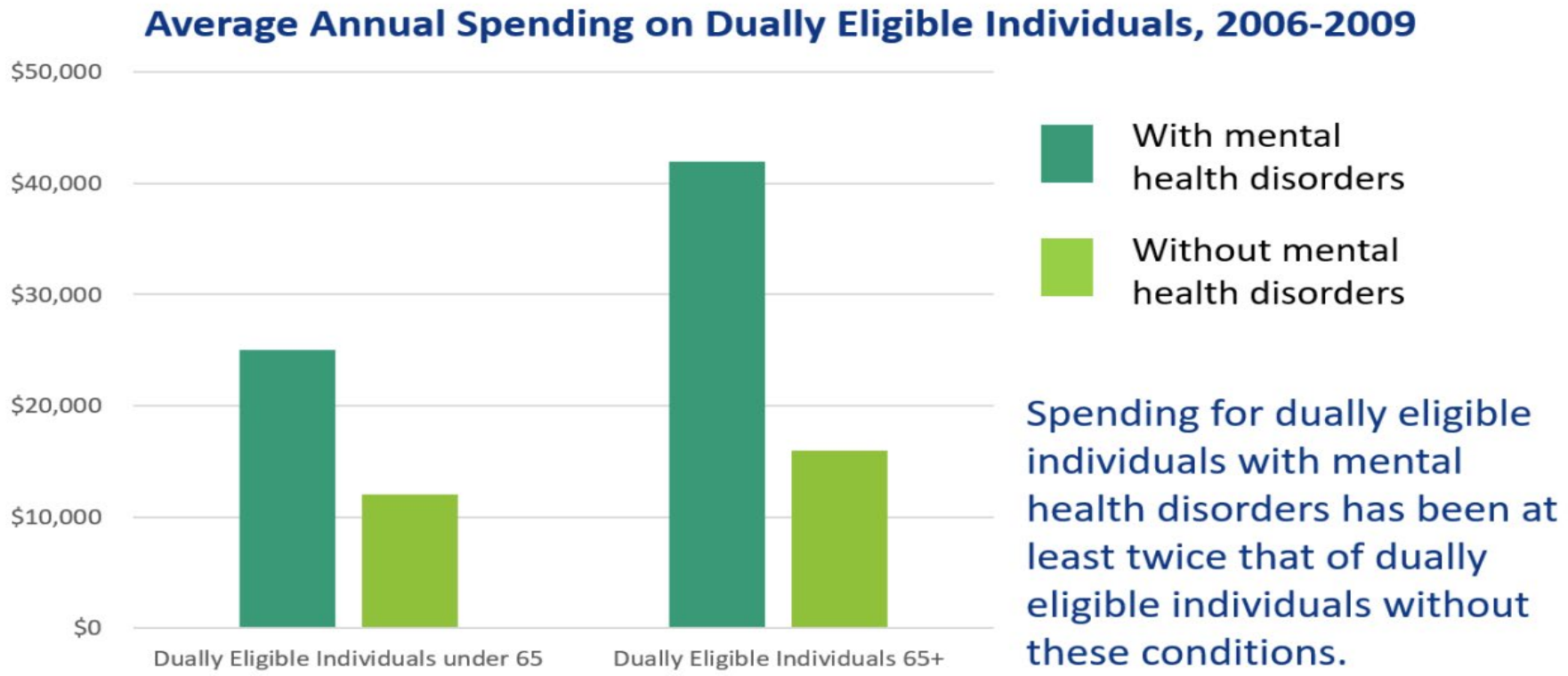

WASHINGTON CONNECTION
your link to services

# DSNP Enrollment Growth

- Overall Medicare Population
  - January 2023
    - 204,264 Total Population
    - 133,085 Full Dual 65% and 71,179 Partial Dual 35%
    - 65,441 Enrolled in D-SNP 32%
  - January 2024
    - 213,614 a 4.6% increase
    - 138,952 Full Dual 65% and 74,662 Partial Dual 35%
    - 109,325 Enrolled in D-SNP 51%



# Comparison of Spending for Dually Eligible Individuals With and Without Mental Health Disorders




Spending for dually eligible individuals with mental health disorders has been at least twice that of dually eligible individuals without these conditions.

