Medicaid Transformation Project One-Year Extension Concept

Title XIX Advisory Committee

November 13, 2020

Washington State Health Care Authority

Agenda

- Introduction
- Overview of COVID Extension Year concept
- Timeline and Next Steps

Washington State Health Care Authority

Medicaid Transformation Project

- Five-year 1115 Medicaid waiver to implement several initiatives
  - Initiative one: Delivery system transformation through Accountable Communities of Health (ACHs) and Indian Health Care Providers (IHCPs)
  - Initiative two: Long term services and supports
  - Initiative three: Foundational Community Supports
  - Initiative four: Enhanced federal funding for substance use disorder treatment
  - Initiative five *(pending approval)*: Enhanced federal funding for mental health treatment

How this extension concept emerged

- MTP is in full implementation (Year 4) and things are going well with some promising early results
- COVID-19 created significant disruption and opportunities to address the pandemic
- The state and partners could benefit from additional implementation and evaluation time due to initial startup and planning delays, in addition to recent disruptions
- Additional funding is potentially available without “new” authorization from CMS

Overview of the COVID Extension Year

- The state will pursue a one-year extension across all MTP initiatives
- This extension would allow the state to utilize federal funding in the additional year (2022) that would otherwise go unspent
- This includes the potential for additional Delivery System Reform Incentive Payment (DSRIP) ACH and IHCP funding
- This sixth year would present a new opportunity to focus on essential activities and transition to a future state

Approval Processes

- CMS
  - Responsible for approving extended waiver authority and program budget
  - Negotiations to start in early 2021 after a formal application

- WA State Legislature
  - Responsible for approving spending authority in the biennial budget process to allow the state to access available federal funding

Beyond the COVID Extension Year

- This one-year extension will not preclude the state from pursuing a long-term extension in the future

- CMS has been clear that a longer-term extension would not include DSRIP, although this approach extends the possibility of a future DSRIP program in the event this stance changes

Timeline and next steps:

- Preliminary concept paper submitted to CMS for staff feedback – **September 1, 2020**
- Tribal consultation – **October through Final Application Submission**
- MTP extension decision package to OFM – **September 14, 2020**
- Legislative engagement – **Fall and Winter 2020**
- Public comment – **Fall 2020**
- Final extension application to CMS – **December 31, 2020 (target)**
- CMS negotiations – **Final Submission and through 2021**

Thank you!

Questions?

General inquiries:
medicaidtransformation@hca.wa.gov

Washington State Health Care Authority

State Opioid & Overdose Response Plan Update

Title XIX Committee Meeting

November 13th, 2020

Washington State Health Care Authority

Kris Shera – State Opioid Coordinator
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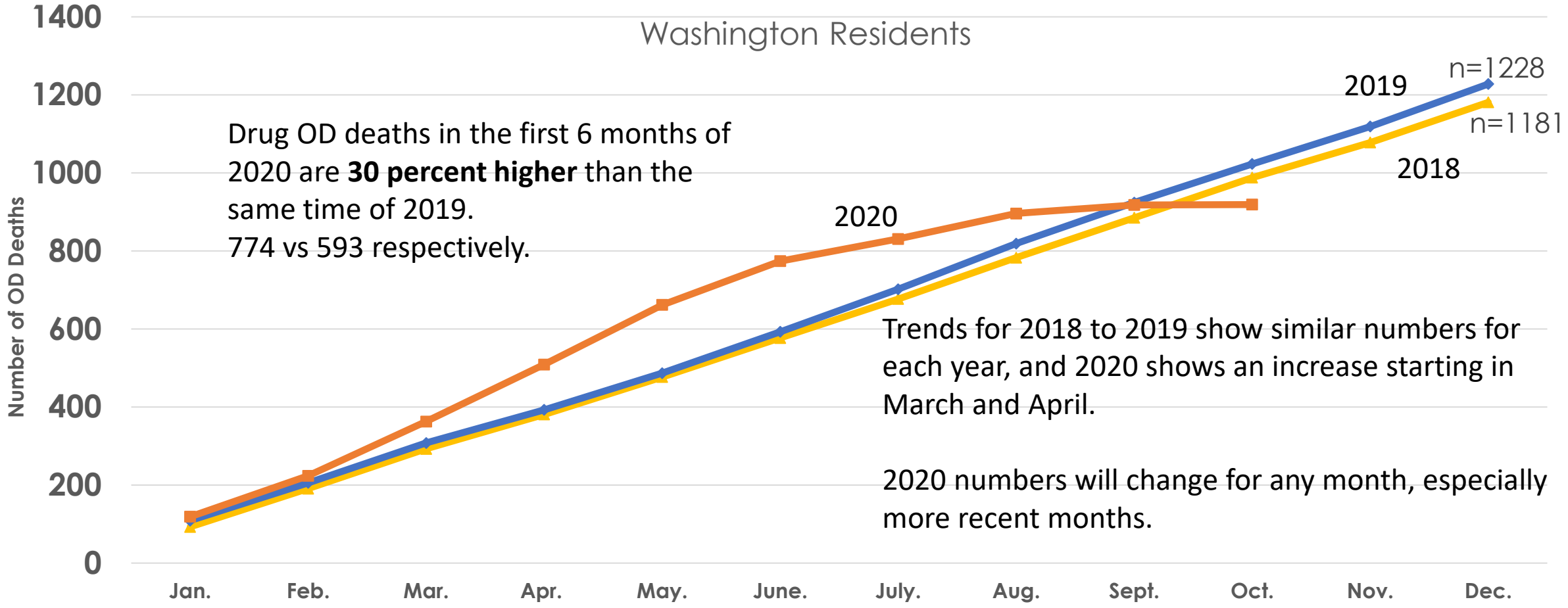
Washington State Health Care Authority

Agenda

- Brief Overview of statewide overdose trends
- State Opioid & Overdose Response Plan
- Roadmap to Recovery

Annual cumulative overall drug overdose deaths by month (2018-2020*)

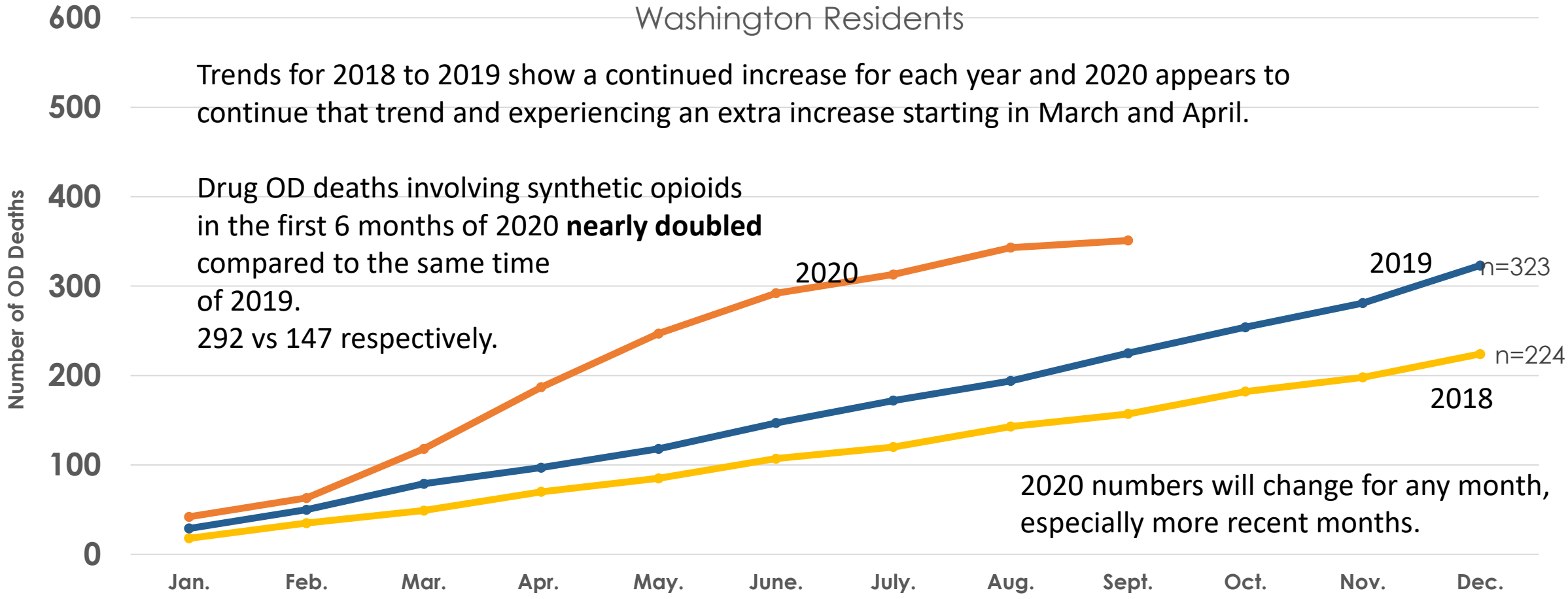


- 2019 & 2020 data not finalized.
- Data run: 19Oct2020

Washington State Department of Health

Source: DOH death certificates

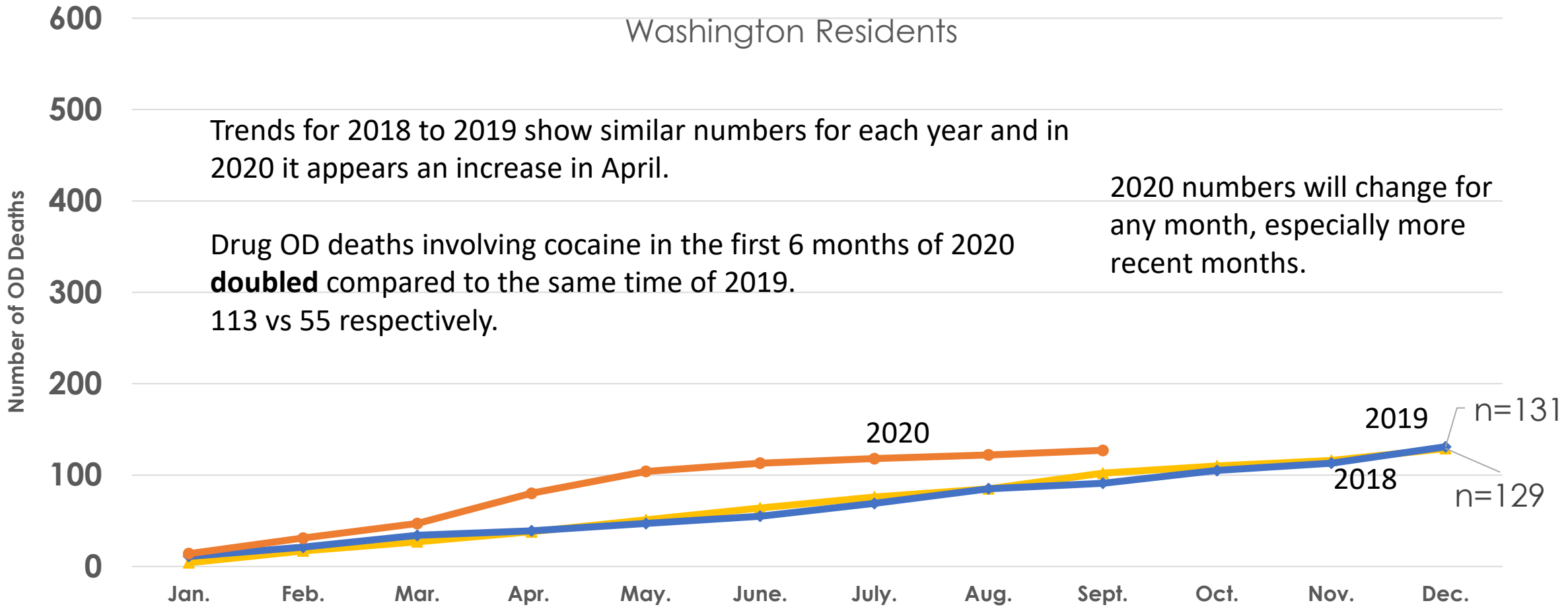
Annual cumulative drug overdose deaths involving non-methadone synthetic opioids by month (2018-2020*)



