Medicaid Transformation Project Evaluation

UPDATE ON STATEWIDE PERFORMANCE AND DOMAIN ONE IMPLEMENTATION PROGRESS

Rapid Cycle Report, September 2022

CENTER FOR HEALTH SYSTEMS EFFECTIVENESS

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SECTION 1

Evaluation Overview

KEY FINDINGS

The performance measures in this report provide an ongoing look at how the COVID-19 Public Health Emergency in Washington State may have impacted health care access and quality among Medicaid members. After notable initial impacts, we are beginning to see evidence of recovery within several domains. Specifically, access to periodontal exams and wellness visits for children over the age of three improved during this period. We continued to see positive trends for other types of care that can be delivered virtually, including medication management for mental health and chronic conditions such as diabetes and heart disease.

We previously reported a dramatic downward trend in rates of care received in emergency departments and acute hospital settings, attributed to barriers to access resulting from the public health emergency. This trend has reversed. While still markedly lower than the previous year, we now see a subtle uptick in care in these settings.

Finally, we continue to note disparities in health care access and quality among subpopulations examined in this report. Black members were less likely to receive follow-up care after an emergency department visit for alcohol or other drug use and were less likely to receive appropriate treatment for an opioid use disorder than other groups. American Indian/ Alaska Native members experienced markedly worse access to well-child visits, cancer screenings, and care related to chronic conditions, alongside higher Emergency Department visit rates. Members with a serious mental illness were more likely to experience homelessness.

Evaluation Progress

This Rapid Cycle Report presents a progress update on the independent external evaluation of Washington's Medicaid Transformation Project (MTP) for the period **July 1 to September 30, 2022**. In this report, we present evaluation findings including:

- **Performance through June 2021**, including key performance indicators in ten measurement domains as well as an examination of equity and disparities among specific populations within measurement domains. *(See Section 2, p. 5)*

In this reporting period (July to September 2022), the Independent External Evaluator completed the evaluation activities necessary to support the ongoing evaluation of MTP. These included:

- **Quantitative analysis of Medicaid data.** The quantitative team obtained and analyzed administrative data, including Medicaid enrollment, encounters, and claims, through June 2021.
- **Qualitative analysis:**
  - The qualitative team continues to analyze previously collected qualitative data. These analyses will be included in the final evaluation report
  - The qualitative team is actively coding and analyzing data from the final round of ACH interviews. These interviews questioned leaders about their reflections on their prior work and their plans for sustainability. The team meets weekly to listen to audio recordings, analyze transcripts, and refine the codebook.
  - The qualitative team submitted an IRB amendment in preparation for the final round of provider organization interviews. While waiting for approval, the qualitative team is identifying potential interviewees in each ACH region and developing an interview guide

Next Steps in the Evaluation

Upon IRB approval, the qualitative team will develop a sampling plan to ensure maximum variation of interview participants, tailor interview guides to each participant, and begin conducting interviews with behavioral health and community-based provider organizations.

The qualitative team will continue to analyze Foundational Community Supports-related data from key informant interviews that were collected in early 2022 and will report on these findings in more detail in the final evaluation report.

Medicaid Performance Measures Through June 2021

The MTP evaluation assesses the performance of Washington State's Medicaid system throughout the demonstration through analysis of administrative data, including Medicaid enrollment, encounters and claims.

This report presents 44 performance measures in ten domains. A description of the methodology used in this analysis can be found within the MTP Interim Evaluation Report.

Measurement domains include:

1. Social Determinants of Health. *See page 9.*
2. Access to Primary and Preventive Care. *See page 11.*
3. Reproductive and Maternal Health Care. *See page 13.*
4. Prevention and Wellness. *See page 16.*
5. Mental Health Care. *See page 19.*
6. Oral Health Care. *See page 22.*
7. Care for People with Chronic Conditions. *See page 24.*
8. Emergency Department, Hospital and Institutional Care Use. *See page 27.*
9. Substance Use Disorder Care. *See page 30.*
10. Opioid Prescribing and Opioid Use Disorder Treatment. *See page 33.*

COVID-19 and Medicaid Performance Measures

This report provides an ongoing assessment of the impacts of the COVID-19 Public Health Emergency (PHE) on Washington's Medicaid system. The report updates measures of health care access and quality from the MTP Interim Evaluation Report, including new data **through June 2021**. We also provide a detailed look at each measure, disaggregated by priority subpopulations, including racial and ethnic groups, people living in rural areas, and people with serious mental illness (SMI).

We note several considerations:

- **This report provides information on how the COVID-19 PHE may have impacted access and quality.** Most rates reported here are based on data collected from July 2020 through June 2021. The COVID-19 PHE began in Washington State in late March of 2020, prior to the start of this measurement period. This is the second Rapid Cycle Report that includes outcomes with measurement periods falling entirely after the onset of the pandemic.
- **Health care claims and member enrollment data from June 2021 were the most recent data available at the time of this report.** Administrative data used to calculate the performance metrics, including Medicaid claims and other data, are typically available with a nine-month lag.
- **Rates presented by the state in other reports may differ from rates in this report.** Although we use performance metrics data from Washington State agencies for this report, metrics presented in other reports may differ due to slight differences in the study population or in how rates were calculated.
- **To capture any impacts of the COVID-19 PHE, we display annual data with quarterly updates** beginning in June 2019. Due to the rolling annual nature of most measures, each quarterly update overlaps with data displayed in previous reports. All years are labeled by end date throughout this report.

Exhibit 2.1: The current measurement period falls entirely after the onset of the COVID-19 PHE in Washington State.

Summary of Findings: Medicaid System Performance

A summary of key changes in performance during the measurement period is presented in Exhibit 2.2, including observed improvements, worsening performance, and measures that exhibited little or no change.

Exhibit 2.2: Summary of Changes in Medicaid System Performance through June 2021

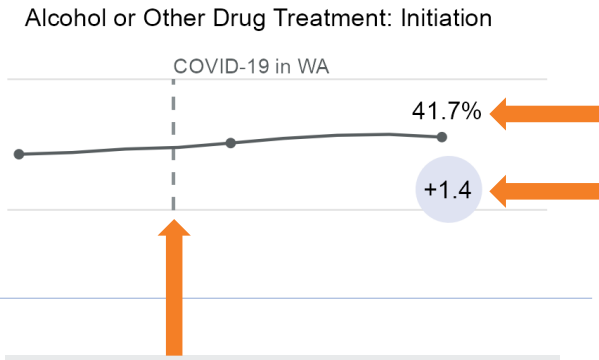
Change in Measures	Description
Better	• Access to **periodontal exams** for adults improved 4 percentage points compared to the previous year. • Utilization of **emergency departments and acute hospital care** continues to fall below previous years' rates but began to rebound in the last quarter of observation. This may reflect a return to pre-pandemic behavioral patterns in the population. Rates of care obtained in these settings varied widely among members of different racial and ethnic groups. • Access to **preventive visits for children** aged 3 to 11 improved marking a reversal of impacts noted at the onset of the COVID-19 PHE. • Access to **primary care for adults** with chronic conditions and serious mental illness was markedly better than the state average for this period. • Access to **antidepressant medication** and **controller medication** for asthma improved significantly over the measurement period.
Mixed	• Changes in outcomes related to **social determinants of health** were small during this period, but members with serious mental illness continued to experience markedly worse outcomes for all measures in this domain. Members in this group persistently experience homelessness at more than three times the statewide average. • Outcomes related to **prevention and wellness** were mixed for this period. The rate of wellness exams for children within the first 30 months of life was worse by 7.4 percentage points compared to the previous year. However, older children aged 3 to 11 experienced improved access. Screenings requiring in-person care continued to decline. • Care for **substance use disorder** and **opioid prescribing** showed minimal change compared to the previous year. Black and Native Hawaiian/ Pacific Islander members experienced worse access to treatment.
Worse	• Access to **reproductive and maternal health** worsened across most measurements. There were significant disparities in access to effective contraception and timely prenatal care.

How to Read this Report

In the subsequent sections, we present detailed information related to 44 performance measures organized into ten domains. An example of these measurement displays is provided below.

Graphs show outcomes for measurement periods spanning June 2019 through June 2021 unless otherwise noted.

Statewide Rates for June 2019 to June 2021 and Annual Change for the most recent year



Within each domain, we present the statewide rate as of **June 2021**.

We also present the change in each performance measure from the prior year, with changes in the measure indicated by **blue** (better) or **orange** (worse) shading.

For context, we include a line to indicate the date of Washington State's stay-at-home order due to COVID-19.

In addition to these measures of change over time, we provide a detailed look at each measure disaggregated for priority subpopulations such as specific racial and ethnic groups, people in rural areas, and people with chronic health conditions. Some measures cannot be publicly reported due to small sample sizes and are presented as "NA."