**ource:** R. Frank. "Mental Illness and a Duals Dilemma." *Journal of the American Society on Aging*, 37, no. 2 (2013): 47-53.

# Comparison of services as Beneficiaries enrolled into Dual Special Needs Plans

Based on data provided by the ICRC and CMS,

- In 2020, Medicare became the primary payer for dually eligible individuals who receive OUD services from OTPs in states that provide this benefit under Medicaid.
- Starting in 2022 and ongoing OTP providers need to enroll as Medicare providers to receive Medicare payment.
- To prevent payment disruptions during the transition from Medicaid to Medicare as the primary payer for OTP services for dually eligible individuals, CMS has issued guidance to states and OTPs regarding coordination of benefits and third-party liability options.
- CMS has also released guidance to Medicare Advantage plans on strategies to promote continuity of care for dually eligible individuals. See guidance available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service

# DSNP vs. FFS Pharmacy Measures Statewide Rate, 2023

## Why are these measures important?

- Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness and identifying and managing side effects. Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated. (NCQA)
  - *Effective Acute Phase Treatment:* Adults who remained on an antidepressant medication for at least 84 days (12 weeks). (WA FFS rate 7% lower than DSNP rate)
  - *Effective Continuation Phase Treatment:* Adults who remained on an antidepressant medication for at least 180 days. (WA FFS rate 7% lower than DSNP rate)
- Medication non-adherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapse or hospitalization. (NCQA)

| Measure | DSNP Rate 18-64 |
|---|---|
| Antidepressant Medication Mgmt - Acute Phase Tx | 81% |
| Antidepressant Medication Mgmt - Continuation Phase Tx | 69% |
| Adherence to Antipsychotics for Persons with Schizophrenia | 84% |

Washington State Health Care Authority

# Ensuring Quality from the MCOs

# Quality is Key

## Managed Care Quality Structure and Oversight

- TEAMonitor Compliance Review: Technical Reports
- Value-Based Purchasing (VBP) Approach:
  - External quality review organization (EQRO) makes recommendations annually based on current performance
  - Each plan is subject to a 2% withhold of total year funding
    - 75% of the withhold contingent upon each plan's performance – awarded if improved compared to the previous year; or scored in the top nation Medicaid quartile of the performance measures
    - The other 25% is for progress in VBP provider contracting
- EQRO Audit and Comparative Analysis

**Enrollee Engagement**:

- Surveys: RDA and CAHPS
- Community Advisory Councils

**Managed Care report cards**:

- Value-Based Purchasing Quality Report Card – Comparison of Key Metrics
- NCQA Plan Accreditation & Star Rating – Comparison of WA to Nation
- Apple Health Plan Report Card – Comparison of WA MCOs

# NCQA Plan Accreditation & Star Rating

| NAME | RATING | ACCREDITATION STATUS | PLAN TYPE | STATE | ADDITIONAL PROGRAMS |
|---|---|---|---|---|---|
| Community Health Plan of Washington | ★★★½ | Accredited - Under Corrective Action | Medicaid HMO | WA | Electronic Clinical Data<br>Health Equity Accreditation |
| Coordinated Care of Washington, Inc. | ★★★½ | Accredited | Medicaid HMO | WA | Health Equity Accreditation |
| Molina Healthcare of Washington, Inc. | ★★★½ | Accredited | Medicaid HMO | WA | Electronic Clinical Data<br>Health Equity Accreditation |
| UnitedHealthcare of Washington, Inc. (UnitedHealthcare Community Plan (WA)) | ★★★½ | Accredited | Medicaid HMO | WA | Electronic Clinical Data<br>Health Equity Accreditation |
| Wellpoint Washington, Inc. | ★★★½ | Accredited | Medicaid HMO | WA | Electronic Clinical Data<br>Health Equity Accreditation<br>Health Equity Accreditation Plus |