- 2019 & 2020 data not finalized.
- Data run: 19Oct2020

Source: DOH death certificates

Annual cumulative drug overdose deaths involving cocaine by month (2018-2020*)

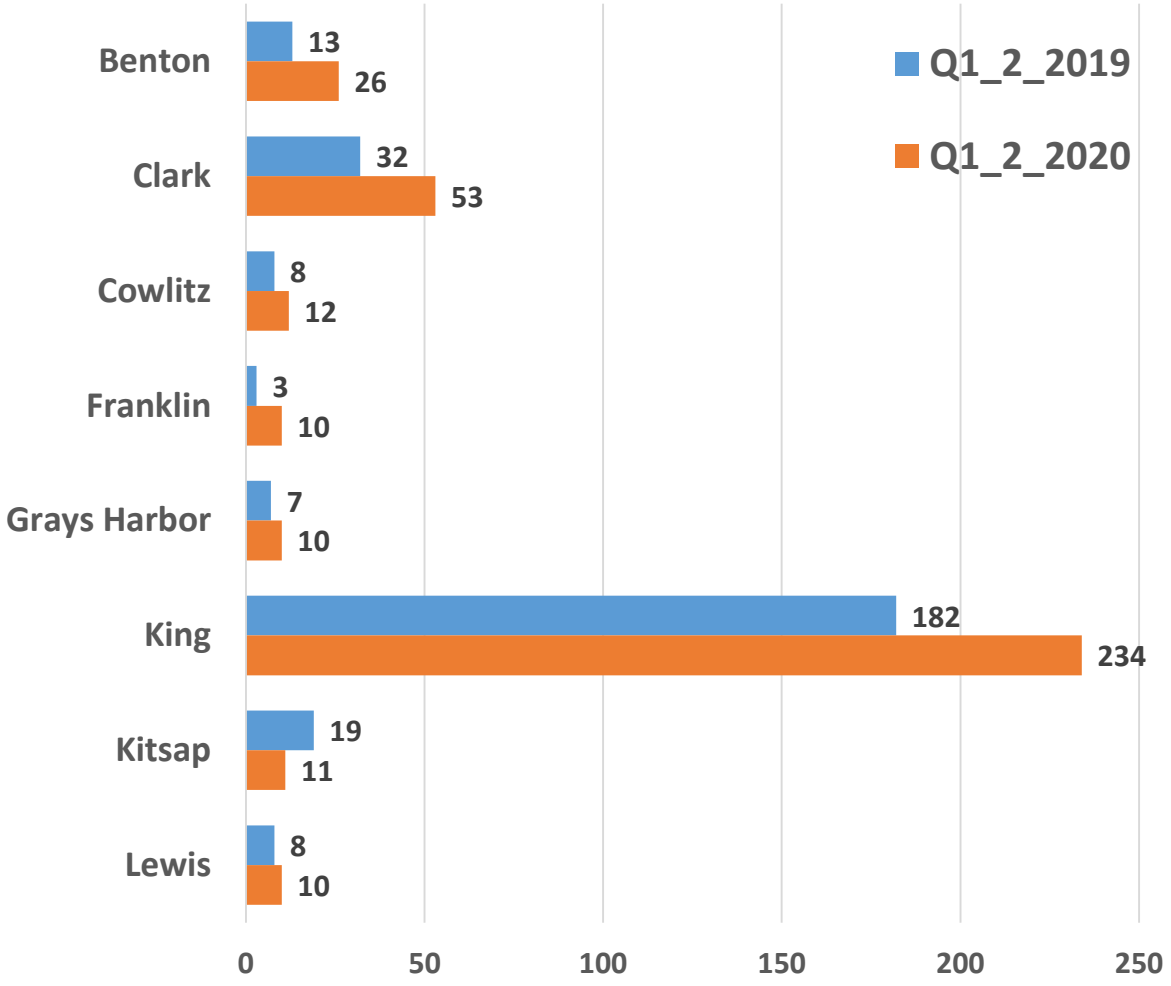


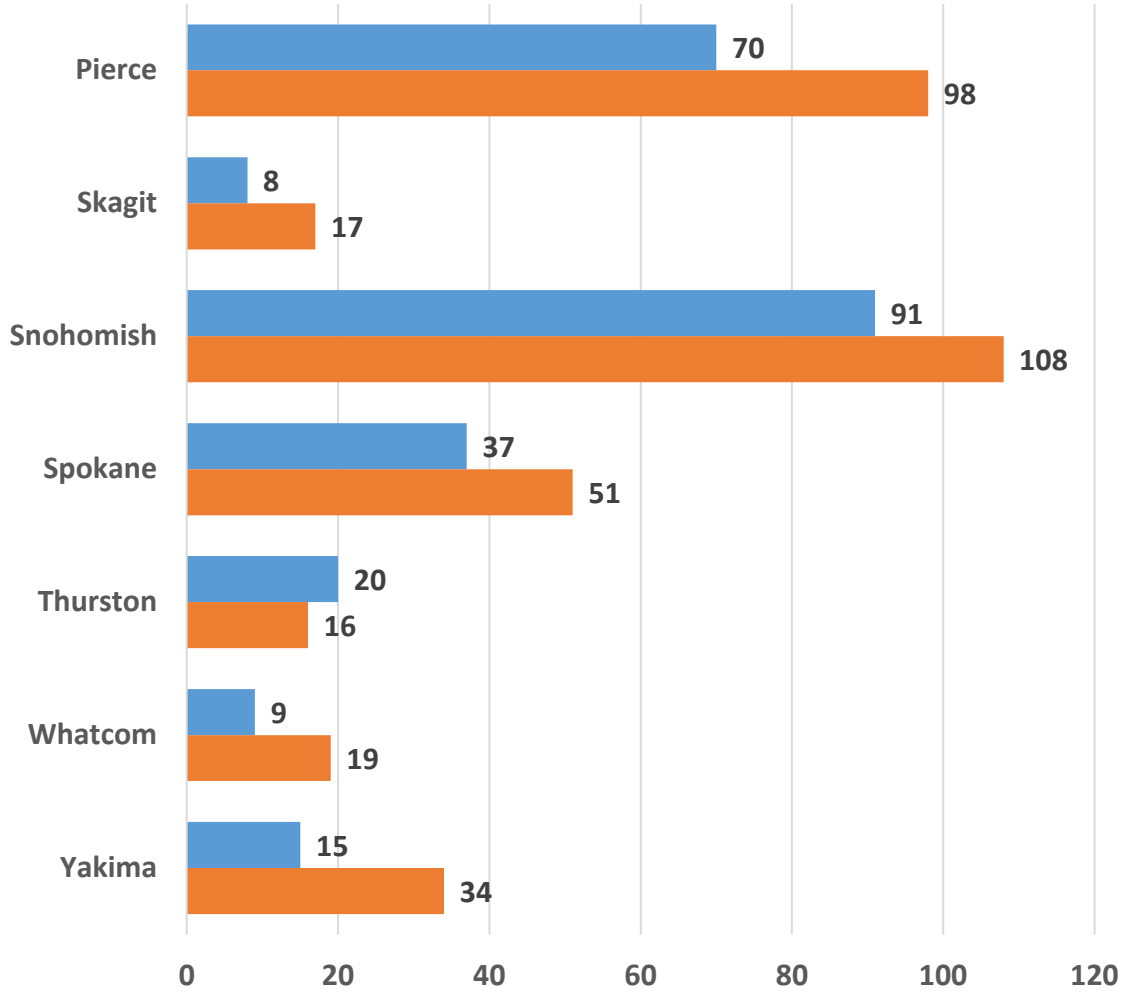
- 2019 & 2020 data not finalized.
- Data run: 19Oct2020

Washington State Department of Health

Source: DOH death certificates

Overall drug overdose death counts by county compare first 6 months of 2019 and 2020

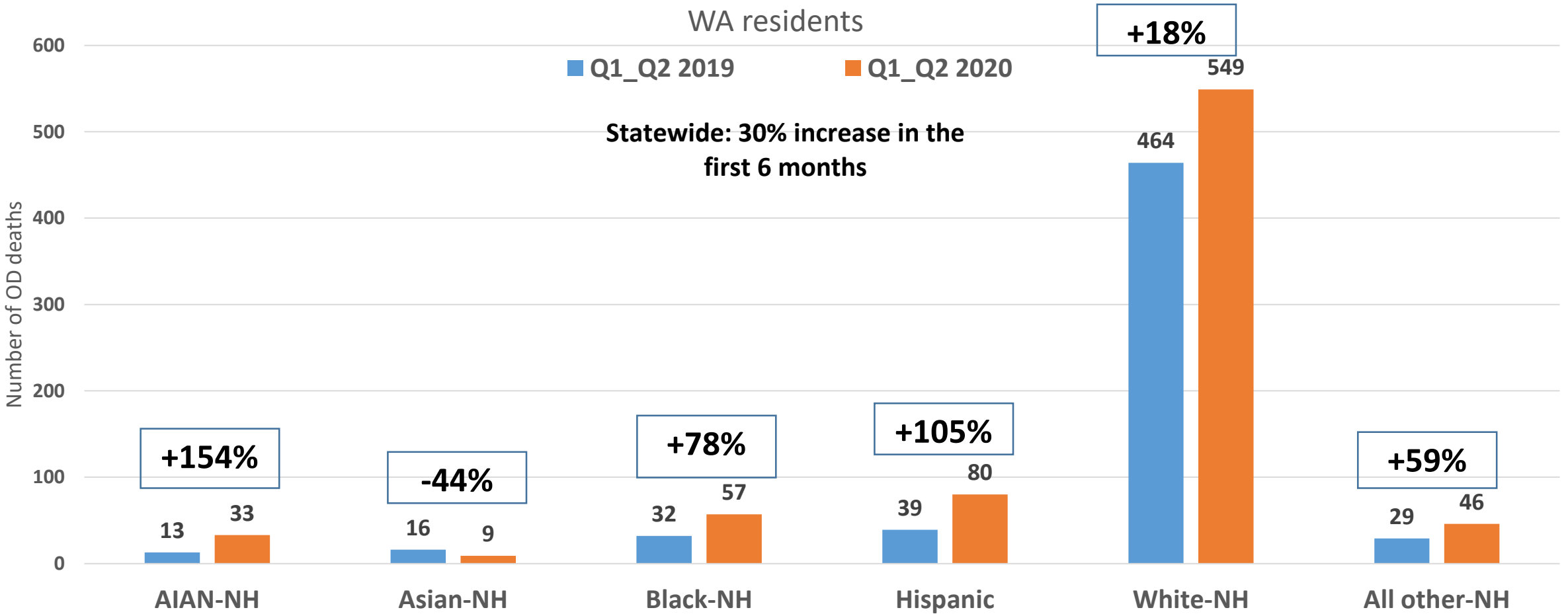




Counties with at least 10 OD deaths in 2019 or 2020
Data for first 6 months of 2019 and 2020.