Statewide Rate by Health Condition and Geography, June 2021

Members With Chronic Health Conditions or Serious Mental Illness and Members Living in Rural or High Poverty Areas

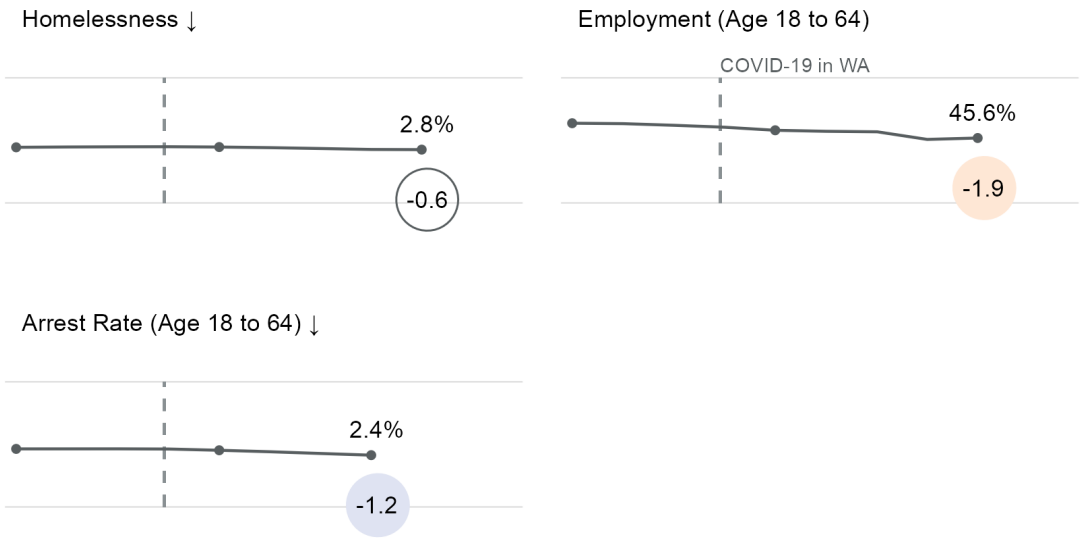
		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
Substance Use Disorder Treatment Penetration	[3]	37.6%	41.3%	36.1%	36.9%
Alcohol or Other Drug Treatment: Initiation	[0]	41.8%	43.9%	40.2%	41.0%
Alcohol or Other Drug Treatment: Engagement	[0]	16.6%	16.9%	16.2%	16.2%
30-Day Follow-Up After ED Visit for Alcohol/Drug Use	[3]	32.1%	35.0%	32.6%	31.9%

[N] Projects where this metric is pay-for-performance (P4P)

Social Determinants of Health

Rates of homelessness were relatively unchanged compared with the previous year, though rates of employment declined slightly. Arrest rate is presented here based on historical data.

Statewide Rate for June 2019 to June 2021 and Annual Change for 2020 to 2021



Outcomes related to social determinants of health were notably worse for Medicaid members with a serious mental illness and somewhat worse for members with a chronic health condition. Outcomes in this domain mostly aligned with statewide averages for members living in rural or high poverty communities.

Statewide Rate by Health Condition and Geography, June 2021

Members With Chronic Health Conditions or Serious Mental Illness and Members Living in Rural or High Poverty Areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
Homelessness	[3] ↓	4.4%	8.8%	2.0%	3.4%
Employment (Age 18 to 64)	[0]	43.4%	37.6%	47.3%	48.8%
Arrest Rate (Age 18 to 64)	[1] ↓	NA	NA	NA	NA

↓ Lower is better

[N] Projects where this metric is pay-for-performance (P4P)

American Indian/Alaska Native members experienced worse rates of employment and homelessness compared to the state average. Employment rates for Black, Hispanic, and Native Hawaiian/Pacific Islander members were higher than the state average.

Statewide Rate by Race, June 2021

American Indian/Alaska Native, Asian and Black Members

		AI/AN	Asian	Black
Homelessness	[3] ↓	5.3%	0.6%	4.7%
Employment (Age 18 to 64)	[0]	38.5%	43.8%	49.6%
Arrest Rate (Age 18 to 64)	[1] ↓	NA	NA	NA

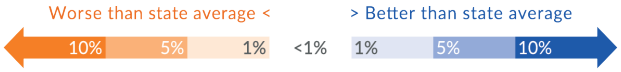
↓ Lower is better

[N] Projects where this metric is pay-for-performance (P4P)

Statewide Rate by Race, June 2021

Native Hawaiian/Pacific Islander, Hispanic and White Members

		NH/PI	Hispanic	White
Homelessness	[3] ↓	1.6%	1.4%	3.6%
Employment (Age 18 to 64)	[0]	51.2%	58.8%	41.9%
Arrest Rate (Age 18 to 64)	[1] ↓	NA	NA	NA



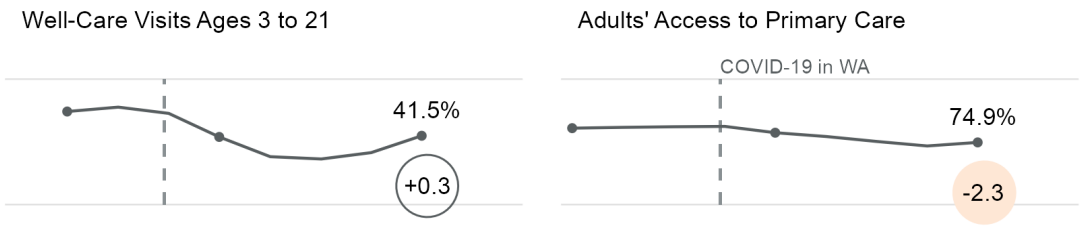
↓ Lower is better

[N] Projects where this metric is pay-for-performance (P4P)

Access to Primary and Preventive Care

Access to primary and preventive care for members under the age of 21 stabilized during this period, while access for adults continued to decline.

Statewide Rate for 2019 to June 2021 and Annual Change for 2020 to 2021



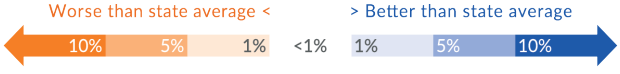
Due to a change in the reporting period, rates of Well-Care Visits Ages 3 to 21 are based on data from September 2019 to June 2021. Adults' Access to Primary Care are based on data from June 2019 to June 2021.

Medicaid members with a chronic condition, those living in rural communities, and those in communities with high poverty received better than average access to primary and preventive care during this period. Rates of well-care visits for members between the ages of 3 and 21 were slightly worse for members with serious mental illness than the state overall.

Statewide Rate by Health Condition and Geography, June 2021

Members With Chronic Health Conditions or Serious Mental Illness and Members Living in Rural or High Poverty Areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
Well-Care Visits Ages 3 to 21	[2]	49.6%	39.8%	43.0%	42.9%
Adults' Access to Primary Care	[0]	87.7%	91.7%	76.3%	75.4%



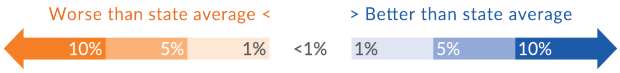
[N] Projects where this metric is pay-for-performance (P4P)

Racial and ethnic disparities in outcomes in this domain persist. Access to well-care visits for American Indian/Alaska Native members was markedly worse during this period, and Native Hawaiian/Pacific Islander and Black members had worse access to care for all ages.

Statewide Rate by Race, June 2021

American Indian/Alaska Native, Asian and Black Members

		AI/AN	Asian	Black
Well-Care Visits Ages 3 to 21	[2]	31.2%	43.6%	39.6%
Adults' Access to Primary Care	[0]	75.3%	72.1%	74.2%

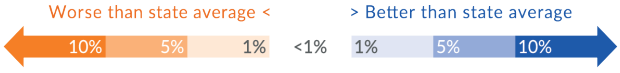


[N] Projects where this metric is pay-for-performance (P4P)

Statewide Rate by Race, June 2021

Native Hawaiian/Pacific Islander, Hispanic and White Members

		NH/PI	Hispanic	White
Well-Care Visits Ages 3 to 21	[2]	35.3%	46.5%	38.5%
Adults' Access to Primary Care	[0]	67.7%	77.8%	75.1%

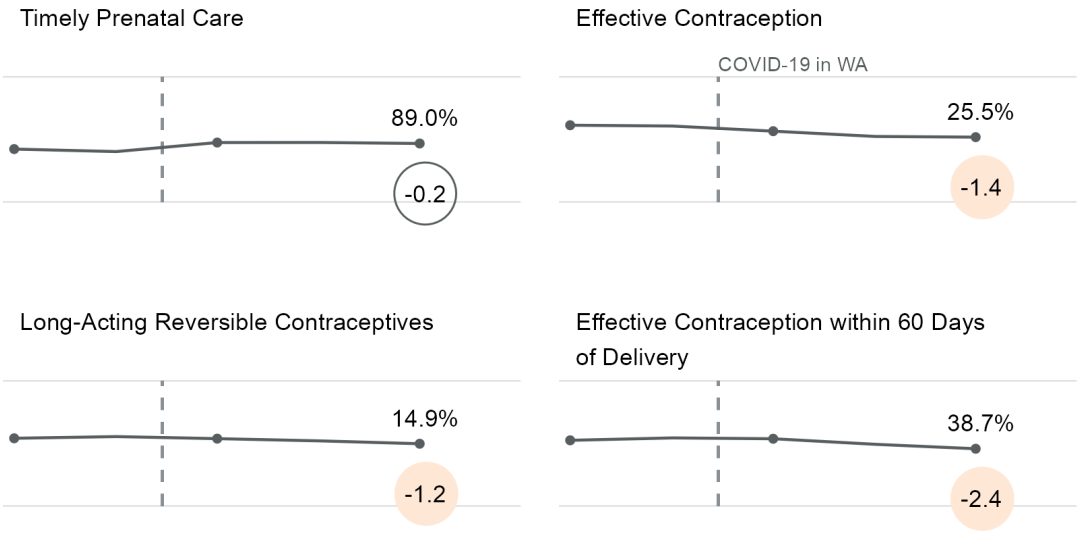


[N] Projects where this metric is pay-for-performance (P4P)

Reproductive and Maternal Health Care

Reproductive and maternal health outcomes worsened slightly compared with the previous year, with the rate of timely prenatal remaining fairly constant.