https://reportcards.ncqa.org/health-plans

# Opportunities for Addressing Barriers

# Behavioral Health Medicaid Rates

## Significant Legislative Investments in Medicaid:

| Item | Effective Date | One-time/On-going |
|---|---|---|
| **1. 2% Community BH Rate Increase** | 1-Apr-21 | On-going |
| **2. $100M BH Provider Relief Funds** | 1-Sep-22 | One-time |
| **3. 7% Community BH Rate Increase** | 1-Jan-23 | On-going |
| **4. 32% Opioid Treatment Program Rate Increase** | 1-Jan-23 | On-going |
| **5. 15% Community BH rate increase** | 1-Jan-24 | On-going |
| **6. 22% FFS BH rate increase** | 1-Jan-24 | On-going |
| **7. Psychiatric per diem rebase** | 1-Jan-24 | On-going |
| **8. Room and board rate increase** | 1-Jul-24 | On-going |
| **9. Long-term Civil Commitment (E&T) rate increase** | 1-Jul-24 | On-going |
| **10. 7% PACT rate increase** | 1-Jan-25 | On-going |
| **11. CLIP bed rate increase** | Multiple | On-going |
| **12. PCAP rate increase** | Multiple | On-going |
| | | |
| | | |
| Resources | | |
| Community behavioral health legislative funding increases FAQ (wa.gov) | | |
| Legislatively funded managed care rate increase overview (wa.gov) | | |
| bh-relief-funds-faq-final.pdf (wa.gov) | | |
| https://leap.leg.wa.gov/ | | |

Note about Actuarial soundness and Medicaid Directed Payments:

Medicaid Managed care rates must be actuarially sound, meaning reasonable costs must be included in the rates.

Any instance in which the state directs how a managed care organization pays for services is considered a “directed payment., which include four broad types:

- Uniform dollar increases
- Uniform percent increases
- Maximum fee schedules
- Minimum fee schedules

CMS must approve state directed payments; states must to justify rate increases and demonstrate how changes advance the state’s quality strategy goals.

# Behavioral Rate comparison and Transparency requirements and directed by the Legislature

- Legislature passed HB 2584 in during the 2019 session requiring HCA to work with its contract actuaries to:
  - Verify that targeted behavioral health rate increases are used for the objective stated in the original appropriation
- Budget proviso language further directs HCA to provide opportunities for MCOs, behavioral health administrative service organizations, and behavioral health providers to review and comment on proposed rate changes
- Rate comparison work- Resources for behavioral health providers | Washington State Health Care Authority
  - Legislature approved three phases
  - Preparing to implement a minimum fee schedule based on the comparison rates.

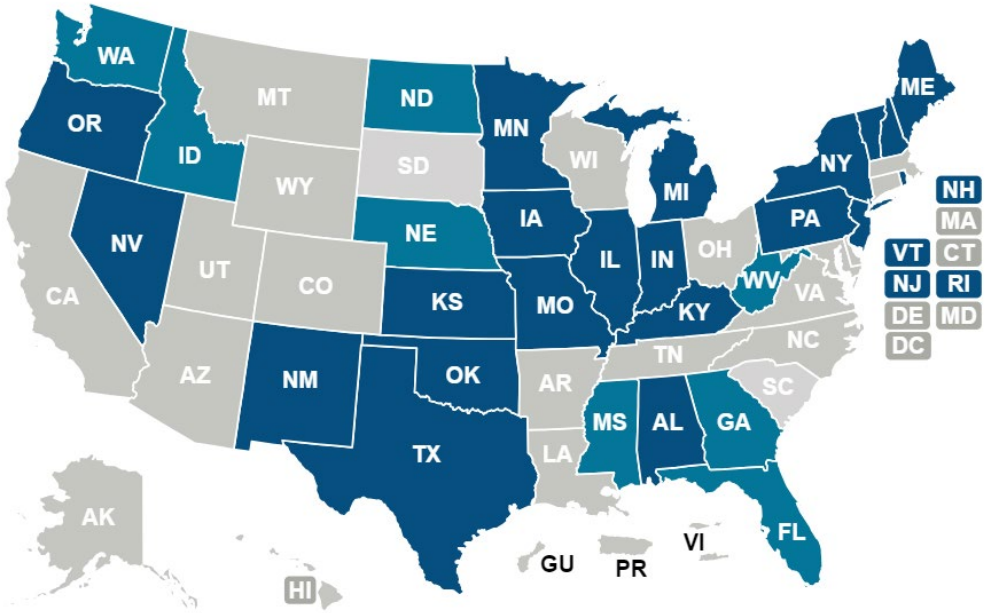
# Future of BH: CCBHC, integrated care

Certified Community Behavioral Health Clinic (CCBHCs) are a new opportunity for behavioral health providers to provide a robust set of services, while getting paid in a new way that makes sure all their costs are covered.