2019 data is not finalized, and 2020 numbers will change.
Data as of 19Oct2020

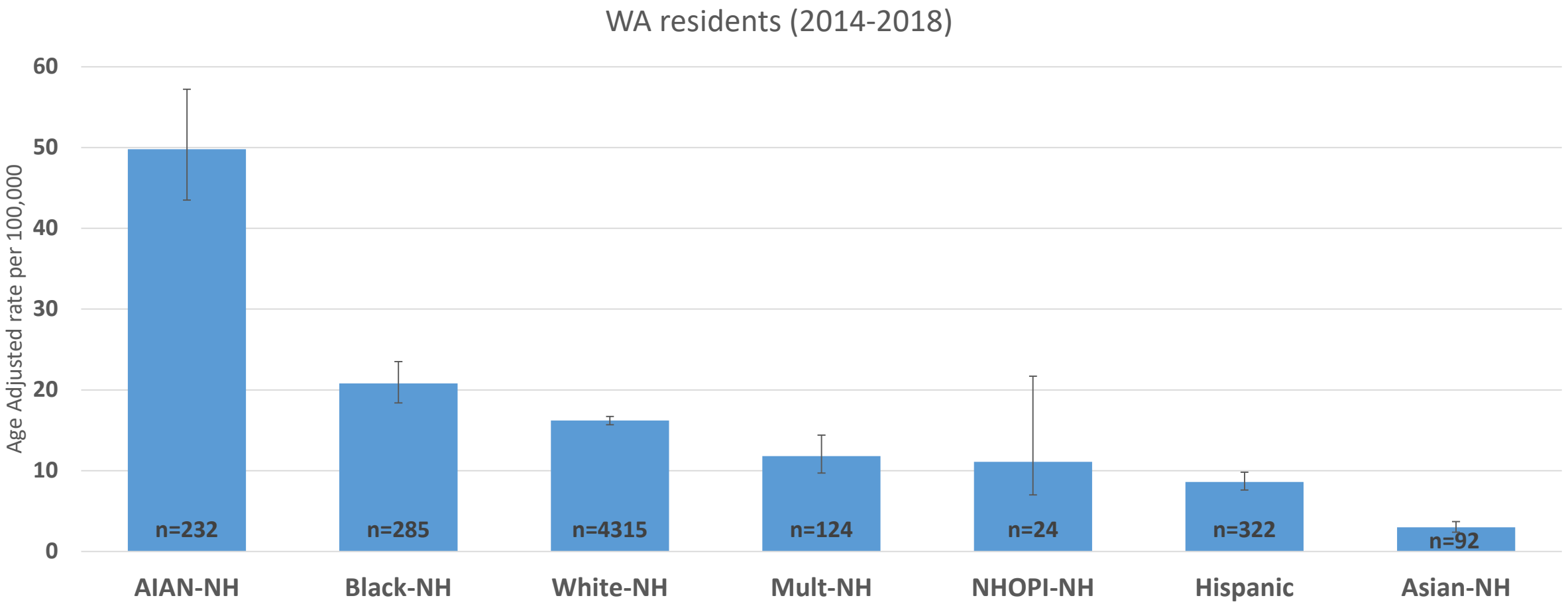
Overall drug overdose death counts by race compare first 6 months of 2019 and 2020



2019 data is not finalized, and 2020 data will change. NH: Non-Hispanic AIAN: American Indian/Alaskan Native
Data as of 19Oct2020

All other includes: Native Hawaiian and other pacific islanders, multi-racial and other (NOS)

Drug overdose deaths disproportionally affect American Indian and Alaskan Native populations



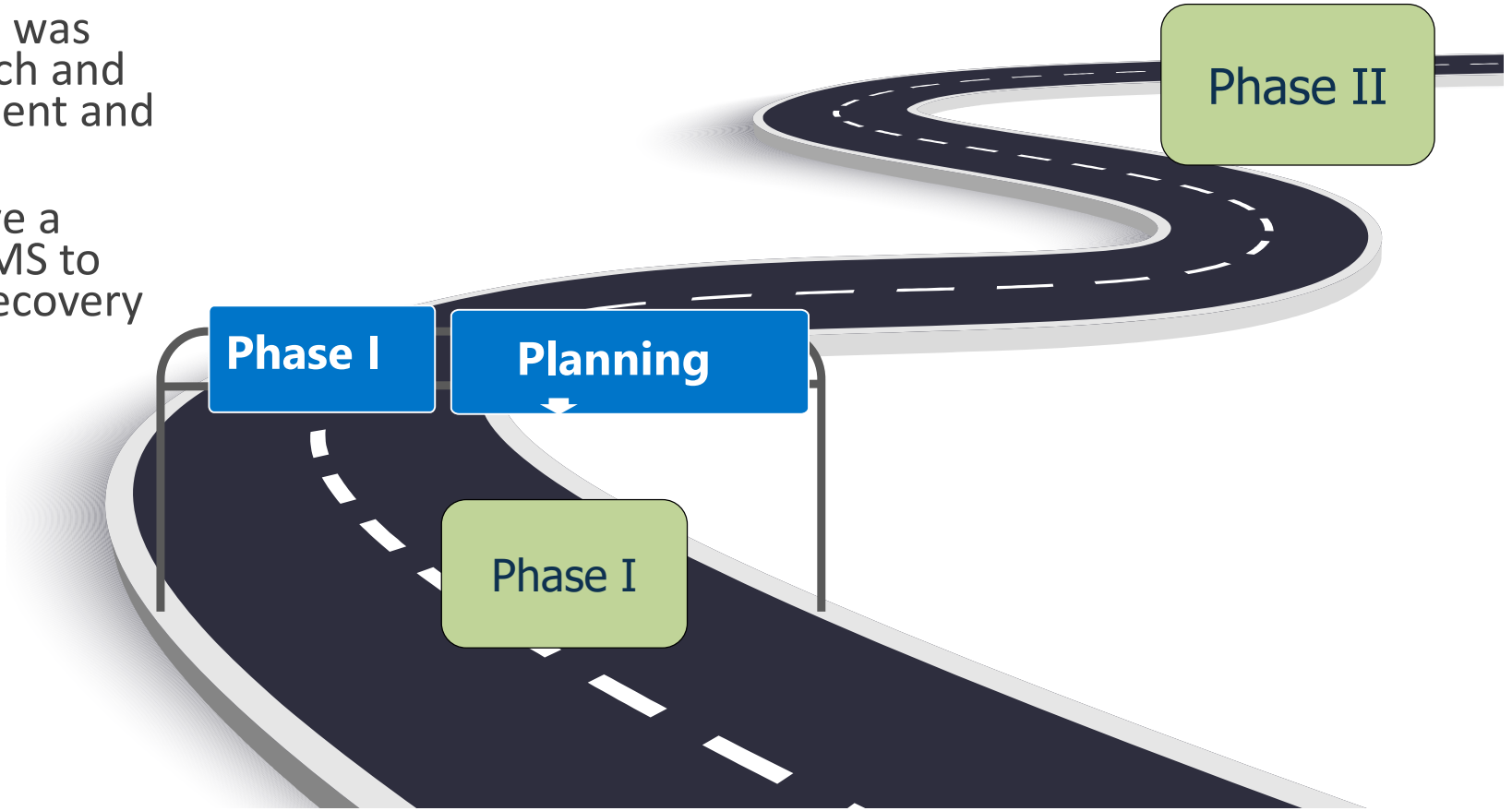
NH: Non-Hispanic
AIAN: American Indian/Alaskan Native

State Opioid & Overdose Response Plan

- Updated plan available this month
- Includes a variety of updates, most notably
  - Health equity and justice
  - Goal 5 – Support individuals in recovery
  - Updated website for planning and meetings
  - Pandemic Planning

Roadmap to Recovery

- In August of 2019 Washington was selected for Phase I – a research and planning grant for SUD Treatment and Recovery Services
- Phase II, if selected, will involve a demonstration project with CMS to provide SUD Treatment and Recovery Services in a new way



Washington State Health Care Authority

State Medicaid agency recipients

SUPPORT ACT SECTION 1003: Planning Grants for the Demonstration Project to Increase Substance Use Provider Capacity

State Medicaid Agency Recipients

Washington State Health Care Authority

Building a policy relevant framework

- Develop framework for integrated Substance Use Disorder Treatment

Types of policy considerations		
Licensure	Certification	Payment policy
Coverage	Workforce	Health IT/HIE

Policy levers considered include:	
Legislative changes	Contracting
Regulatory/Rulemaking activities	RFPs, requests for funding

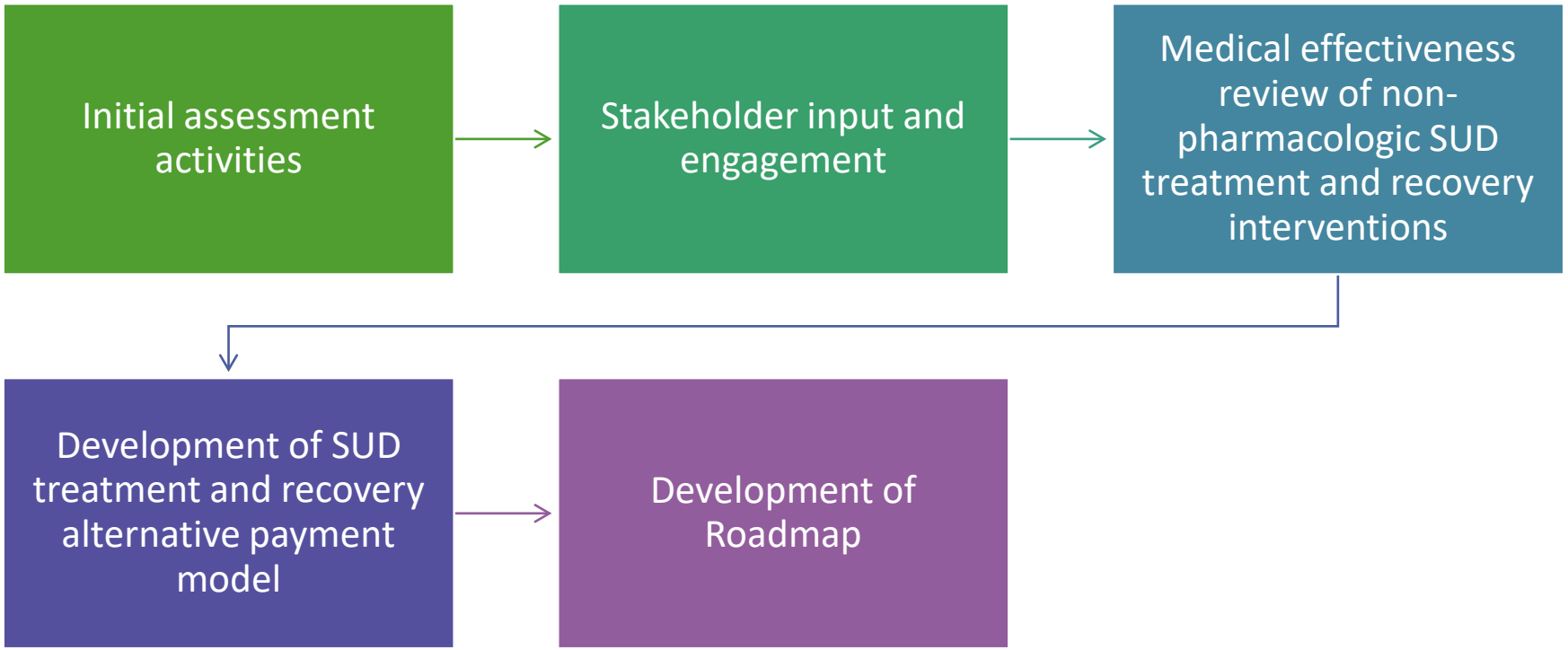
Building upon other resources

- Medicaid transformation efforts
  - ACHs, SUD IMD Waiver, MH IMD Waiver
- Behavioral Health programs
  - STR/SOR
  - OTPs, OTNs, Hub & Spoke
  - Foundational Community Supports
- Health IT (HIT) and health information exchange (HIE)
- Value based payments
- Work related to PPW supported by federal, state, local sources

Populations of Interest

- Medicaid beneficiaries with SUD, including OUD include:
  - Pregnant and post-partum women with SUD
  - Adolescents, age 13-18
  - Transition Age Youth Adults (TAYA), age 16-25
  - Individuals who receive services at syringe service programs (SSPs)
  - American Indian and Alaska Natives with SUD/OUD
  - Justice involved individuals
  - Those experiencing homelessness

Roadmap to Recovery Tasks



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Roadmap to Recovery project map

Initial assessment	Stakeholder input	Non-pharmacologic	Alternative payment model	Roadmap development
• What data exist showing success for programing?	• Role and capacity for staff in community for providing programming? What services does your community need, support?	• What does the literature say about the effectiveness of services or programming?	• If effective, how would and APM take into account use of services?	• If effective, what licensing, coverage, payment, workforce, and HIT/HIE policy changes are needed to enable statewide?