Statewide Rate for June 2019 to June 2021 and Annual Change for 2020 to 2021

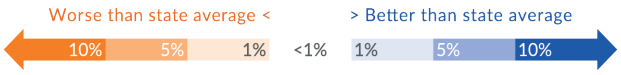


Most outcomes related to reproductive and maternal healthcare were better than or closely aligned with statewide averages for Medicaid members with a chronic condition or serious mental illness and those living in rural or high poverty areas. Members with serious mental illness received slightly lower rates of timely prenatal care than the statewide average. All of these groups experienced better than average access to effective contraception.

Statewide Rate by Health Condition and Geography, June 2021

Members With Chronic Health Conditions or Serious Mental Illness and Members Living in Rural or High Poverty Areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
Timely Prenatal Care	[1]	88.4%	85.9%	89.8%	89.4%
Effective Contraception	[1]	29.6%	30.6%	27.0%	26.3%
Long-Acting Reversible Contraceptives	[0]	15.2%	14.9%	16.7%	17.8%
Effective Contraception within 60 Days of Delivery	[1]	40.4%	43.3%	44.9%	43.5%



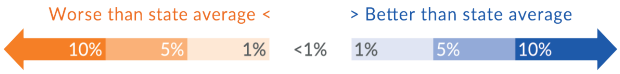
[N] Projects where this metric is pay-for-performance (P4P)

Racial and ethnic health inequities related to reproductive and maternal health care persisted in the most recent quarter. American Indian/Alaska Native, Black, and Native Hawaiian/Pacific Islander members had worse outcomes for most metrics in this domain, while Hispanic members' outcomes were somewhat better than statewide averages. Asian members experienced mixed outcomes, with better access to timely prenatal care but worse access to effective contraception than the statewide average.

Statewide Rate by Race, June 2021

American Indian/Alaska Native, Asian and Black Members

		AI/AN	Asian	Black
Timely Prenatal Care	[1]	83.5%	93.8%	86.6%
Effective Contraception	[1]	23.7%	21.9%	23.5%
Long-Acting Reversible Contraceptives	[0]	14.1%	14.7%	14.3%
Effective Contraception within 60 Days of Delivery	[1]	37.0%	31.8%	33.8%



[N] Projects where this metric is pay-for-performance (P4P)

Statewide Rate by Race, June 2021

Native Hawaiian/Pacific Islander, Hispanic and White Members

		HI/PI	Hispanic	White
Timely Prenatal Care	[1]	81.5%	91.6%	88.3%
Effective Contraception	[1]	20.5%	26.5%	26.4%
Long-Acting Reversible Contraceptives	[0]	12.6%	20.4%	12.6%
Effective Contraception within 60 Days of Delivery	[1]	32.4%	46.8%	37.5%

[N] Projects where this metric is pay-for-performance (P4P)

Prevention and Wellness

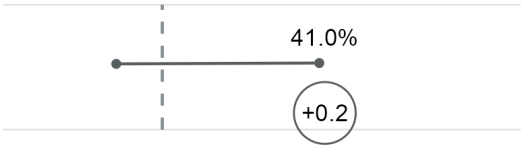
Well-child visits for members ages 3 to 11 improved over the measurement period, an encouraging trend suggesting a rebound from the COVID-19 PHE. Well-child exams within the first 30 months of life and breast and cervical cancer screening remained below historical averages for those measures. Rates of immunization for children and colorectal cancer screening remained stable.

Statewide Rate for June 2019 to June 2021 and Annual Change for 2020 to 2021

Well-Child Visits in the First 30 Months

Well-Child Visits Ages 3 to 11

Immunization for Children



Chlamydia Screening for Women

Cervical Cancer Screening

Breast Cancer Screening

Colorectal Cancer Screening

Data on the rates of childhood immunization are updated on an annual basis. Some historical data was unavailable for the rates of well-child visits between the ages of 3 and 11 for this reporting period.

Medicaid members living with a chronic health condition or serious mental illness received better than average rates for well-child visits and cancer screening. Members living in rural areas had slightly worse access to chlamydia screening, colorectal cancer screening, and well-child care within the first 30 months of life. Those living in high poverty areas, on the other hand, had the same or better than average prevention and wellness measures, with the exception of colorectal cancer screening, which was slightly worse than the statewide average.

Statewide Rate by Health Condition and Geography, June 2021

Members With Chronic Health Conditions or Serious Mental Illness and Members Living in Rural or High Poverty Areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
Well-Child Visits in the First 30 Months	[1]	62.9%	NA	53.3%	56.3%
Well-Child Visits Ages 3 to 11	[1]	62.1%	57.5%	51.1%	51.3%
Immunization for Children	[1]	NA	NA	NA	NA
Chlamydia Screening for Women	[1]	48.4%	52.5%	44.9%	51.5%
Cervical Cancer Screening	[0]	50.7%	51.0%	46.3%	47.4%
Breast Cancer Screening	[0]	50.1%	46.7%	44.4%	44.6%
Colorectal Cancer Screening	[0]	44.9%	46.6%	37.3%	38.1%

[N] Projects where this metric is pay-for-performance (P4P)

Access to preventive care was markedly worse among American Indian/Alaska Native members compared to statewide averages, with the exception of chlamydia screening for women, which was somewhat better than average. Black members also experienced lower rates of preventive care in all measured areas except for chlamydia and cervical cancer screening, which were higher than the statewide rate. Hispanic members received prevention and wellness care at a greater rate than the statewide averages for all measures within this domain.

Statewide Rate by Race, June 2021

American Indian/Alaska Native, Asian and Black Members

		AI/AN	Asian	Black
Well-Child Visits in the First 30 Months	[1]	43.4%	62.9%	49.6%
Well-Child Visits Ages 3 to 11	[1]	39.1%	52.2%	47.0%
Immunization for Children	[1]	NA	NA	NA
Chlamydia Screening for Women	[1]	49.7%	45.5%	55.4%
Cervical Cancer Screening	[0]	39.2%	50.1%	48.7%
Breast Cancer Screening	[0]	31.9%	56.3%	40.5%
Colorectal Cancer Screening	[0]	30.4%	48.9%	37.3%

[N] Projects where this metric is pay-for-performance (P4P)

Statewide Rate by Race, June 2021

Native Hawaiian/Pacific Islander, Hispanic and White Members

		NH/PI	Hispanic	White
Well-Child Visits in the First 30 Months	[1]	49.9%	61.4%	50.7%
Well-Child Visits Ages 3 to 11	[1]	41.8%	55.5%	46.7%
Immunization for Children	[1]	NA	NA	NA
Chlamydia Screening for Women	[1]	49.8%	51.2%	44.9%
Cervical Cancer Screening	[0]	44.1%	53.7%	45.2%
Breast Cancer Screening	[0]	46.3%	54.9%	43.1%
Colorectal Cancer Screening	[0]	36.7%	43.6%	38.6%

[N] Projects where this metric is pay-for-performance (P4P)

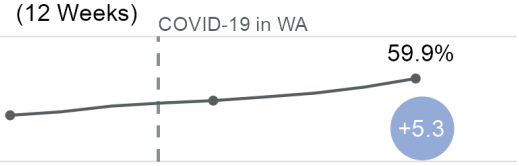
Mental Health Care

Measures related to mental health care were stable across most domains, with improvement in antidepressant medication for adults and diabetes screening for people with schizophrenia/bipolar disorder over the previous year.

Statewide Rate for June 2019 to June 2021 and Annual Change for 2020 to 2021

Mental Health Treatment Penetration

Antidepressant Medication for Adults (12 Weeks)



Antidepressant Medication for Adults (6 Months)

Antipsychotic Medication for People with Schizophrenia

Diabetes Screening for People with Schizophrenia/Bipolar Disorder

30-Day Follow-Up After ED Visit for Mental Illness

30-Day Follow-Up After Hospitalization for Mental Illness

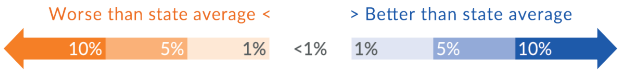
30-Day Hospital Readmission for a Psychiatric Condition ↓

Mental health care outcomes for members with a chronic condition were similar to statewide averages. Follow-up care after an ED visit or hospitalization for mental illness was better among members living in rural communities. Members living in high poverty areas and those with a serious mental illness had poorer access to antidepressant medication than the state average.

Statewide Rate by Health Condition and Geography, June 2021

Members With Chronic Health Conditions or Serious Mental Illness and Members Living in Rural or High Poverty Areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
Mental Health Treatment Penetration	[3]	55.7%	75.3%	51.8%	54.2%
Antidepressant Medication for Adults (12 Weeks)	[1]	59.9%	57.9%	60.6%	57.6%
Antidepressant Medication for Adults (6 Months)	[1]	43.6%	42.5%	43.1%	40.7%
Antipsychotic Medication for People with Schizophrenia	[0]	63.3%	63.3%	63.4%	62.9%
Diabetes Screening for People with Schizophrenia/Bipolar Disorder	[0]	78.2%	78.3%	80.4%	78.9%
30-Day Follow-Up After ED Visit for Mental Illness	[3]	67.9%	71.3%	73.8%	67.5%
30-Day Follow-Up After Hospitalization for Mental Illness	[3]	69.1%	72.6%	72.0%	68.5%
30-Day Hospital Readmission for a Psychiatric Condition	[0] ↓	15.6%	17.1%	13.2%	16.4%



↓ Lower is better

[N] Projects where this metric is pay-for-performance (P4P)

Outcomes related to mental health treatment were generally better for White members, while most outcomes were worse among all other racial groups, except for Asian members with schizophrenia, who received antipsychotic medications at a markedly better rate than the statewide average. Rates of diabetes screening were highest among American Indian/Alaska Natives.