CCBHCs must meet stringent criteria related to timeliness of access, care coordination, quality reporting, staffing and scope of services.

We believe this new model will lead to better health outcomes for individuals and more financial stability for the provider.

https://www.thenationalcouncil.org/program/ccbhc-success-center/ccbhc-locator/



# 2022 APCD commercial claims repriced to % of Medicare

| Health care service | Percent of Medicare |
|---|---|
| Mental health/SUD professional fees | 88% |
| Primary care providers | 149% |
| Specialists | 144% |
| Hospital – Emergency room visit | 309% |
| Hospital – Outpatient surgery | 232% |
| Hospital -- Inpatient surgery | 202% |

# Federal Access to Care Rules

# New Medicaid Access to Care Rules

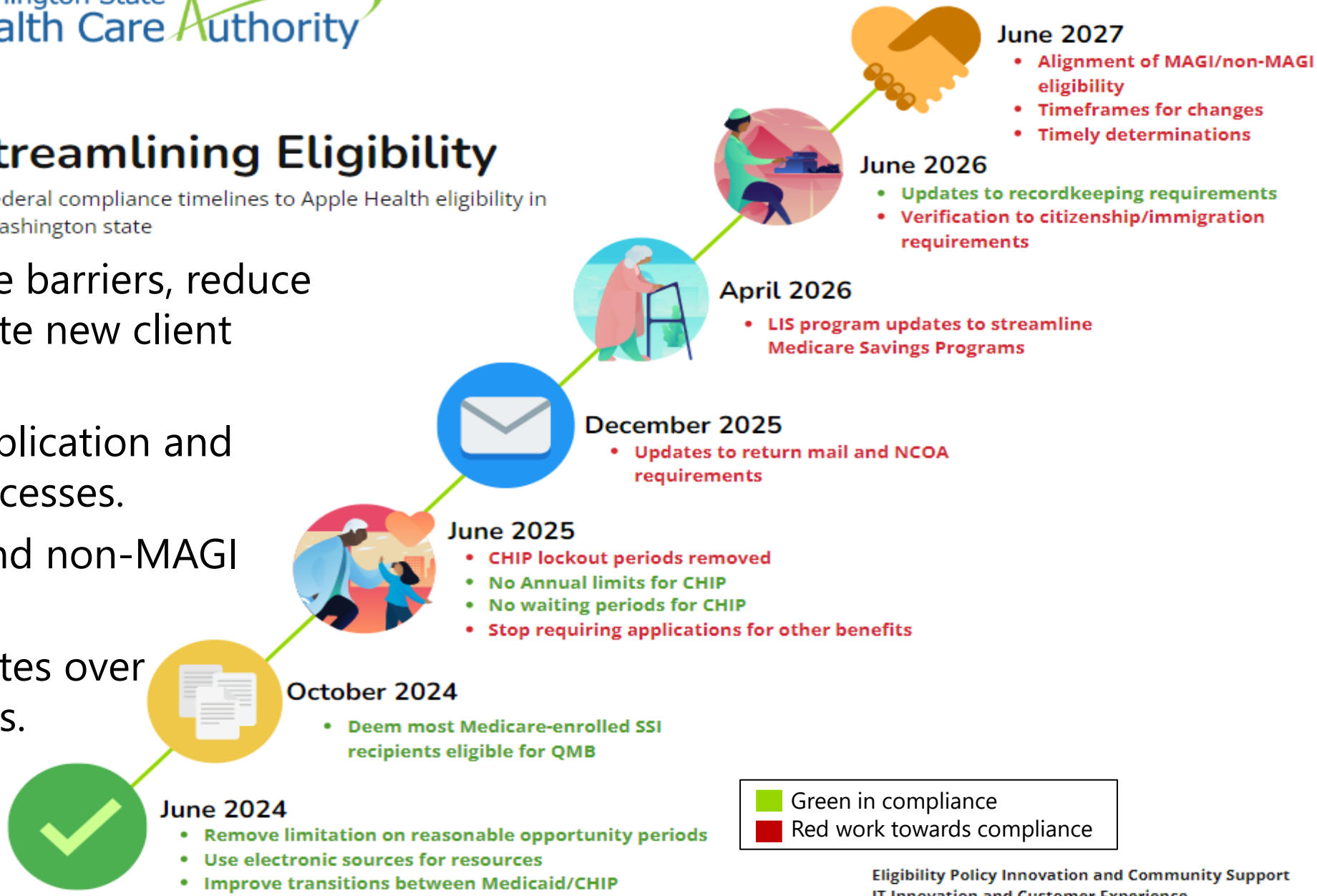
- In April 2024, CMS finalized the Managed Care (MC) Final Rule and the Access Final Rule to develop a comprehensive access strategy in Medicaid
- The rules focus on many different elements of multiple delivery systems, sharing the common goals of improving access to care through eligibility, provider access and fair payment.
- Five main impacts:
  - Eligibility
  - Managed care
  - Fee-For-Service (FFS)
  - Delivery System and the Home and Community Based Services (HCBS) Delivery System
  - Medicare Dually-eligible Special Need Plan (DSNP) alignment requirements increase for January 2025 special enrollment periods
- Although the final rules take effect in July 2024, CMS has defined implementation deadlines for each of the new rules spanning over the next six years.