Questions?

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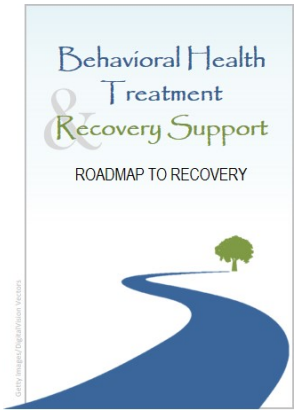
Washington State Health Care Authority



Washington State Behavioral Health Treatment and Recovery Support Services Utilization

Roadmap to Recovery Planning Grant Current State Assessment

Katie Bittinger, PhD • Elizabeth Greener, PhD • Barbara Lucenko, PhD • Barbara Felver, MES, MPA

Report to the Health Care Authority §1003 SUPPORT ACT Roadmap to Recovery Planning Grant Steering Committee Co-Chairs, Dr. Charissa Fotinos and Dr. Keri Waterland.

IN SEPTEMBER 2019, the Centers for Medicare and Medicaid Services (CMS) awarded Washington state $3.8 million under the §1003 SUPPORT ACT to develop a policy framework. This framework will guide future activities to advance statewide whole-person, integrated substance use disorder (SUD) treatment and recovery service improvements. An understanding of the current utilization of behavioral health treatment and recovery support services is crucial to identifying both strengths and gaps in the existing behavioral health system in Washington. This report responds to these questions:

- **What is the prevalence of substance use disorder and opioid use disorder among Medicaid beneficiaries? Does the prevalence vary across the Medicaid population?**
- **What is the penetration rate for behavioral health treatment and what types of treatment services are Medicaid beneficiaries using?**
- **How do physical health outcomes differ among Medicaid beneficiaries with different types of behavioral health treatment needs?**

The SUPPORT ACT is primarily focused on the experience of all Medicaid beneficiaries with SUDs and opioid use disorders (OUDs). However, it also identifies target populations, such as pregnant and postpartum women, and persons experiencing homelessness, which are discussed in this report.

Key Findings

1. **The prevalence of SUD and OUD diagnoses among Medicaid beneficiaries varies depending on the population.** While some Medicaid populations have lower prevalence rates of SUD/OUD diagnoses (such as the Classic, Non-Disabled Medicaid population), other populations have much higher prevalence rates (such as pregnant/postpartum women or those involved in the criminal justice system).
2. **While use of treatment has increased, there is considerable variability in the type of treatment received.** Overall, use of SUD and OUD treatment services has increased from state fiscal year (SFY) 2017 to SFY 2019. However, the increase is not equal across populations or treatment types.
3. **Medicaid beneficiaries with SUD and OUD diagnoses have worse physical health and social outcomes.** Across measures of physical health and social outcomes, Medicaid beneficiaries with SUD or OUD diagnoses fare worse than those with a mental health (MH) diagnosis, serious mental illness (SMI) diagnosis, or no behavioral health diagnoses. In particular, those with SUD or OUD diagnoses have higher rates of emergency department and inpatient services utilization and dramatically higher rates of unemployment, arrests, and homelessness.

Data and Methods

All data is drawn from the Department of Social and Health Service's Integrated Client Database (ICDB). The ICDB contains data from several state administrative data systems, including the State's ProviderOne data system that contains Medicaid claims and encounter data.[1] Adult and child Medicaid beneficiaries (ages 0 to 64) with SUDs and/or OUDs[2] are the primary focus of the SUPPORT ACT. Within this population, there are seven target populations:

- Pregnant and postpartum women.
- Adolescents age 13 to 18.
- Transition Age Young Adults (TAYA) age 16 to 25.
- Persons who receive services at Syringe Services Programs.
- American Indian and Alaska Natives (AI/AN).
- Justice-involved persons.
- Individuals experiencing homelessness or unstable housing.

Utilization of services at Syringe Services Programs is not captured in state administrative data systems. Thus, individuals who utilize Syringe Services Programs are not included as a specific target population in these analyses. Individuals experiencing homelessness or unstably housing are reported as two categories: a narrow definition of homelessness defined as homeless without housing and a broader view of housing instability that includes persons experiencing either homelessness or housing instability. Additional information about how the target populations are defined is included in the Technical Notes section at the end of the report.

Medicaid beneficiaries with a non-Medicaid primary health care coverage (also referred to as third-party liability) and those who are dually-enrolled in Medicaid and Medicare were excluded from the analyses, as complete health care information may not be available for these individuals. Analyses were further restricted to individuals who met minimum Medicaid enrollment criteria (11 out of 12 months in the measurement year) to meet eligibility requirements for the treatment penetration rates and the physical health outcome metrics.

Prevalence of Substance Use Disorder Diagnoses among Medicaid Beneficiaries

As shown in Tables 1-3 below, the prevalence of SUD and OUD diagnoses is not evenly distributed throughout the Medicaid population. Table 1 focuses on differences in the number of Medicaid beneficiaries with an SUD diagnosis or an OUD diagnosis by age, race/ethnicity, gender, and Medicaid coverage type. Table 2 focuses on differences in SUD and OUD diagnosis prevalence across rural/urban regions and Integrated Managed Care (IMC) regions. Table 3 describes differences in SUPPORT ACT target populations. In each table, the general Medicaid population (including both those with and without SUD/OUD diagnoses) is included for comparison purposes.

TABLE 1.

Substance Use Disorder or Opioid Use Disorder Diagnoses among Medicaid Beneficiaries

By Demographics, SFY 2019

	Medicaid Beneficiaries		Medicaid Beneficiaries with a Substance Use Disorder Diagnosis		Medicaid Beneficiaries with an Opioid Use Disorder Diagnosis	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Population Size	1,226,959	—	139,560	—	53,345	—

[1] See, DSHS Integrated Client Databases, DSHS Research and Data Analysis Division, Mancuso, March 2020.
[2] Medicaid Beneficiaries with OUD are a subset of Medicaid Beneficiaries with SUD.

	Medicaid Beneficiaries		Medicaid Beneficiaries with a Substance Use Disorder Diagnosis		Medicaid Beneficiaries with an Opioid Use Disorder Diagnosis	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Age						
17 and Younger	633,941	52%	10,897	8%	623	1%
18 to 24	117,807	10%	15,007	11%	3,274	6%
25 to 34	160,206	13%	38,792	28%	19,004	36%
35 to 44	120,367	10%	30,371	22%	14,172	27%
45 to 54	96,159	8%	24,013	17%	9,084	17%
55 to 64	96,754	8%	20,334	15%	7,132	1%
65 and Older	1,725	<1%	146	<1%	56	<1%
Race/Ethnicity						
White, Non-Hispanic	540,235	44%	88,226	63%	37,362	70%
Any Minority	562,415	46%	45,123	32%	14,237	27%
African American	105,399	9%	12,084	9%	3,380	6%
Hispanic/Latino(a)	292,069	24%	17,193	12%	4,615	9%
Asian American	56,054	5%	2,134	2%	602	1%
Native Hawaiian or Pacific Islander	39,523	3%	2,077	1%	582	1%
American Indian or Alaskan Native	55,716	5%	11,572	8%	4,988	9%
Other	185,517	15%	10,077	7%	2,554	5%
Unknown Race	89,983	7%	2,820	2%	662	1%
Gender						
Female	642,128	52%	67,559	48%	27,553	52%
Male	584,831	48%	72,001	52%	25,792	48%
Medicaid Coverage Type						
Classic, Non-Disabled	741,275	60%	33,403	24%	10,120	19%
Disabled	84,470	7%	21,828	16%	8,821	17%
New Adult	400,591	33%	84,294	60%	34,399	64%

Age. While over half of all Medicaid beneficiaries are 17 years old or younger, only 8 percent of those with an SUD diagnosis and only 1 percent of those with an OUD diagnosis are under the age of 18. Medicaid beneficiaries between the ages of 25 and 44 years old accounted for 50 percent and 63 percent of the SUD and OUD diagnoses, respectively. A smaller, but not insubstantial, number of Medicaid beneficiaries 55 and older (approximately 15 percent) had an SUD diagnosis, while less than 2 percent had an OUD diagnosis. It is important to note that Medicaid beneficiaries dually-enrolled in Medicare are not included in this analysis. This may result in an undercounting of those with an SUD and/or OUD diagnosis, particularly among the older population.

Race/Ethnicity. A higher proportion of white, Non-Hispanic Medicaid beneficiaries have an SUD or OUD diagnoses compared to the general Medicaid population. Medicaid beneficiaries who identify with any other race/ethnicity have a lower proportion of SUD or OUD diagnoses. However, Medicaid beneficiaries may identify with more than one race/ethnicity and the broad "Any Minority" category obscures important differences in diagnosis rates. American Indian/Alaskan Native Medicaid beneficiaries have a higher proportion of SUD and OUD diagnoses (8 and 9 percent) compared to their proportion of the population (5 percent). Medicaid beneficiaries who identify as Hispanic/Latino(a), Asian American, and/or Native Hawaiian/Pacific Islander have a lower proportion of SUD and OUD diagnoses compared to their proportion of the Medicaid population.

Gender. The proportion of males/females is generally consistent across all populations. Of the whole Medicaid population, 52 percent are female. Of those with SUD diagnoses, 48 percent are female. Medicaid beneficiaries with OUD diagnoses are 52 percent female.

Medicaid Coverage Type. The New Adult (Affordable Care Action expansion population) and Disabled Medicaid populations have substantially higher proportions of Medicaid beneficiaries with an SUD or OUD diagnosis. The New Adult population represents 33 percent of the whole Medicaid population, but represents 60 percent of those with an SUD diagnosis and 64 percent of those with an OUD diagnosis. Similarly, the Disabled coverage type population represents only 7 percent of the Medicaid population, but 16 and 17 percent of those with an SUD and OUD diagnosis. In comparison, the Classic, Non-Disabled coverage population is 60 percent of the Medicaid population but only 24 and 19 percent, respectively, of the SUD and OUD diagnosis population.

TABLE 2.

Substance Use Disorder or Opioid Use Disorder Diagnoses among Medicaid Beneficiaries
By Geography, SFY 2019

	Medicaid Beneficiaries		Medicaid Beneficiaries with a Substance Use Disorder Diagnosis		Medicaid Beneficiaries with an Opioid Use Disorder Diagnosis	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Population Size	1,226,959	—	139,560	—	53,345	—
Urban/Rural						
Urban	737,909	60%	85,872	62%	34,797	65%
Rural	488,114	40%	53,598	38%	18,516	35%
Integrated Managed Care Region						
Salish	52,408	4%	7,058	5%	2,688	5%
Great Rivers	64,600	5%	8,779	6%	3,293	6%
Thurston-Mason	51,517	4%	6,206	4%	2,255	4%
North Sound	173,522	14%	20,428	15%	9,430	18%
King	248,884	20%	26,476	19%	10,999	21%
Pierce	143,041	12%	16,399	12%	6,228	12%
Southwest	82,730	7%	7,693	6%	2,440	5%
North Central	61,499	5%	5,267	4%	1,489	3%
Greater Columbia	169,095	14%	15,008	11%	4,202	8%
Spokane	131,546	11%	15,921	11%	5,982	11%

Urban/Rural. Urban areas have a higher proportion of total Medicaid beneficiaries, persons with SUD diagnoses, and persons with OUD diagnoses compared to rural areas. Two-thirds of Medicaid beneficiaries with an OUD diagnosis reside in urban areas, while 35 percent reside in rural areas.