Statewide Rate by Race, June 2021

American Indian/Alaska Native, Asian and Black Members

		AI/AN	Asian	Black
Mental Health Treatment Penetration	[3]	51.6%	51.4%	52.2%
Antidepressant Medication for Adults (12 Weeks)	[1]	50.9%	57.6%	50.3%
Antidepressant Medication for Adults (6 Months)	[1]	35.4%	43.4%	35.0%
Antipsychotic Medication for People with Schizophrenia	[0]	54.8%	75.3%	55.8%
Diabetes Screening for People with Schizophrenia/Bipolar Disorder	[0]	79.2%	72.8%	77.8%
30-Day Follow-Up After ED Visit for Mental Illness	[3]	57.4%	68.6%	61.9%
30-Day Follow-Up After Hospitalization for Mental Illness	[3]	62.6%	75.1%	63.5%
30-Day Hospital Readmission for a Psychiatric Condition	[0] ↓	15.7%	16.5%	19.5%

↓ Lower is better

[N] Projects where this metric is pay-for-performance (P4P)

Statewide Rate by Race, June 2021

Native Hawaiian/Pacific Islander, Hispanic and White Members

		NH/PI	Hispanic	White
Mental Health Treatment Penetration	[3]	49.4%	53.5%	55.0%
Antidepressant Medication for Adults (12 Weeks)	[1]	60.3%	55.6%	62.5%
Antidepressant Medication for Adults (6 Months)	[1]	43.3%	37.4%	46.4%
Antipsychotic Medication for People with Schizophrenia	[0]	63.8%	59.4%	65.0%
Diabetes Screening for People with Schizophrenia/Bipolar Disorder	[0]	75.8%	77.7%	78.5%
30-Day Follow-Up After ED Visit for Mental Illness	[3]	62.4%	67.4%	69.6%
30-Day Follow-Up After Hospitalization for Mental Illness	[3]	61.8%	66.4%	70.3%
30-Day Hospital Readmission for a Psychiatric Condition	[0] ↓	14.9%	12.8%	15.6%

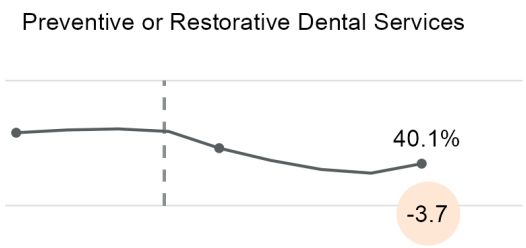
↓ Lower is better

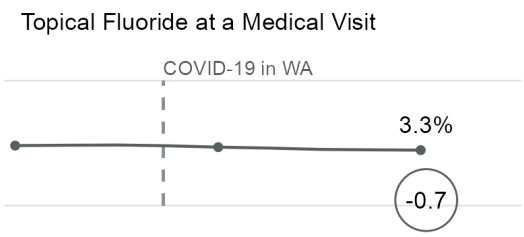
[N] Projects where this metric is pay-for-performance (P4P)

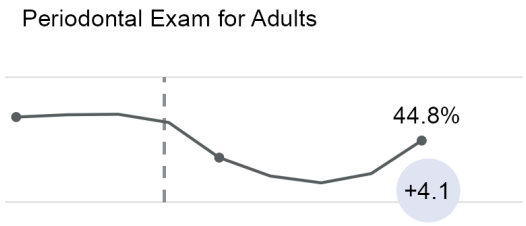
Oral Health Care

Periodontal exams for adults demonstrated encouraging improvements over the previous year, recovering from the presumed impact of the COVID-19 PHE. Preventive or Restorative Dental Services remained below historical averages, and the rate of fluoride at medical visits remained flat.

Statewide Rate for June 2019 to June 2021 and Annual Change for 2020 to 2021





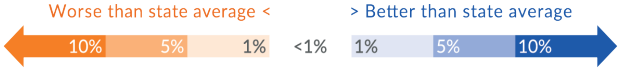


Outcomes for members with a chronic condition or serious mental illness and those in rural or high poverty communities were mixed during this period compared with the statewide averages.

Statewide Rate by Health Condition and Geography, June 2021

Members With Chronic Health Conditions or Serious Mental Illness and Members Living in Rural or High Poverty Areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
Preventive or Restorative Dental Services	[1]	38.1%	34.2%	44.5%	42.5%
Topical Fluoride at a Medical Visit	[1]	4.7%	4.4%	2.3%	3.0%
Periodontal Exam for Adults	[2]	45.7%	44.8%	45.1%	44.1%



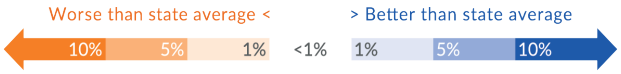
[N] Projects where this metric is pay-for-performance (P4P)

Disparities in access to oral health care by race and ethnicity persisted in this quarter, with American Indian/Alaska Native, Black, and Native Hawaiian/Pacific Islander members generally experiencing worse access to oral healthcare than average. Hispanic members faired better than all groups for access to exams and preventive or restorative dental services.

Statewide Rate by Race, June 2021

American Indian/Alaska Native, Asian and Black Members

		AI/AN	Asian	Black
Preventive or Restorative Dental Services	[1]	36.8%	37.1%	37.6%
Topical Fluoride at a Medical Visit	[1]	3.2%	3.8%	3.1%
Periodontal Exam for Adults	[2]	40.5%	49.7%	43.3%



[N] Projects where this metric is pay-for-performance (P4P)

Statewide Rate by Race, June 2021

Native Hawaiian/Pacific Islander, Hispanic and White Members

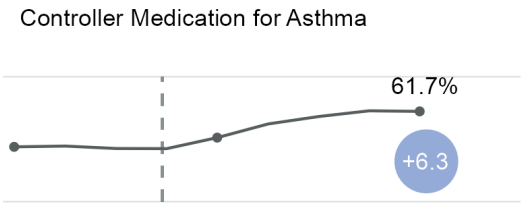
		NH/PI	Hispanic	White
Preventive or Restorative Dental Services	[1]	33.9%	52.2%	35.0%
Topical Fluoride at a Medical Visit	[1]	3.9%	2.6%	4.0%
Periodontal Exam for Adults	[2]	43.3%	46.5%	43.7%

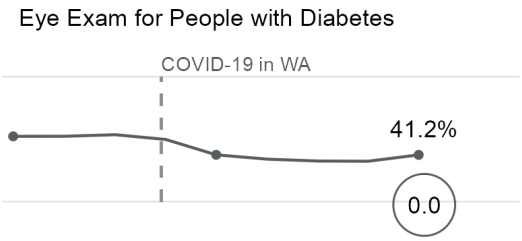
[N] Projects where this metric is pay-for-performance (P4P)

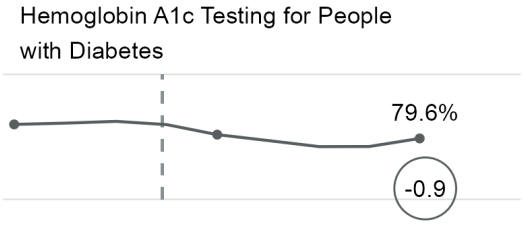
Care for People with Chronic Conditions

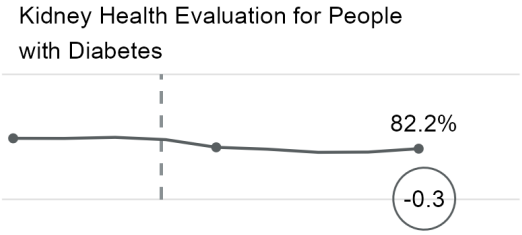
All outcomes for care for people with chronic conditions remained stable with minimal change since the previous year, with one exception. The rate of prescriptions for controller medication for asthma improved 6.3 percentage points over the previous year. We previously reported negative impacts of the COVID-19 PHE for care that must be delivered in person to patients with diabetes. However, these rates have recovered to previous PHE levels.

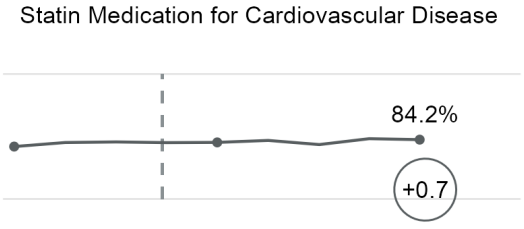
Statewide Rate for June 2019 to June 2021 and Annual Change for 2020 to 2021









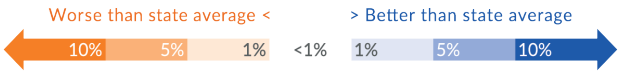


Outcomes for members with a chronic health condition aligned closely with the state overall in this domain. However, members with diabetes living in rural communities had better than average outcomes for the measures reported here.