Washington State Health Care Authority

# Streamlining Eligibility

Federal compliance timelines to Apple Health eligibility in Washington state

- Aims to remove barriers, reduce churn and create new client protections.
- Streamlines application and enrollment processes.
- Aligns MAGI and non-MAGI programs.
- Compliance dates over next three years.





Eligibility Policy Innovation and Community Support
IT Innovation and Customer Experience
Health Care Authority
May 2024

# Categories of work and key provisions

## Network/access

- Provider directory
- Appointment wait time standards
- Secret shopper
- Website accessibility
- Duals/DSNP

## Finance

- State Directed Payments (SDP)
- Medical Loss Ratio (MLR)
- Provider payment rate analysis
- In Lieu of Services (ILOS)
  - Crosses over into Quality

## Quality

- External Quality Review (EQR)
- Quality Rating System (QRS)
- MC State Quality Strategies
- Quality Assessment and Performance Improvement (QAPI)

## Community Engagement

- Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC)
- Enrollee experience surveys

# Implementation Timeline

**July 2024**

- SDP Payment Methodologies
- Codify Average Commercial Rate (ACR)
- Establish SDP Appeals Process
- EQR PCCM exemption
- New optional EQR activities
- QAPI Technical Changes

**Sept 2024**

- SDP Reporting Requirements
- MLR Standards
- ILOS contract requirements

**July 2025**

- MLR Standards
- MC State Quality Strategy
- Expand the scope of the MAC and establish the BAC
- DSNP alignment

**Dec 2025**

- EQR publishing and reporting additional data

**July 2026**

- SDP preprint submission and contract requirements
- Analysis of Provider Payment Rates in MC
- Website Transparency
- Enrollee Experience Surveys for CHIP

**July 2027**

- SDP Payment Methodologies
- SDP Evaluation Plan Standards and Report Requirement
- Appointment Wait Time Standards
- Enrollee Experience Surveys for Medicaid
- Submit first MAC and BAC report

**January 2028**

- SDP Non-Federal Share Financing – provider attestation

**July 2028**

- SDP contract submissions
- Secret Shopper Surveys
- Remedy Plans to Improve Access

**Dec 2028**

- QRS: Phase 1

**Dec 2030**

- QRS: Phase 2

Network/ access

Finance

Quality

Community Engagement