Integrated Managed Care (IMC) Regions. In general, the proportion of Medicaid beneficiaries with SUD and OUD was consistent with the distribution of Medicaid beneficiaries across the IMC Regions. Regions with more Medicaid beneficiaries tend to have more Medicaid beneficiaries with an SUD or OUD diagnosis (e.g. King and Pierce) and vice versa (e.g. Salish, Great Rivers, and Thurston-Mason). There are some notable exceptions. Both the Southwest and North Central regions tended to have fewer Medicaid beneficiaries with SUD and OUD diagnoses compared to their proportion of the population. The North Sound IMC Region has 14 percent of the Medicaid population, but 18 percent of Medicaid beneficiaries with an OUD diagnosis. Conversely, the Greater Columbia region has 14 percent of the Medicaid population, but only 8 percent of Medicaid beneficiaries with an OUD diagnosis.

Table 3 highlights the differences in SUD and OUD diagnoses among Medicaid beneficiaries in six target populations: pregnant and/or postpartum women; adolescents; transition age young adults; American Indian/Alaskan Native; Criminal Justice involved persons; and those experience homelessness (reported as two categories – homelessness and homelessness/unstably housed). Overall, there are distinct differences in the proportion of these populations in the overall Medicaid population and those with SUD and OUD diagnoses, with most target populations being over-represented among those with SUD and OUD diagnoses.

TABLE 3.

Substance Use Disorder or Opioid Use Disorder Diagnoses among Medicaid Beneficiaries

By Populations of Interest, SFY 2019

	Medicaid Beneficiaries		Medicaid Beneficiaries with a Substance Use Disorder Diagnosis		Medicaid Beneficiaries with an Opioid Use Disorder Diagnosis	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Population Size	1,226,959	—	139,560	—	53,345	—
Populations of Interest						
Pregnant and/or Postpartum Women	36,664	3%	8,164	6%	3,000	6%
Adolescents (13 to 18 Years Old)	194,260	16%	9,792	7%	545	1%
TAYA (16 to 25 Years Old)	193,392	16%	22,302	16%	4,574	9%
American Indian or Alaskan Native	55,716	5%	11,572	8%	4,988	9%
Criminal Justice Involved Persons	43,202	4%	27,635	20%	13,662	26%
Homeless without Housing	38,878	3%	20,300	15%	10,192	19%
Homelessness or Unstably Housed	96,463	8%	40,632	29%	19,336	36%

Pregnant and/or Postpartum Women. Women who are pregnant or within 60 days postpartum make up 3 percent of the Medicaid beneficiaries in Washington. However, they are 6 percent of those with an SUD diagnosis and 6 percent of those with an OUD diagnosis.

Adolescents (13 to 18 years Old). Adolescents, aged 13 to 18 years old, are 16 percent of the Medicaid population and a disproportionately small proportion of those with an SUD diagnosis (7 percent) and OUD diagnosis (1 percent). This is consistent with the previously reported age breakouts.

TAYA (16 to 25 Years Old). The TAYA group accounts for 16 percent of the Medicaid population, 16 percent of the population with SUD diagnoses, and 9 percent of those with OUD diagnoses. It is important to note that while the TAYA population has a generally proportionate number of SUD diagnoses and a smaller proportion of OUD diagnoses, the proportion of SUD and OUD diagnoses increases dramatically for the 25-34-year-old population. While the 25-34-year-old population makes up 13 percent of the Medicaid population, 28 percent and 36 percent of those with an SUD or OUD diagnosis are ages 25-34. Given that the proportions of SUD and OUD diagnoses increase dramatically at age 25, the TAYA population could be a critical intervention point for decreasing the prevalence of SUD and OUD in the Medicaid population.

American Indian or Alaskan Native. As noted above, the American Indian/Alaskan Native Medicaid population accounts for 5 percent of the total Medicaid population, but 8 percent of those with SUD diagnoses and 9 percent of those with OUD diagnoses.

Persons Involved in the Criminal Justice System. Overall, a relatively small proportion (4 percent) of the Medicaid population was involved with the criminal justice system in SFY 2019. However, 20 percent of those with an SUD diagnosis and 26 percent of those with an OUD diagnosis were involved with the criminal justice system in that same time period.

Persons Experiencing Homelessness or Housing Instability. As with persons involved in the criminal justice system, a small proportion of the Medicaid population experienced homelessness (3 percent) or homelessness/housing instability (8 percent). A substantial proportion of those with an SUD or OUD diagnosis have experienced homelessness or housing instability in the past year. Of those with an SUD diagnosis 15 percent were homeless without housing while 29 percent experience homelessness or housing instability. An even higher proportion of those with an OUD diagnosis experienced homelessness without housing (19 percent) while over a third experienced homelessness or housing instability (36 percent).

Treatment Penetration Rates for Medicaid Beneficiaries with Behavioral Health Treatment Needs

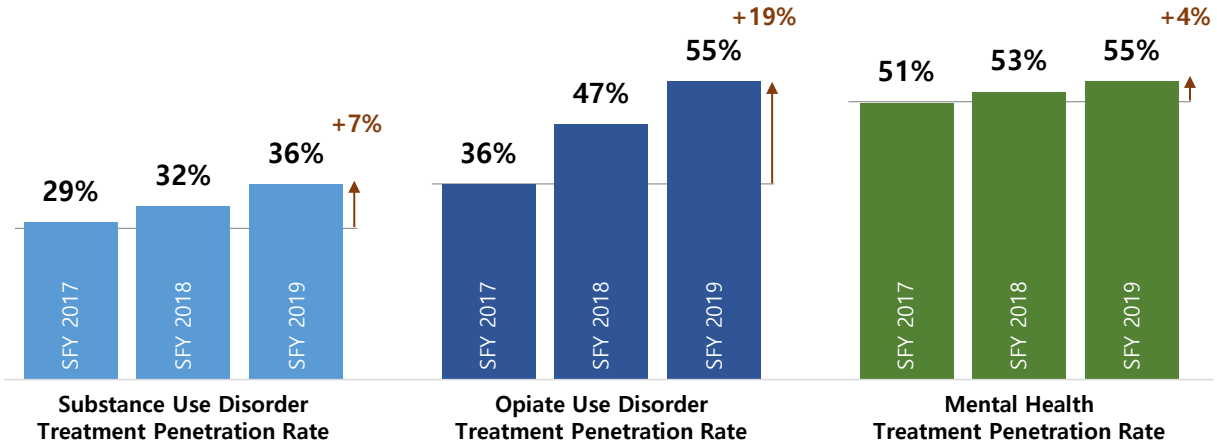
An overarching goal of the SUPPORT ACT is to enhance and expand access to SUD and OUD treatment across the state. To help identify potential gaps in treatment, this report examines treatment penetration rates for SUD and OUD treatment. MH treatment penetration rates are included for comparison purposes (see Technical Notes section for additional information).

- The **Substance Use Disorder Treatment Penetration Rate** (**LIGHT BLUE**) is the percentage of Medicaid beneficiaries with a SUD treatment need identified within the past two years, who received at least one qualifying SUD treatment during the measurement year.
- The **Opioid Use Disorder Treatment Penetration Rate** (**MEDIUM BLUE**) is the percentage of Medicaid beneficiaries with an OUD treatment need identified within the past two years, who received at least one qualifying medication for OUD treatment (Buprenorphine, Naltrexone, Buprenorphine/Naloxone) during the measurement year.
- The **Mental Health Treatment Penetration Rate** (**GREEN**) focuses on Medicaid beneficiaries with a MH treatment need identified within the past two years, regardless of whether they had a co-occurring SUD, who received at least one qualifying MH service during the measurement year.

Understanding current utilization of treatment services is critical to identifying the potential gap among those who may need treatment but are not currently receiving treatment. It is important to remember that not everyone who has a SUD or OUD diagnosis will seek treatment, but understanding current system use can help establish appropriate baselines and/or potential goals for the policy framework. As shown in Figure 1, treatment penetration rates for SUD and OUD have increased among Washington State Medicaid beneficiaries in the last three years.

FIGURE 1.

Washington State Behavioral Health Treatment Penetration Rates



From SFY 2017 to SFY 2019, the OUD treatment penetration rate increased by almost 20 percentage points. This reflects the substantial expansion in the availability of pharmaceutical treatments for OUD. The increase in Buprenorphine availability and changes in prescribing guidelines (removal of prescription time limits and increases in number of prescriptions allowed) contributed to the increase in the OUD treatment penetration rate. While less dramatic than the OUD rate, SUD treatment penetration has also increased over the past three years. MH treatment penetration had more modest increases compared to SUD and OUD penetration rates and increased by only 4% from SFY 2017 to SFY 2019.

Though the increases in treatment rates at the statewide level are encouraging, these rates among Medicaid beneficiaries in general obscure differences across geographies and subpopulations. To examine variability in treatment use across the state and among the populations of interest, the SUD, OUD, and MH treatment penetration rates for each integrated managed care region and target population are detailed in Tables 4 and 5 below. The treatment penetration rates for the broader all Washington Medicaid beneficiaries are included for reference.

TABLE 4.

Trends in Treatment Penetration Rates across Integrated Managed Care Regions

SFY 2017 – SFY 2019

	SFY 2017	SFY 2018	SFY 2019
Substance Use Disorder Treatment Penetration Rate			
All Washington Medicaid Beneficiaries	*29%*	*32%*	*36%*
Salish	31%	34%	37%
Great Rivers	30%	37%	40%
Thurston-Mason	28%	33%	35%
North Sound	34%	38%	41%
King	30%	33%	35%
Pierce	24%	28%	33%
Southwest	32%	36%	37%
North Central	22%	25%	27%
Greater Columbia	24%	29%	32%
Spokane	26%	30%	36%
Opioid Use Disorder Treatment Penetration Rate			
All Washington Medicaid Beneficiaries	*36%*	*47%*	*55%*
Salish	27%	41%	50%
Great Rivers	35%	50%	61%
Thurston-Mason	35%	47%	56%
North Sound	42%	52%	59%
King	44%	51%	55%
Pierce	34%	43%	51%
Southwest	27%	44%	54%
North Central	27%	40%	49%
Greater Columbia	25%	37%	49%
Spokane	38%	49%	59%
Mental Health Treatment Penetration Rate			
All Washington Medicaid Beneficiaries	*51%*	*53%*	*55%*
Salish	52%	55%	57%
Great Rivers	52%	54%	56%
Thurston-Mason	51%	53%	55%

	SFY 2017	SFY 2018	SFY 2019
North Sound	49%	53%	55%
King	52%	53%	54%
Pierce	47%	49%	52%
Southwest	51%	53%	54%
North Central	50%	51%	56%
Greater Columbia	50%	54%	54%
Spokane	53%	55%	57%

Substance Use Disorder Treatment Penetration Rate. Regional SUD treatment penetration rates increased ranging from 5 to 10 percentage points from SFY 2017 to SFY 2019. North Central IMC region had the lower SUD treatment penetration rates across all three years, but saw an overall increase from 22 percent to 27 percent. North Sound IMC region had the highest SUD treatment penetration rates across all three years, from 34 percent to 41 percent. Great Rivers and Spokane IMC region had the largest increase from SFY 2017 to SFY 2019 (10 percentage points). King, Southwest, and North Central IMC regions had the smallest increase (5 percentage points).

Opioid Use Disorder Treatment Penetration Rate. Increases in regional OUD treatment penetration rates increased ranging from 11 percentage points to 26 percentage points. King County IMC had the highest OUD treatment penetration rate in SFY 2017 (44 percent), but had the lowest percentage point increase in OUD treatment (up 11 percentage points to 55 percent). Conversely, Greater Columbia IMC had the lowest OUD treatment penetration rate in SFY 2017 (25 percent), and had the second highest percentage point increase in OUD treatment (up 24 percentage points to 49 percent). Great Rivers IMC had the greatest percentage point increase in OUD treatment, up 26 percentage points from 35 percent to 61 percent, which was the highest regional OUD treatment penetration rate.

Mental Health Treatment Penetration Rate. Of the three treatment penetration rates, the MH rate had the smallest increases between SFY 2017 and SFY 2019. While all IMC regions did increase their MH treatment penetration rate, the increases ranged from 2 to 6 percentage points. King County IMC had the smallest increase of 2 percentage points from 52 to 54 percent. North Sound and North Central IMC regions had the largest increase of 6 percentage points from 49 to 55 percent and 50 to 56 percent, respectively. Spokane IMC had the highest MH treatment penetration rate across all three years. Pierce County IMC had the lowest MH treatment penetration rate across all three years.