Statewide Rate by Health Condition and Geography, June 2021

Members With Chronic Health Conditions or Serious Mental Illness and Members Living in Rural or High Poverty Areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
Controller Medication for Asthma	[2]	61.8%	58.1%	57.7%	58.5%
Eye Exam for People with Diabetes	[2]	41.7%	39.9%	42.3%	41.9%
Hemoglobin A1c Testing for People with Diabetes	[2]	80.0%	78.3%	82.7%	78.6%
Kidney Health Evaluation for People with Diabetes	[2]	82.5%	82.4%	83.4%	82.3%
Statin Medication for Cardiovascular Disease	[1]	84.2%	80.5%	83.8%	83.0%



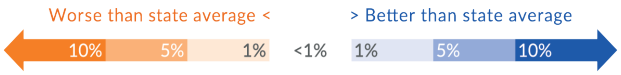
[N] Projects where this metric is pay-for-performance (P4P)

Black and American Indian/Alaska Native members experienced lower rates of care in this domain across all measures, while Asian and Hispanic members' outcomes were generally better than state averages. These trends represent a continuation of previously reported inequities in care for people with asthma, diabetes, and cardiovascular disease.

Statewide Rate by Race, June 2021

American Indian/Alaska Native, Asian and Black Members

		AI/AN	Asian	Black
Controller Medication for Asthma	[2]	50.5%	69.4%	59.9%
Eye Exam for People with Diabetes	[2]	37.5%	50.3%	38.1%
Hemoglobin A1c Testing for People with Diabetes	[2]	74.0%	86.4%	76.1%
Kidney Health Evaluation for People with Diabetes	[2]	81.4%	86.2%	80.7%
Statin Medication for Cardiovascular Disease	[1]	74.1%	94.4%	82.1%

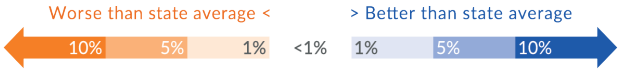


[N] Projects where this metric is pay-for-performance (P4P)

Statewide Rate by Race, June 2021

Native Hawaiian/Pacific Islander, Hispanic and White Members

		NH/PI	Hispanic	White
Controller Medication for Asthma	[2]	62.8%	66.4%	60.1%
Eye Exam for People with Diabetes	[2]	40.0%	45.1%	39.7%
Hemoglobin A1c Testing for People with Diabetes	[2]	77.7%	81.8%	79.2%
Kidney Health Evaluation for People with Diabetes	[2]	81.8%	82.6%	81.9%
Statin Medication for Cardiovascular Disease	[1]	86.2%	84.7%	84.0%

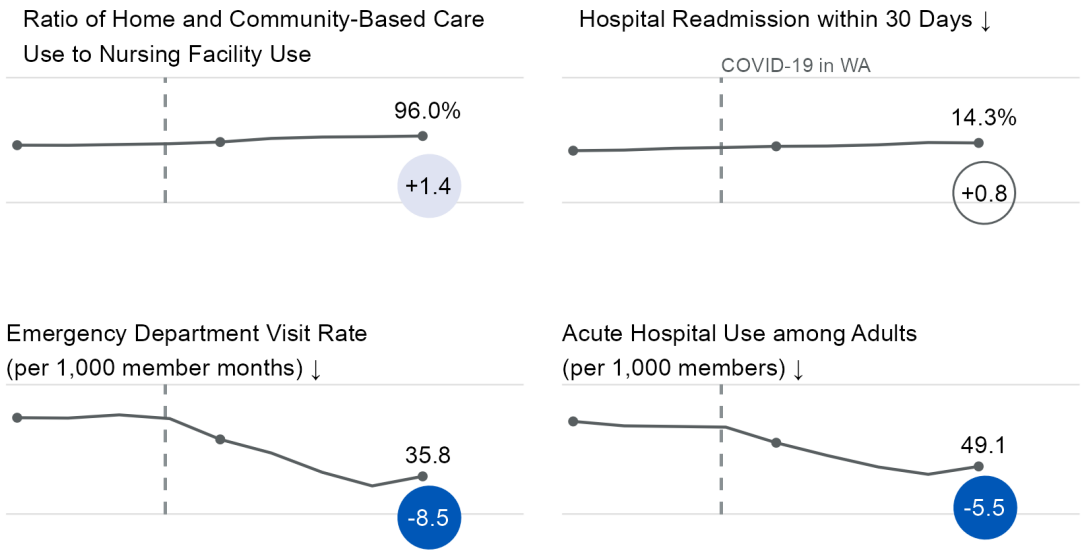


[N] Projects where this metric is pay-for-performance (P4P)

Emergency Department, Hospital and Institutional Care Use

The ratio of home and community-based care to nursing home use and the rate of hospital readmissions remained stable compared to the previous year. Emergency department (ED) visits and acute hospital use demonstrated a reversal of their previous downward trajectories.

Statewide Rate for June 2019 to June 2021 and Annual Change for 2020 to 2021



Members with chronic conditions or serious mental illness had more ED visits and hospital use than the statewide average, likely due to poor health status and higher care needs. Members living in high poverty communities also received more care in these settings, while members in rural communities had lower rates of utilization.

Statewide Rate by Health Condition and Geography, June 2021

Members With Chronic Health Conditions or Serious Mental Illness and Members Living in Rural or High Poverty Areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
Ratio of Home and Community-Based Care Use to Nursing Facility Use	[0]	96.0%	97.0%	96.0%	95.4%
Hospital Readmission within 30 Days	[3] ↓	14.6%	19.0%	11.1%	14.5%
Emergency Department Visit Rate (per 1,000 member months)	[8] ↓	59.0	118.7	34.4	43.2
Acute Hospital Use among Adults (per 1,000 members)	[5] ↓	73.6	105.5	45.8	52.3

↓ Lower is better

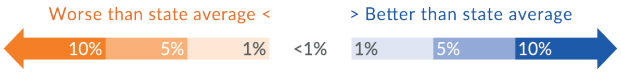
[N] Projects where this metric is pay-for-performance (P4P)

Rates of care obtained in EDs and acute hospital settings varied widely among members of different racial and ethnic groups. Asian, Native Hawaiian/Pacific Islander, and Hispanic members were much less likely to receive care in these settings. In contrast, American Indian/Alaska Native, Black, and White members were much more likely to receive such care.

Statewide Rate by Race, June 2021

American Indian/Alaska Native, Asian and Black Members

		AI/AN	Asian	Black
Ratio of Home and Community-Based Care Use to Nursing Facility Use	[0]	93.6%	97.7%	96.4%
Hospital Readmission within 30 Days	[3] ↓	16.1%	12.2%	17.3%
Emergency Department Visit Rate (per 1,000 member months)	[8] ↓	51.3	15.3	45.6
Acute Hospital Use among Adults (per 1,000 members)	[5] ↓	53.5	26.2	53.9



↓ Lower is better

[N] Projects where this metric is pay-for-performance (P4P)

Statewide Rate by Race, June 2021

Native Hawaiian/Pacific Islander, Hispanic and White Members

		HI/PI	Hispanic	White
Ratio of Home and Community-Based Care Use to Nursing Facility Use	[0]	96.7%	95.6%	96.1%
Hospital Readmission within 30 Days	[3] ↓	10.6%	10.5%	14.8%
Emergency Department Visit Rate (per 1,000 member months)	[8] ↓	26.5	30.5	40.4
Acute Hospital Use among Adults (per 1,000 members)	[5] ↓	46.6	35.8	55.3

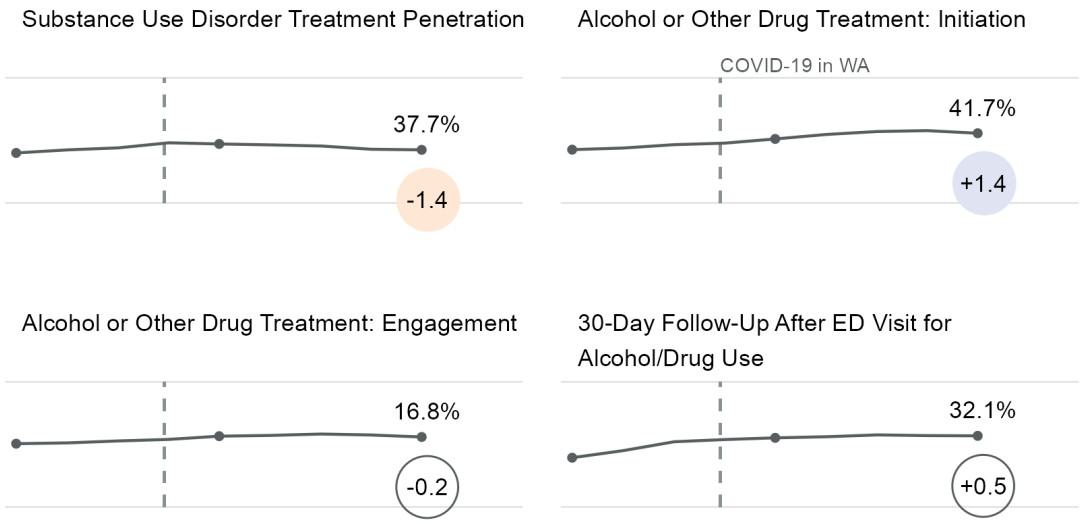
↓ Lower is better

[N] Projects where this metric is pay-for-performance (P4P)

Substance Use Disorder Care

Most metrics tracking substance use disorder (SUD) treatment and care were relatively unchanged compared with the previous year.

Statewide Rate for June 2019 to June 2021 and Annual Change for 2020 to 2021

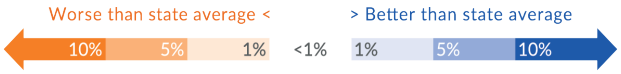


Outcomes for members with serious mental illness were better or in line with the state average for these measures, while measures of SUD treatment penetration and initiation were worse for members living in rural areas. Members living in areas of high poverty received care on par with average statewide rates.