As shown in table 5, Treatment penetration rates also vary considerably by target populations, with some populations seeing increases in treatment penetration and others seeing little or no increase.

TABLE 5.

Trends in Treatment Penetration Rates among SUPPORT ACT Target Populations

SFY 2017 – SFY 2019

	SFY 2017	SFY 2018	SFY 2019
Substance Use Disorder Treatment Penetration Rate			
All Washington Medicaid Beneficiaries	*29%*	*33%*	*36%*
Pregnant and/or Postpartum Women	32%	34%	38%
Adolescents (Age 13 to 18)	31%	33%	31%
TAYA (Age 16 to 25)	27%	29%	30%
American Indian or Alaskan Native	41%	42%	44%
Criminal Justice Involved Persons	44%	48%	53%
Homeless without Housing	37%	42%	46%
Homelessness or Unstably House	37%	41%	46%

	SFY 2017	SFY 2018	SFY 2019
Opioid Use Disorder Treatment Penetration Rate			
All Washington Medicaid Beneficiaries	*36%*	*47%*	*55%*
Pregnant and/or Postpartum Women	47%	55%	61%
Adolescents (Age 13 to 18)	4%	8%	13%
TAYA (Age 16 to 25)	28%	39%	47%
American Indian or Alaskan Native	43%	50%	56%
Criminal Justice Involved Persons	33%	47%	57%
Homeless without Housing	38%	49%	57%
Homelessness or Unstably Housed	38%	50%	58%
Mental Health Treatment Penetration Rate			
All Washington Medicaid Beneficiaries	*51%*	*53%*	*55%*
Pregnant and/or Postpartum Women	45%	46%	49%
Adolescents (Age 13 to 18)	60%	63%	66%
TAYA (Age 16 to 25)	52%	55%	57%
American Indian or Alaskan Native	54%	54%	55%
Criminal Justice Involved Persons	57%	59%	58%
Homeless without Housing	53%	55%	55%
Homelessness or Unstably House	54%	56%	56%

Pregnant and Postpartum Women. Pregnant and postpartum women had the lowest MH treatment penetration rate among all the populations of interest examined and were well below the statewide treatment penetration rate. Conversely, compared to the other target populations, Pregnant and Postpartum women had the highest OUD treatment penetration rate across all three years of study. This likely reflects the emphasis on providing Buprenorphine to pregnant women diagnosed with OUD.

Adolescents. The OUD treatment penetration rate is much lower among adolescents due to age-based restrictions for prescribing most medication for opioid use disorder (MOUD). Typically, MOUD is not prescribed to those who are 15 years old or younger. Even with a small proportion of individuals eligible to receive MOUD, it is clear that access to MOUD has increased substantially in the last three years. While this population had lower rates of SUD (in SFY 2019) and OUD treatment, the MH treatment penetration rate was higher than the Medicaid beneficiaries state average and steadily increased over the three years examined.

TAYA. As with the Adolescent population, the MH and OUD treatment penetration rates for the TAYA population increased over the three years examined, with OUD treatment penetration rates increasing by 29% from SFY 2017-SFY 2019. However, this increase in OUD treatment did not correlate with substantial increases to SUD treatment penetration rates. .

American Indian/Alaskan Native. The American Indian/Alaskan Native population had MH and SUD treatment penetration rates that were mildly increased over the three years examined. This population had higher SUD treatment penetration rates compared with the overall Medicaid population across all three years. This population also had the second highest starting OUD treatment penetration rate (second to pregnant/postpartum women) with modest increases in OUD treatment penetration each year.

Persons Involved in the Criminal Justice System. Persons with arrests in the measurement year had the highest SUD and the second highest MH treatment penetration rates across all three years. In addition, while the OUD treatment penetration rate was lower than the statewide rate in SFY 2017, by SFY 2019, the OUD treatment penetration rate exceeded the state rate.

Persons Experiencing Homelessness or Housing Instability. Persons experiencing homelessness had higher baseline rates of SUD treatment penetration and saw increases similar to that of the broader Medicaid population. OUD and MH treatment penetration rates had increases similar to the increase in statewide rates (an increase of nearly 20 percentage points for OUD and a slight increase in MH treatment penetration rates). Interestingly, taking a broader view of housing instability and looking at persons experiencing either homelessness or housing instability does not change the overall rates of MH, SUD, and OUD treatment penetration. Though the population more than doubles, the pattern remains the same. From SFY 2017 to SFY 2019, there was a substantial increase in OUD and SUD treatment penetration rates and the MH treatment penetration rate has remained stable.

Utilization of Substance Use Disorder Treatment Modalities

As with treatment penetration rates, the use of different treatment modalities has increased over the past three years, but varies among Medicaid beneficiaries. Table 6 shows the differences in use of outpatient, inpatient/residential, Buprenorphine (with and without Naloxone), Naltrexone, and Methadone[3] across time, across populations, and by SUD or OUD treatment need. It is important to note that these categories are not mutually exclusive. Medicaid Beneficiaries with an OUD treatment need are also included in the broader SUD treatment need category. In addition, an individual may have received more than one or all types of treatment within the year.

Table 6.
Trends in Substance Use Disorder Treatment Modalities for Medicaid Beneficiaries with SUD and OUD Treatment Need
SFY 2017 – SFY 2019

	Percent with a SUD Treatment Need who Received Type of Treatment			Percent with an OUD Treatment Need who Received Type of Treatment		
	SFY 2017	SFY 2018	SFY 2019	SFY 2017	SFY 2018	SFY 2019
Outpatient Treatment						
All Washington Medicaid Beneficiaries	*22%*	*23%*	*25%*	*32%*	*33%*	*38%*
Pregnant and/or Postpartum Women	25%	25%	29%	44%	44%	50%
Adolescents (Age 13 to 18)	30%	30%	28%	31%	37%	42%
TAYA (Age 16 to 25)	23%	23%	24%	39%	37%	41%
American Indian or Alaskan Native	35%	34%	35%	51%	49%	51%
Criminal Justice Involved Persons	36%	36%	40%	42%	41%	46%
Homeless without Housing	28%	30%	33%	40%	40%	43%
Homelessness or Unstably House	28%	29%	33%	40%	40%	44%
Inpatient/Residential Treatment						
All Washington Medicaid Beneficiaries	*6%*	*6%*	*6%*	*9%*	*9%*	*10%*
Pregnant and/or Postpartum Women	6%	5%	6%	11%	10%	12%
Adolescents (Age 13 to 18)	6%	6%	4%	20%	21%	24%
TAYA (Age 16 to 25)	6%	6%	6%	16%	15%	16%
American Indian or Alaskan Native	9%	7%	10%	14%	10%	16%
Criminal Justice Involved Persons	12%	12%	13%	17%	17%	17%
Homeless without Housing	10%	10%	12%	15%	15%	16%
Homelessness or Unstably House	10%	10%	11%	15%	15%	15%

[3] Opioid substitution treatment programs (OTP) are not located in every county in Washington. A complete list of OTPs can be found at https://www.hca.wa.gov/assets/free-or-low-cost/opioid-treatment-programs.pdf.

	Percent with a SUD Treatment Need who Received Type of Treatment			Percent with an OUD Treatment Need who Received Type of Treatment		
	SFY 2017	SFY 2018	SFY 2019	SFY 2017	SFY 2018	SFY 2019
Buprenorphine						
All Washington Medicaid Beneficiaries	*6%*	*9%*	*12%*	*16%*	*25%*	*32%*
Pregnant and/or Postpartum Women	9%	12%	15%	25%	34%	41%
Adolescents (Age 13 to 18)	<1%	<1%	<1%	1%	3%	8%
TAYA (Age 16 to 25)	4%	5%	7%	16%	26%	35%
American Indian or Alaskan Native	7%	10%	13%	18%	25%	31%
Criminal Justice Involved Persons	7%	13%	20%	17%	29%	40%
Homeless without Housing	7%	13%	18%	15%	27%	36%
Homelessness or Unstably House	7%	12%	18%	17%	28%	38%
Naltrexone						
Washington Medicaid Beneficiaries	2%	3%	3%	5%	7%	8%
Pregnant and/or Postpartum Women	1%	1%	2%	3%	4%	5%
Adolescents (Age 13 to 18)	<1%	<1%	<1%	2%	3%	5%
TAYA (Age 16 to 25)	1%	1%	2%	3%	6%	7%
American Indian or Alaskan Native	2%	3%	4%	6%	7%	9%
Criminal Justice Involved Persons	2%	4%	4%	4%	8%	9%
Homeless without Housing	2%	3%	4%	4%	7%	7%
Homelessness or Unstably House	2%	3%	4%	4%	7%	8%
Methadone						
Washington Medicaid Beneficiaries	6%	6%	7%	17%	17%	18%
Pregnant and/or Postpartum Women	7%	8%	8%	21%	21%	21%
Adolescents (Age 13 to 18)	<1%	<1%	<1%	<1%	1%	1%
TAYA (Age 16 to 25)	2%	2%	2%	10%	10%	9%
American Indian or Alaskan Native	8%	8%	9%	21%	21%	21%
Criminal Justice Involved Persons	6%	7%	7%	15%	15%	15%
Homeless without Housing	9%	10%	10%	21%	20%	20%
Homelessness or Unstably House	8%	8%	9%	19%	19%	19%

Across all years and treatment modalities, a higher percentage of individuals with an OUD treatment need received treatment compared to individuals with an SUD treatment need. This is consistent with the increases in the SUD and OUD treatment penetration rates explored in the previous sections. However, changes in accessing treatment are not consistent across the target populations.

Outpatient Treatment. Overall use of outpatient treatment among those with an SUD or OUD treatment need increased from SFY 2017 to SFY 2019. One exception to this trend is the use of outpatient treatment among adolescents with a SUD treatment need, which decreased from 30 percent to 28 percent. However, the use of outpatient treatment among adolescents with an OUD treatment need increased substantially from 31 percent to 42 percent. Among American Indian/Alaskan Native Medicaid beneficiaries with an SUD or OUD treatment need, outpatient treatment use remained consistent and higher than most other target populations (35 percent for those with an SUD treatment need and 51 percent for those with an OUD treatment need).

Inpatient/Residential Treatment. The use of inpatient/residential treatment remained stable or slightly increased for most target populations between SFY 2017 and SFY 2019. Inpatient/residential

treatment use slightly decreased for adolescents with a SUD treatment need, but increased for adolescents with an OUD treatment need. Among American Indian/Alaskan Natives and Pregnant and/or Postpartum Women with a SUD or OUD treatment need, use of inpatient/residential treatment decreased from SYF 2017 to SFY 2018, but increased to above SFY 2017 rates in SFY 2019.

Buprenorphine (With and Without Naloxone). Buprenorphine use increased dramatically from SYF 2017 to SFY 2019. Across all Medicaid beneficiaries with an OUD treatment need, there was a 16 percentage point increase in Buprenorphine use (from 16 percent to 32 percent). Some target populations saw a smaller increase in Buprenorphine use for OUD treatment need (6 percentage point increase among adolescents), while other target populations had a much larger increase (23 percentage points for persons involved with the criminal justice system). Pregnant and/or postpartum women had the highest use of Buprenorphine across all three years, though the overall increase was more modest when compared to other populations. Adolescents had the lowest use of buprenorphine across all three years.

Naltrexone. Naltrexone use also increased from SFY 2017 to SFY 2019, but not as drastically as Buprenorphine. However, Naltrexone use overall is much lower than Buprenorphine use for most populations. One exception is for adolescents with an OUD treatment need. This population had similar use of Naltrexone and Buprenorphine in SFY 2017 and SFY 2018, but use of Buprenorphine surpassed use of Naltrexone for this population in SYF 2019.