Statewide Rate by Health Condition and Geography, June 2021

Members With Chronic Health Conditions or Serious Mental Illness and Members Living in Rural or High Poverty Areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
Substance Use Disorder Treatment Penetration	[3]	37.6%	41.3%	36.1%	36.9%
Alcohol or Other Drug Treatment: Initiation	[0]	41.8%	43.9%	40.2%	41.0%
Alcohol or Other Drug Treatment: Engagement	[0]	16.6%	16.9%	16.2%	16.2%
30-Day Follow-Up After ED Visit for Alcohol/Drug Use	[3]	32.1%	35.0%	32.6%	31.9%



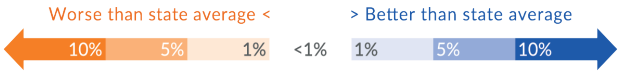
[N] Projects where this metric is pay-for-performance (P4P)

American Indian/Alaska Native and White Medicaid members experienced better than average access to SUD care across most measures, except for 30 day follow-up after an ED visit for alcohol or drug use, where American Indian/Alaska Native members fared slightly worse than the statewide rate. ED follow-up for Black members within 30 days of a visit for alcohol or drug use was 12 percentage points lower than the statewide average, reflecting a continuation of a previously reported disparity in this measure.

Statewide Rate by Race, June 2021

American Indian/Alaska Native, Asian and Black Members

		AI/AN	Asian	Black
Substance Use Disorder Treatment Penetration	[3]	43.9%	30.1%	31.0%
Alcohol or Other Drug Treatment: Initiation	[0]	44.2%	37.2%	38.4%
Alcohol or Other Drug Treatment: Engagement	[0]	19.4%	13.9%	12.6%
30-Day Follow-Up After ED Visit for Alcohol/Drug Use	[3]	28.6%	28.8%	20.6%



[N] Projects where this metric is pay-for-performance (P4P)

Statewide Rate by Race, June 2021

Native Hawaiian/Pacific Islander, Hispanic and White Members

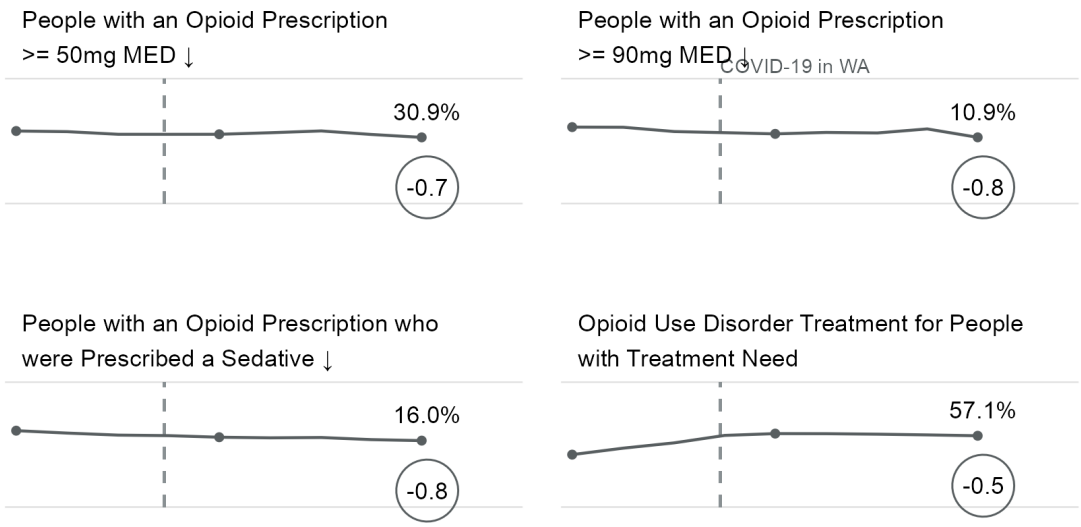
		HI/PI	Hispanic	White
Substance Use Disorder Treatment Penetration	[3]	31.4%	32.6%	39.7%
Alcohol or Other Drug Treatment: Initiation	[0]	36.9%	37.9%	42.9%
Alcohol or Other Drug Treatment: Engagement	[0]	12.1%	14.8%	17.7%
30-Day Follow-Up After ED Visit for Alcohol/Drug Use	[3]	24.4%	27.7%	36.0%

[N] Projects where this metric is pay-for-performance (P4P)

Opioid Prescribing and Opioid Use Disorder Treatment

Statewide measures related to opioid use disorder (OUD) remained flat over the most recent quarter. Care patterns among people with an OUD treatment need have remained stable since the onset of the COVID-19 public health emergency.

Statewide Rate for June 2019 to June 2021 and Annual Change for 2020 to 2021



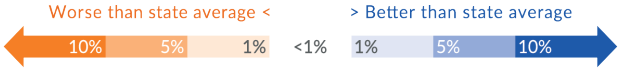
Three of the four outcome metrics in this domain are based on data from just one quarter, in contrast to most outcome measures presented in this report, which are based on four quarters. Only the metric for OUD treatment is calculated from a full year of data.

Most metrics in this domain aligned closely with statewide averages for members with chronic conditions or serious mental illness and for those living in rural or high poverty communities. One exception was a higher rate of concurrent prescriptions of opioids and sedatives for members with serious mental illness. Conversely, members living in high poverty communities had somewhat better outcomes than the state average for both measures addressing morphine equivalent dosing.

Statewide Rate by Health Condition and Geography, June 2021

Members With Chronic Health Conditions or Serious Mental Illness and Members Living in Rural or High Poverty Areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High Poverty
People with an Opioid Prescription >= 50mg MED	[1] ↓	30.8%	31.1%	30.7%	28.3%
People with an Opioid Prescription >= 90mg MED	[1] ↓	10.8%	10.1%	10.4%	9.1%
People with an Opioid Prescription who were Prescribed a Sedative	[1] ↓	15.9%	24.9%	15.2%	15.3%
Opioid Use Disorder Treatment for People with Treatment Need	[3]	57.2%	56.6%	56.4%	57.0%



↓ Lower is better

[N] Projects where this metric is pay-for-performance (P4P)

Black members experienced worse access to OUD treatment and higher daily morphine equivalent dosing than the statewide average. All subpopulations except White members received worse access to treatment for OUD, representing a continuation of previously reported disparities for these groups.

Statewide Rate by Race, June 2021

American Indian/Alaska Native, Asian and Black Members

		AI/AN	Asian	Black
People with an Opioid Prescription >= 50mg MED	[1] ↓	29.8%	18.4%	37.3%
People with an Opioid Prescription >= 90mg MED	[1] ↓	10.5%	NA	12.7%
People with an Opioid Prescription who were Prescribed a Sedative	[1] ↓	13.9%	19.4%	11.8%
Opioid Use Disorder Treatment for People with Treatment Need	[3]	55.7%	52.9%	46.8%

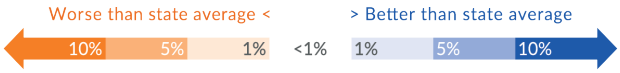
↓ Lower is better

[N] Projects where this metric is pay-for-performance (P4P)

Statewide Rate by Race, June 2021

Native Hawaiian/Pacific Islander, Hispanic and White Members

		HI/PI	Hispanic	White
People with an Opioid Prescription >= 50mg MED	[1] ↓	23.7%	25.4%	30.9%
People with an Opioid Prescription >= 90mg MED	[1] ↓	NA	7.4%	11.0%
People with an Opioid Prescription who were Prescribed a Sedative	[1] ↓	NA	13.6%	16.6%
Opioid Use Disorder Treatment for People with Treatment Need	[3]	50.1%	54.3%	59.0%



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[N] Projects where this metric is pay-for-performance (P4P)

Foundational Community Supports Summary of Qualitative Findings

This report provides an update on the findings from the Foundational Community Supports program.

Background

Supportive Housing and Employment Models

The Foundational Community Supports program includes supportive housing, based on the Permanent Supportive Housing model, and supportive employment, based on the Individual Placement and Support model.

The Permanent Supportive Housing model was defined by the federal Substance Abuse and Mental Health Services Administration (United States Interagency Council on Homelessness, n.d.). It combines low-barrier affordable housing, health care, and supportive services to help individuals and families in need lead more stable lives. Permanent Supportive Housing is predominantly intended for people with mental illness and substance use disorders who are unhoused or otherwise unstably housed and unable to maintain housing without supportive services. Permanent Supportive Housing services are voluntary and multidisciplinary, provide choice, and have low barriers to entry.