Methadone. Unlike Buprenorphine and Naltrexone, Methadone use remained stable from SFY 2017 to SFY 2019. There is very little difference across time in the percentages of those with an SUD or OUD treatment need who use Methadone. Use of Methadone is highest among pregnant and/or postpartum women, American Indian/Alaskan Native, and persons experiencing homelessness (with or without housing). Methadone use is lowest among the adolescent and TAYA populations.

There are also distinct geographic differences in which treatments Medicaid beneficiaries use. Access to Methadone, Buprenorphine, and Naltrexone for those with an OUD diagnosis may be dependent on proximity to facilities licensed to provide Methadone and the number of providers able to prescribe Buprenorphine or Naltrexone. As such, rates of Methadone use varied from less than 1 percent (eleven counties) to 27 percent (Snohomish County). Rates of Buprenorphine use vary from 24 percent (King County) to 63 percent (Garfield County). Complete county and integrated managed care region results are available in Appendix Tables 1 and 2.

Comparison of Physical and Social Outcomes among Medicaid Beneficiaries with Behavioral Health Diagnoses

To understand how measures of physical health and social outcomes may differ across beneficiaries with different behavioral health diagnoses, this analysis examined six broad categories of behavioral health diagnoses. The six categories are Medicaid beneficiaries with SUD diagnoses, OUD diagnoses, mental health (MH) diagnoses, serious mental illness (SMI) diagnoses, co-occurring SUD and MH diagnoses (COD), or no behavioral health diagnoses. Metrics that measure access to care, quality of care, coordination of care, utilization of high-intensity services, and social outcomes are included.

The rates reported in Table 7 reflect the percentage of individuals in that population who met the criteria for that metric. For example, Access to Ambulatory and Preventive Care is the percentage of persons who received ambulatory or preventive care service in that year. Of the Medicaid beneficiaries without a behavioral health diagnosis, 64 percent received a qualifying service. Of those with a diagnosis of SUD, 86 percent received a qualifying service. Metrics where are higher rate indicates a more favorable outcome are indicated by ↑. Metrics where a lower rate indicates a more favorable outcome are indicated by ↓. Additional information about the measures is available in the Technical Notes section.

TABLE 7.

Physical and Social Outcomes in SFY 2019 among Medicaid Beneficiaries with and without Behavioral Health Diagnoses

		Medicaid Beneficiaries without any Behavioral Health Diagnoses	Medicaid Beneficiaries with a diagnosis of...				
			SUD	OUD	MH	SMI	COD
Access	Access to Ambulatory and Preventive Care (↑)	64%	86%	87%	91%	93%	92%
	Breast Cancer Screening (↑)	44%	46%	43%	55%	54%	48%
	Cervical Cancer Screening (↑)	49%	50%	45%	57%	57%	54%
	Chlamydia Screening (↑)	53%	62%	59%	56%	57%	63%
	Colorectal Cancer Screening (↑)	33%	45%	48%	49%	50%	48%
Quality	Antidepressant Medication Management (Acute) (↑)	N/A*	53%	52%	56%	57%	55%
	Antidepressant Medication Management (Continuation) (↑)	N/A*	40%	38%	40%	41%	41%
	Asthma Medication Ratio (↑)	49%	41%	37%	51%	52%	43%
	Comprehensive Diabetes Care - Eye Exam (↑)	44%	38%	37%	47%	46%	39%
	Comprehensive Diabetes Care - HbA1C Testing (↑)	82%	75%	74%	83%	83%	77%
	Comprehensive Diabetes Care - Nephropathy Screening (↑)	82%	84%	85%	86%	85%	85%
	Plan All Cause Readmissions (↓)	4%	15%	18%	13%	15%	16%
	Psychiatric Inpatient Readmissions (↓)	N/A*	13%	14%	12%	12%	13%
	Adherence to Antipsychotics for Persons with Schizophrenia (↑)	N/A*	53%	48%	61%	61%	53%
	Received Statin Therapy (↑)	41%	51%	51%	55%	56%	55%
	Statin Therapy Adherence - 80% (↑)	41%	51%	51%	55%	56%	55%
Coordination	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (↑)	N/A*	84%	86%	80%	80%	84%
	Follow-Up After ED Visit for Alcohol or Other Drug Dependence (AOD) - Within 7 Days (↑)	N/A*	18%	28%	19%	20%	20%
	Follow-Up After ED Visit for AOD - Within 30 Days (↑)	N/A*	29%	43%	30%	31%	31%
	Follow-Up After Hospitalization for Mental Illness - Within 7 Days (↑)	N/A*	53%	48%	54%	54%	53%
	Follow-Up After Hospitalization for Mental Illness - Within 30 Days (↑)	N/A*	74%	67%	74%	75%	74%
	Follow-Up After ED Visit for Mental Illness - Within 7 Days (↑)	N/A*	50%	49%	51%	55%	52%
	Follow-Up After ED Visit for Mental Illness - Within 30 Days (↑)	N/A*	62%	62%	64%	68%	65%
Utilization	High Emergency Department Utilization (3+ visits in year) (↓)	3%	22%	23%	15%	17%	27%
	Inpatient Utilization (any visits within year) (↓)	4%	18%	20%	11%	13%	22%
	Home and Community Based Services Utilization (any visits within year) (↑)	1%	3%	4%	4%	5%	5%
Social	Homeless without Housing (↓)	3%	16%	20%	8%	10%	18%
	Homelessness or Unstably Housed (↓)	7%	31%	37%	17%	20%	34%
	Employed (↑)	49%	40%	35%	44%	41%	38%
	Arrested (↓)	3%	21%	26%	9%	11%	21%

*Requires a behavioral health diagnosis to be included in the measure.

Outside of access to care measures, Medicaid beneficiaries with behavioral health diagnoses tended to fare worse than Medicaid beneficiaries with no behavioral health diagnoses. Of those Medicaid beneficiaries with behavioral health diagnoses, individuals with SUD diagnoses, and particularly those with OUD diagnoses or co-occurring SUD and MH diagnoses, had substantially worse outcomes than those with MH or SMI diagnoses.

Access to Care. Medicaid beneficiaries with behavioral health diagnoses had higher rates of service use associated with access to care when compared to Medicaid beneficiaries with no behavioral health diagnoses. For example, Access to Ambulatory and Preventive Care, which measures use of primary care type services, 64 percent of Medicaid beneficiaries with no behavioral health diagnoses accessed ambulatory/preventive care. However, 86 percent of Medicaid beneficiaries with SUD diagnoses and 93 percent of Medicaid beneficiaries with SMI diagnoses accessed ambulatory/preventive care.

Quality of Care. The impact of behavioral health diagnoses on quality of care metrics varied across metrics. For some metrics, there were minor differences between behavioral health diagnoses (Antidepressant Medicaid Management, Nephropathy Screening, and Psychiatric Inpatient Readmissions). For other metrics, Medicaid beneficiaries with SUD, OUD, or co-occurring diagnoses fared worse than those with no behavioral health diagnoses, but those with MH or SMI diagnoses fared better (Asthma Medication Ratio, Eye Exam, HbA1C Testing, Adherence to Antipsychotics for Persons with Schizophrenia). For two metrics, Statin Therapy and Statin Therapy Adherence, Medicaid beneficiaries with behavioral health diagnoses had higher rates than those with no behavioral health diagnoses. However, one measure showed substantially worse outcomes for Medicaid beneficiaries with behavioral health diagnoses (Plan All Cause Readmissions). Individuals with no behavioral health diagnoses had a 4 percent rate of readmission. Those with behavioral health diagnoses had a readmission rate between 13 and 18 percent.

Coordination of Care. Follow-up after an emergency department visit at 7 and 30 days was higher for Medicaid beneficiaries with an OUD diagnoses than for those with an SUD diagnoses (28 and 43 percent compared to 18 and 29 percent). Conversely, follow-up after hospitalization for mental illness was lower for individuals with an OUD diagnoses compared to all other behavioral health diagnoses. Interestingly, the difference between SUD/OUD and MH/SMI was not as large for follow-up after an emergency department visit for mental illness. Diabetes screening for people with schizophrenia was slightly higher for Medicaid beneficiaries with an SUD, OUD, or co-occurring disorder compared to MH or SMI diagnoses.

Utilization of High Intensity Services. Across all three types of services, Medicaid beneficiaries with behavioral health diagnoses had markedly higher rates of utilization than Medicaid beneficiaries with no behavioral health diagnoses. The rate of high emergency department utilization (defined as 3 or more visits in a year) was at 3 percent for Medicaid beneficiaries with no behavioral health diagnoses and 15 percent or more for those with behavioral health diagnosis. Twenty-seven percent of individuals with a co-occurring SUD and MH diagnoses were high ED utilizers. Inpatient utilization was 4 percent for those with no behavioral health diagnoses and 11-22 percent for those with behavioral health diagnoses. Use of home and community based services (HCBS) followed the same pattern, though had a much lower frequency of use across all populations. One percent of Medicaid beneficiaries with no behavioral health diagnosis used HCBS compared to 3-5 percent of those with behavioral health diagnoses.

Social Outcomes. For all social outcomes reported, Medicaid beneficiaries with behavioral health diagnoses fared substantially worse than Medicaid beneficiaries with no behavioral health diagnoses. Those with OUD diagnoses fared worst of all, with 20 percent Homeless without housing, 37 percent homelessness or unstably housed, only 35 percent employed, and 26 percent who had been arrested in the past year.

Discussion

Overall, this descriptive analysis highlights the current variability in prevalence, treatment, and outcomes among Medicaid beneficiaries. While some Medicaid populations have lower prevalence rates of SUD/OUD diagnoses (such as the Classic, Non-Disabled Medicaid population), other populations have much higher prevalence rates (such as pregnant/postpartum women, individuals who are homeless, and individuals involved in the criminal justice system). Use of SUD and OUD treatment services has increased from SFY 2017 to SFY 2019. However, the increase is not consistent among populations of interest or treatment types. For example, although pregnant women had comparatively high rates of MOUD treatment compared to the general Medicaid Beneficiary population, their rates of mental health treatment and general SUD treatment penetration are similar or lower. Treatment penetration rates for adolescent and transition age young adults were also low relative to other target populations. Access to treatment also varies depending on geographic location. Across measures of physical health and social outcomes, Medicaid beneficiaries with SUD or OUD diagnoses fare worse than those with a mental health diagnosis, serious mental illness diagnosis, or no behavioral health diagnoses. In particular, those with SUD or OUD diagnoses have higher rates of emergency department and inpatient services utilization and dramatically higher rates of unemployment, arrests, and homelessness.

It is important to note that this report does not include Medicaid beneficiaries who are dually eligible for Medicare or Medicaid beneficiaries or who did not meet the minimum eligibility requirements. These populations may have different rates of SUD/OUD diagnoses and treatment use.

The goal of the §1003 SUPPORT ACT is to develop a policy framework to guide the advancement of statewide, whole-person, integrated SUD/OUD treatment and recovery support services. Understanding the prevalence of SUD/OUD, the variation in treatment, and the disparate physical health and social outcomes among those with behavioral health diagnoses is critical to identifying opportunities for improvement.

TABLE 1.

Variation in Substance Use Disorder Treatment Modalities by County in SFY 2019

	% with a Diagnosis of SUD who Received Type of Treatment					% with a Diagnosis of OUD who Received Type of Treatment				
	Outpatient	Inpatient/ Residential	Buprenorphine	Naltrexone	Methadone	Outpatient	Inpatient/ Residential	Buprenorphine	Naltrexone	Methadone
Washington	25%	6%	12%	3%	7%	38%	10%	32%	8%	18%
Adams	21%	1%	4%	1%	0%	15%	2%	27%	5%	0%
Asotin	14%	3%	19%	2%	0%	23%	6%	51%	5%	0%
Benton	23%	5%	17%	2%	1%	29%	8%	46%	5%	2%
Chelan	19%	5%	12%	6%	<1%	27%	10%	38%	19%	1%
Clallam*	29%	10%	21%	5%	1%	34%	15%	45%	11%	2%
Clark*	28%	8%	11%	2%	5%	39%	14%	32%	7%	17%
Columbia	16%	3%	15%	3%	0%	12%	3%	42%	9%	0%
Cowlitz*	25%	4%	17%	2%	8%	31%	7%	44%	6%	21%
Douglas	18%	6%	14%	6%	0%	23%	10%	41%	16%	0%
Ferry	21%	5%	12%	2%	0%	25%	10%	38%	6%	0%
Franklin	20%	4%	8%	1%	<1%	19%	6%	31%	5%	1%
Garfield	16%	5%	14%	0%	0%	38%	13%	63%	0%	0%
Grant	15%	4%	9%	2%	<1%	19%	8%	34%	8%	<1%
Grays Harbor*	33%	4%	15%	2%	12%	46%	5%	34%	5%	27%
Island	23%	5%	9%	2%	6%	34%	9%	30%	7%	20%
Jefferson	22%	11%	12%	4%	1%	25%	17%	34%	10%	1%
King*	24%	4%	10%	4%	10%	38%	6%	24%	9%	25%
Kitsap*	22%	7%	10%	5%	2%	29%	11%	29%	14%	7%
Kittitas	22%	7%	10%	2%	<1%	28%	13%	33%	7%	1%
Klickitat	18%	4%	6%	4%	0%	24%	11%	26%	18%	0%
Lewis	23%	4%	11%	1%	3%	32%	6%	37%	5%	9%
Lincoln	16%	4%	12%	2%	1%	20%	6%	30%	4%	2%
Mason	27%	5%	11%	4%	8%	41%	8%	28%	9%	20%
Okanogan	16%	5%	10%	2%	<1%	21%	9%	39%	8%	1%
Pacific	25%	4%	10%	3%	3%	47%	7%	38%	11%	10%
Pend Oreille	14%	2%	11%	2%	2%	22%	4%	36%	7%	6%
Pierce*	25%	5%	10%	3%	7%	42%	9%	26%	9%	20%
San Juan	17%	5%	11%	2%	1%	23%	8%	37%	8%	5%
Skagit*	30%	7%	18%	2%	10%	44%	11%	40%	5%	22%
Skamania	19%	3%	10%	3%	1%	16%	6%	38%	12%	2%
Snohomish*	27%	7%	15%	3%	13%	41%	10%	30%	7%	27%
Spokane*	24%	7%	15%	3%	7%	38%	12%	38%	7%	19%
Stevens	20%	6%	17%	1%	2%	28%	9%	45%	4%	5%
Thurston*	22%	5%	11%	5%	6%	32%	8%	30%	14%	18%
Wahkiakum	24%	3%	12%	0%	4%	35%	15%	55%	0%	20%
Walla Walla	16%	5%	12%	3%	<1%	18%	8%	38%	8%	1%
Whatcom*	30%	7%	17%	3%	7%	43%	11%	38%	7%	17%
Whitman	12%	4%	6%	1%	1%	17%	12%	27%	5%	3%
Yakima*	23%	7%	9%	1%	2%	33%	14%	39%	5%	7%

*Indicates at least one Opioid Substitution Treatment Program located within the county as of April 2020.

TABLE 2.

Variation in Substance Use Disorder Treatment Modalities by Integrated Managed Care Region in SFY 2019

	% with a Diagnosis of SUD who Received Type of Treatment					% with a Diagnosis of OUD who Received Type of Treatment				
	Outpatient	Inpatient/ Residential	Buprenorphine	Naltrexone	Methadone	Outpatient	Inpatient/ Residential	Buprenorphine	Naltrexone	Methadone
Washington	25%	6%	12%	3%	7%	38%	10%	32%	8%	18%
Salish*	24%	8%	13%	5%	2%	31%	13%	35%	12%	4%
Great Rivers*	27%	4%	15%	2%	8%	37%	6%	39%	6%	20%
Thurston-Mason*	23%	5%	11%	4%	7%	34%	8%	30%	12%	19%
North Sound*	28%	7%	15%	3%	11%	41%	10%	33%	6%	24%
King*	24%	4%	10%	4%	10%	38%	6%	24%	9%	25%
Pierce*	25%	5%	10%	3%	7%	42%	9%	26%	9%	20%
Southwest*	27%	8%	10%	2%	5%	38%	14%	32%	8%	15%
North Central	17%	5%	11%	4%	0%	22%	9%	37%	12%	0%
Greater Columbia*	21%	6%	11%	2%	1%	28%	10%	41%	6%	3%
Spokane*	23%	7%	15%	2%	7%	36%	11%	39%	6%	17%

*Indicates at least one Opioid Substitution Treatment Program located within the Integrated Managed Care Region as of April 2020.

STUDY POPULATION

Adult (age 18-64) and Youth (0-17) individuals enrolled in Title XIX Medicaid are the focus of these analyses. Medicaid beneficiaries with non-Medicaid primary health care coverage (also referred to as third-party liability) or who were dually eligible for Medicare and Medicaid were excluded from the analyses, as complete health care information may not be available for these individuals. Analyses were further restricted to individuals who met minimum Medicaid enrollment criteria (11 out of 12 months in the measurement year) to meet eligibility requirements for the treatment penetration rates and the physical health outcome metrics.

This report focuses on individuals who have been diagnosed with substance use disorder (SUD) and/or opioid use disorder (OUD):

1. **Substance Use Disorder** is defined as the presence of a SUD diagnosis within the measurement year or the year prior to the measurement year.
2. **Opioid Use Disorder Diagnosis** is defined as the presence of an OUD diagnosis within the measurement year or the year prior to the measurement year.

Six populations of interest, as defined in the SUPPORT ACT planning grant, were also examined:

1. **Pregnant and Postpartum Women** are defined as the presence of any pregnancy or delivery related diagnosis code within the measurement year. To ensure consistency with current Medicaid eligibility definitions, postpartum is defined as the 60 days after a delivery. Women who had given birth within the last 60 days but did not have a pregnancy or delivery related diagnosis within the measurement year were included to capture the 60 day postpartum time period. For example, if a woman gave birth in June 2018, she would be included in the SFY 2018 population (pregnant) and the SFY 2019 population (postpartum).
2. **Adolescents** are defined as individuals aged 13 to 18 years old as of the last day of the measurement year.
3. **Transition Age Young Adults** are defined as individuals aged 16 to 25 years old as of the last day of the measurement year.
4. **American Indian/Alaskan Native** are self-identified by the individual through the DSHS Economic Service Administration's Automated Client Eligibility System (ACES) or when enrolling with in Medicaid. Individuals who self-identify as only AI/AN and those who identify as AI/AN and another race/ethnicity are included.
5. **Persons involved with the criminal justice system** are defined as ever arrested in the measurement year. Arrests are identified via the WASIS database that is maintained by the Washington State Patrol. The database is comprised of arrest charges for offenses resulting in fingerprint identification. The database provides a relatively complete record of felony and gross misdemeanor charges, but excludes some arrest charges for misdemeanor offenses that are not required to be reported.
6. **Persons experiencing homelessness and/or housing instability** are defined as ever being homeless without housing or homeless with housing in the measurement year. Housing status is identified using the DSHS Economic Services Administration's Automated Client Eligibility System (ACES) that is used by caseworkers to record information about client self-reported living arrangements and shelter expenses. Separate rates are reported for persons who are homeless without housing (narrow definition) and for any homelessness or housing instability (broad definition).

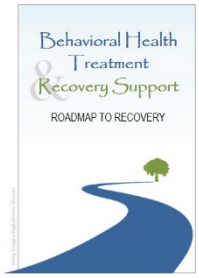
DATA SOURCES AND MEASURES

Data used in this report came from the integrated administrative data maintained in the Department of Social and Health Services Integrated Client Databases (ICDB). The ICDB contains data from several state administrative data systems, including the State's ProviderOne MMIS data system that contains Medicaid claims and encounter data. The ICDB allows for the examination of a broad set of measures across the topics of: access to care, quality of care, coordination of care, utilization of services, and social determinants of health.

- **Client Profile Variables:** Demographic characteristics included age, gender, and race/ethnicity. Medicaid coverage information included three different categories of Medicaid coverage: New Adults covered by Medicaid Expansion under the Affordable Care Act, Disabled Adults, and "Classic" non-disabled Medicaid adults enrolled in coverage categories that existed prior to Medicaid Expansion. Medicaid beneficiaries were attributed to a particular Managed Care Region based on their county of residence for the majority of the measurement year.
- **Treatment Penetration Rates:** Reported measures adhered to DSHS-RDA 2019 Specifications.

- *Substance Use Disorder Treatment Penetration Rate:* The percentage of Medicaid beneficiaries with a substance use disorder treatment need identified within the past two years, who received at least one qualifying substance use disorder treatment during the measurement year. SUD treatment need is identified by the presence of any of the following in the identification window: diagnosis of a drug or alcohol use disorder in any health service event, receipt of brief intervention services, receipt of medically managed detox services, or receipt of inpatient/residential, outpatient, methadone, or other form of medication for opioid use disorder.
- *Opioid Use Disorder Treatment Penetration Rate:* The percentage of Medicaid beneficiaries with an opioid use disorder treatment need identified within the past two years, who received at least one qualifying opioid use disorder treatment during the measurement year. OUD treatment need is identified by the presence of any of the following within the identification window: diagnosis of an OUD in any health service event, receipt of methadone, or receipt of other form of medication for opioid use disorder.
- *Mental Health Treatment Penetration Rate:* The percentage of Medicaid beneficiaries with a mental health treatment need identified within the past two years, who received at least one qualifying MH service during the measurement year. MH treatment need is identified by the presence of any of the following with the identification window: qualifying diagnosis of mental illness, receipt of any qualifying MH service, or receipt of any qualifying psychotropic medication.

- **Substance Use Disorder Treatment Modalities:** Five treatment modalities were examined in this report: outpatient, inpatient/residential, buprenorphine (with and without naloxone), naltrexone, and methadone. Detailed information about treatment modalities can be found in the Service Encounter Reporting Instructions. Additional treatment modalities, evidence-based approaches, and screenings, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT), were not included due to limited prevalence in the population and/or known underreporting issues.
  - *Outpatient Treatment:* Receipt of an outpatient SUD treatment service, including case management. Excludes opiate substitution treatment (OST), also known as methadone treatment.
  - *Inpatient/Residential Treatment:* Receipt of inpatient or residential treatment for a SUD (excludes detoxification services).
  - *Buprenorphine:* Receipt of Buprenorphine, or Buprenorphine-Naloxone for the treatment of a SUD.
  - *Naltrexone:* Receipt of Naltrexone for the treatment of a SUD.
  - *Methadone:* Receipt of opiate substitution treatment (methadone) for treatment of SUD.
- **Physical Health and Social Outcomes:** Reported measures adhered to measure steward specifications, including Medicaid eligibility and demographic requirements (e.g. Breast Cancer Screening is only measured for women between the ages of 50 and 64). A list of the measure stewards and the respective measures is below. A link to the specifications is included.
  - NCQA HEDIS® 2019 Specifications: Access to Ambulatory and Preventive Care, Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening, Colorectal Cancer Screening**,** Antidepressant Medication Management (Acute and Continuation Phases), Asthma Medication Ratio, Comprehensive Diabetes Care (Eye Exam, HbA1C testing, Nephropathy Screening), Plan All Cause Readmission, Adherence to Antipsychotics for Persons with Schizophrenia, Received Statin Therapy, Statin Therapy Adherence – 80%, Diabetes Screening for People with Schizophrenia or Bipolar Disorder, Follow-Up After ED Visit for Alcohol or Other Drug Dependence, Follow-Up After Hospitalization for Mental Illness, Follow-Up After ED Visit for Mental Illness.
  - DSHS-RDA 2019 Specifications: Psychiatric Inpatient Readmissions, High Emergency Department Utilization (3+ visits within a year), Inpatient Utilization, Home and Community Based Services Utilization, Homelessness-Narrow, Homelessness-Broad, Arrested, Employed.



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