Individual Placement and Support is a model that supports individuals who desire employment to find and maintain regular jobs of their choosing, focusing on people with serious mental illness and behavioral health conditions. Individual Placement and Support emphasizes the following:

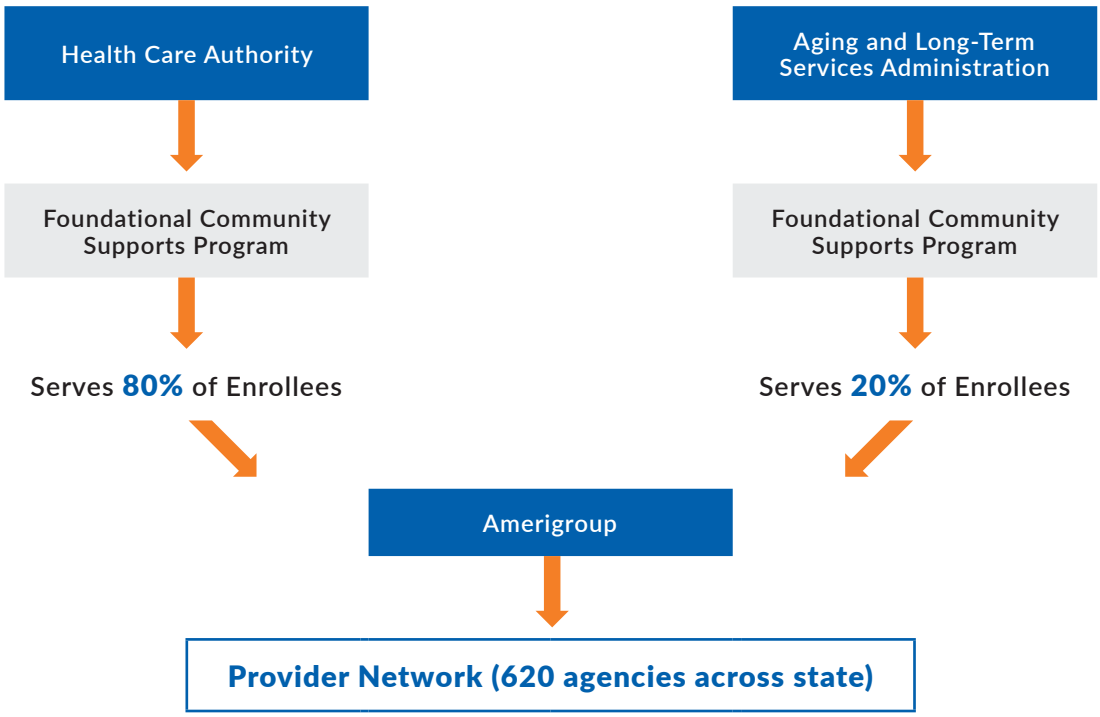
- Client choice
- Competitive employment that does not steer individuals into jobs specifically for those with disabilities
- Relationships building between employment specialists, clients, and employers
- Opportunities for job development, when possible
- Rapid job searching with minimized assessments, training, and counseling
- Integrated services where employment specialists meet with clients' other providers to facilitate maintained employment

In this rapid cycle report, we conducted key informant interviews to compare and contrast ways in which the Foundational Community Support program was administered by the Health Care Authority and the Aging and Long-Term Support Administration. We described how support services were tailored, the kind of experience and expertise provider organizations had (particularly with respect to billing and access to housing stock), whether potential misalignment with client needs existed, and the ways in which the COVID-19 pandemic affected service delivery. We close with recommendations to improve the programs.

Foundational Community Supports Program Structure

Two agencies, the Health Care Authority and the Aging and Long-Term Support Administration, oversee the Foundational Community Supports program in Washington. Figure 1 shows how the programs are structured.

Figure 1. Foundational Community Supports Program Structure



The Health Care Authority oversees about 80% of total program enrollees, while the Aging and Long-Term Support Administration oversees the other 20%. These agencies serve distinctly different populations. The Aging and Long-Term Support Administration tends to serve older clients with functional disabilities who are often dually eligible for Medicaid and Medicare, and who may receive nursing home care. In contrast, the Health Care Authority serves the general Apple Health (Medicaid) population, which tends to be younger.

Amerigroup, one of the five managed care organizations in the state of Washington, serves as the Foundational Community Supports third-party administrator, making final program eligibility determinations and managing the provider network. The provider network is comprised of organizations that deliver supportive housing and employment services. In Washington, there are

over 600 organizations that provide Foundation Community Supports, including traditional healthcare organizations, community-based organizations, and social support organizations. Housing and Employment specialists work at these organizations to directly support and help clients find housing and employment.

The Health Care Authority and the Aging and Long-Term Support Administration oversees the Foundational Community Supports program differently. Aging and Long-Term Support Administration beneficiaries are assigned a case manager who screens for program eligibility and determines which services are needed (e.g., housing, employment, other community resources) before referring them to Amerigroup, which identifies the service provider. Case managers receive training and education and are well-versed in program eligibility. In contrast, Health Care Authority is not responsible for determining eligibility and is not a direct service provider.

Methods

The following qualitative data were collected and analyzed for this rapid cycle report:

- Seven key informant interviews were conducted with representatives from the Aging and Long-Term Support Administration (n=3), Health Care Authority (n=3) and Amerigroup (n=1) between June-December 2021
- Six key informant interviews were conducted with representatives from six provider organizations (n=6) between January-February 2022

Participant selection and interview guide questions were informed by three prior interviews with state leaders in April 2019 and September 2020. Participants from the Aging and Long-Term Support Administration, Health Care Authority, and Amerigroup were program administrators or individuals with experience delivering technical assistance to service providers. During interviews, we asked participants about their experiences providing technical assistance, the provider organizations they work with, and their implementation successes and challenges.

Provider organizations that delivered Foundational Community Supports were purposefully selected to vary on characteristics such as organization type, size, and location. These organizations were asked about the clients they serve, their experiences with billing and providing supportive housing and employment, and how they assessed Foundational Community Supports program success.

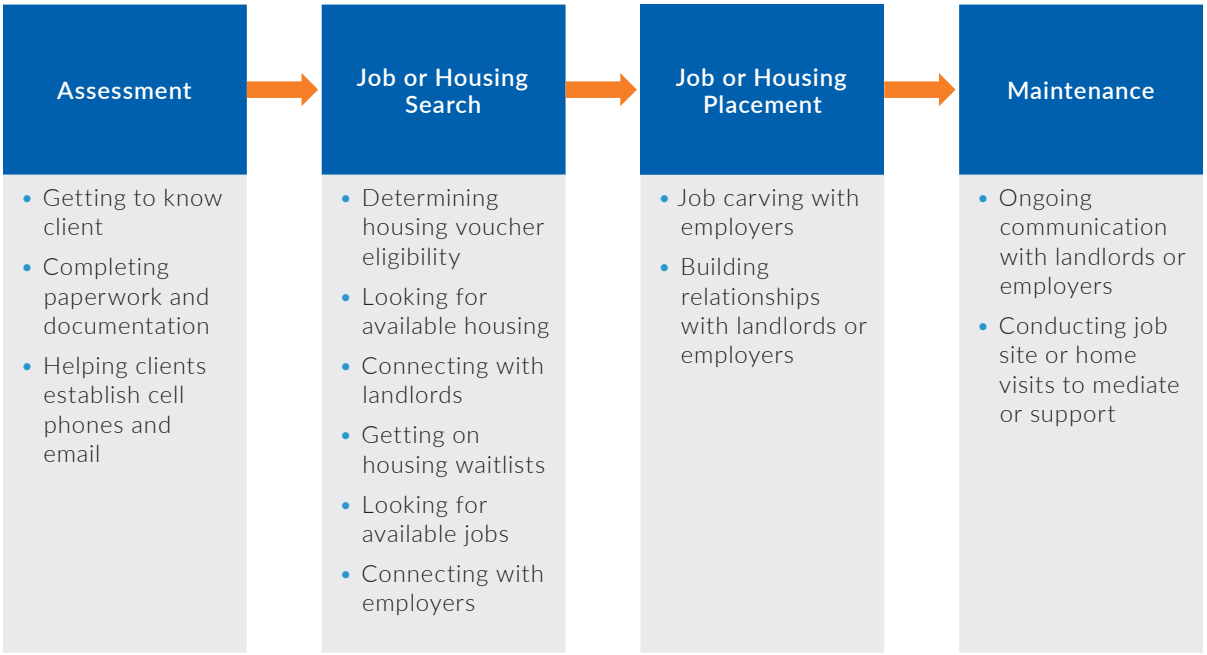
Interviews lasted approximately 45 to 60 minutes. They were recorded, professionally transcribed, and checked for accuracy. Qualitative research staff entered de-identified transcripts into Atlas.ti (Version 9, Atlas.ti Scientific Software Development GmbH, Berlin, Germany) for data management and analysis.

The team used an iterative and inductive analytic approach to categorize and tag interview data. We met as a group to discuss the first transcripts and collectively developed codes to identify and make sense of emerging themes. Then, one team member coded the remaining interview data, developed analytic memos, and met weekly with the team to further analyze the data, which included reviewing and refining how data were analyzed and coded and discussing emerging findings. We then reviewed the data again, making comparisons across organizations. After findings were identified, these were member checked with a key informant from each the Aging and Long-Term Support Administration and the Health Care Authority for accuracy and revised.

Findings

Key informants from supportive housing and supportive employment programs identified four key program steps: assessment, job or housing search, job or housing placement, and maintenance. Figure 2 summarizes what we learned about this process and the activities involved in each step.

Figure 2. Supportive Housing and Employment Steps



Foundational Community Supports Services were Highly Tailored

According to key informants, the steps shown in Figure 2 were customized and aligned with clients' preferences, needs, and interests. For example, some clients needed support establishing cell phone and email accounts to apply for jobs, while others required assistance determining their interests and speaking with potential employers.

> *[What we provide] can really vary depending on the capabilities of the person…It'll be everything from doing a resume, helping them create an email address, maybe even setting up a cell phone for them—it can be really basic at first, just getting all of that basic information set up.*
>
> *–Social Service Provider Organization Interviewee, Organization 6*

Once connected with a job or housing, some clients needed minimal ongoing support, while others preferred the specialist's presence and support at job sites and when engaging with landlords.

Provider Organizations had Varied Expertise and Experience

Foundational Community Supports services were provided by differing types of organizations, including traditional health care organizations (e.g., primary care practices), behavioral health agencies, and social service organizations. These organizations delivered supportive housing, supportive employment, or both programs. Their prior experience also varied, as some organizations previously conducted similar work for years, making the program a natural addition. Others were delivering these services for the first time and had to build new skills, particularly around billing.

Billing was Particularly Challenging for Social Service Organizations

Billing for Foundational Community Supports was challenging for most organizations; they experienced a learning curve due to the unique billing structure and documentation requirements. However, billing was particularly difficult for organizations that were not clinical practices (e.g., social service organizations), as learning to document and submit Medicaid encounters was a completely new skill. Organizations that had never billed for Medicaid services spent administrative time and resources learning the billing system and conducting resubmissions. They also experienced denied claims and reimbursement delays, which were challenging for these organizations to endure financially.

> *The billing is very cumbersome. It's very time intensive. I tried to do batch billing and that didn't work well, and so we have to do each claim individually one-by-one, and I know that this is a thing for anybody that has to do any medical billing, but it's particularly tough for social service providers like us. 1) We've never had to do it before, and 2.) We only have one stream of income from any kind of insurance. Whereas a clinic has different procedures [they can bill for], which I'm sure can sort of help float you as you try to contest claims that were denied. It's really tough.*
>
> *–Social Service Provider Organization Interviewee, Organization 5*

Provider Organizations had Variable Access to Housing Stock

Although housing stock was low across the state, more experienced organizations leveraged their history and prior connections to landlords to secure client housing. These organizations also purchased buildings or master leased units, which allowed them to better control and access housing. Smaller and less experienced organizations often lacked the expertise and funding required to make these acquisitions or obtain financing to keep units in good condition. It was unclear whether provider-owner housing had more restriction than other types of units and future work should consider the advantages and disadvantages to different unit ownership structures.

> *We own some housing. We oversee about 90 units. About half of those we own, and [for] the other half, we work with private landlords. One of our strategies is we master-lease a lot so that we're actually the tenant. We have master leases on close to 50 units… We are responsible for those units. Then, we also work with the landlords. Washington State has a landlord-mitigation fund. If there are damages—above the normal wear and tear— then a landlord can be reimbursed up to $5,000 for damages. We've also written a couple of grants that could help [cover the cost of damages] above and beyond that.*
>
> *–Community Health Care Provider Organization Interviewee, Organization 2*

Fidelity Reviews Functioned as Learning Collaboratives

Supportive housing and employment programs were informed by national programs, Permanent Supportive Housing and Individual Placement and Support (see background for more details.) Administrators and the organizations delivering client services were aware of these programs, but did not have processes in place for ensuring strict fidelity to these models. Instead, administrators used "fidelity reviews" to share best practices, train and teach organizations about the models, and provide opportunities for self-assessment and reflection. Reviews were "hosted" by peer organizations and functioned as learning collaboratives.

> *They're not an audit by any means. They're not punitive. It's really designed to share best practice. They're conducted by their peers, so other agencies will come as part of a review panel. It's really a way for people to learn from what other providers are doing and provide suggestions based on how a different agency might implement FCS.*
>
> *–Health Care Authority Interviewee*

During these sessions, participants learned how other organizations conducted supportive employment and housing services and found the process useful. Nevertheless, participation was optional, and the learning sessions did not provide mechanisms for ensuring that core program elements were implemented consistently.

> *When I did the review, I actually learned a ton and learned where we could improve and our shortfalls. When I signed up to get reviewed, I knew it was gonna be horrific. The report was not good, but we are doing somethings right, but there's a lot of things that we need to improve upon. I'm slowly working with the team to try and get those things implemented and [to] smooth out the process and really strengthen the program to better help our recovery-community members.*
>
> *–Social Service Provider Organization Interviewee, Organization 6*

The Program Structure was Misaligned with Clients' Continuing Needs

Foundational Community Supports was designed as a six-month program. During this time period, clients could receive up to 30 hours of services with the option to renew after six months. However, the renewal process was administratively burdensome and potentially delayed client access to services.

Key informants reported that the program limits were not well-aligned with clients' needs. First, clients needed more than 30 hours of support. Service providers could apply for an "Exception to the Rule" justification and request additional time. However, these approvals took months, exceeding the six-month limit, and led to service and billing lapses. Therefore, provider organizations used the "Exception to the Rule" minimally and found applying for a renewal easier than asking for an exception.

Let's say we use 30 hours in three months. We can write something called an ETR, Exception to the Rule. If that's approved, we can get additional hours for the rest of those times. I will say, though, those have been taking an unbelievable— they're never back in time before their authorization actually expires. At that point, there's almost no point in turning it in because by the time it gets back and it's approved, we're ready to do another [six month] authorization anyway. It's very concerning because we might find someone a job or find someone a house and then they need lots of job coaching or housing retention services and they're out of hours."

–Social Service Provider Organization Interviewee, Organization 3

Second, clients were often transient and living with behavioral health issues that could stall progress and prevent them from consistently engaging in services within the six-month period.

Many… have the same barriers…in terms of ability to locate and maintain housing due to any number of issues with behavioral health or inability to forge relationships, or inability to follow through with tasks because your depression takes over, your anxiety takes over, or you're having a bad day with your other chronic conditions.

–Aging and Long Term Services Administration Interviewee

Third, provider organizations often needed more than six months to find housing or employment. For enrollees entering the program between January 1, 2018 and June 30, 2020, over 70% had more than six months of consecutive Foundational Community Supports enrollment. The meager housing stock and limited job openings coincident with the COVID pandemic tended to extend this time. Jobs in construction, food services, and retail were common placement fields but were particularly impacted by the pandemic.

"People are so desperate just for any help at all. Sometimes we work at it, sometimes we just get lucky, and all of a sudden some of the client moves with time for a wait list, all of a sudden, then they have a voucher, then we can start helping them find housing and even then, it can be really difficult with the housing market."

–Social Service Provider Organization Interviewee, Organization 3

Lastly, housed or employed beneficiaries required renewals to receive maintenance services (e.g., support keeping their housing or job). However, renewing every six months was the only mechanism by which organizations were permitted to continue to bill. The renewal process created an administrative burden and contributed to coverage and service lapses, and delayed or denied reimbursement for rendered services.

Not All Services were Billable

Provider organizations delivered some services that were not billable. Important and time-consuming tasks, including outreach and relationship-building with landlords and employers, were not billable services unless they were connected to a specific beneficiary. Therefore, some of the efforts necessary for the success of Foundational Community Supports were not reimbursable. Provider organizations, particularly those that were not clinical practices, also reported a steep learning curve to billing, expending time for which they were not paid.

FCS does not allow the provider to get paid for just general search. As a provider, I can't go out and just start talking to a Target regional manager. I can't get paid for that. I have to have a client that wants to work at Target. Then I call the Target regional manager and start talking to them about how do I get this person into your system. Then that's how they get paid for it. Again, it's very person-centered, but with the caveat that older, established providers tend to have a fairly robust network of employers that they've worked with for many years and they can facilitate a quicker access to some employers.

-Aging and Long Term Care Administration Employment Interviewee

Additionally, the billing system was complicated and varied between the two programs. For supportive employment, clients received 30 hours of time billed in 15-minute increments. For instance, after spending an hour with an employment specialist, there were 29 hours remaining. For supportive housing, the billing was more complex. Clients received 30 units. A unit included all services rendered on a single day, with a unit consisting of a minimum of 45 minutes. Services that took under 45 minutes were not billable. Services exceeding 45 minutes were billed as a single unit, regardless of whether the time spent was 45 minutes or 8 hours in a single day. Provider organizations that were not sensitive to the billing structure were potentially losing revenue that would be important to sustaining their programs.

We have to encourage staff to try not to go over that one [unit] too often because then all of a sudden, if you work six hours, but two hours with each [of three] clients, we only get paid for three [units]...with employment, we bill out in 15-minute increments. If you do an hour and a half with the client that day and they have 30 hours at the beginning of the day, the next day they'll have 28 ½ hours.

–Social Service Provider Organization Interviewee, Organization 3

The Impacts of COVID-19

COVID-19 had various impacts on Foundational Community Supports at different time points throughout its implementation. Supportive housing and employment training activities were previously offered in person, which was important for making connections with prospective landlords and employers. Meetings with clients were also previously held in person and were valuable for building relationships with clients. During the pandemic, this disruption led to virtual engagement and may have impacted client engagement in services.

COVID-19 also impacted the housing market and the labor force. COVID-19 led to increased housing prices and reduced turnover in housing units, making it even more difficult to house individuals. For supportive employment, provider organization staff noted that potential employers, such as retailers and restaurants, closed temporarily or permanently due to COVID-19-related restrictions, reducing staff and hours, and making new job placements challenging. However, by the end of 2021 and into 2022, the labor market changed due to labor shortages, making part-time positions more appealing to employers, which was desirable for supportive employment clients and workers with disabilities.

We are finding that the more jobs there are, the more open employers are to working with participants that might have different needs.

–Social Service Provider Organization Interviewee, Organization 4

Given job vacancies, employers became more willing to hire individuals with different needs or do "light job carving," whereby employers tailored job duties to leverage an individual's specific skills, possibly giving clients more choice or a better job fit than they had previously.

Recommendations

Based on this qualitative analysis of the Foundational Community Supports programs, we have identified the following recommendations:

1. **Provide smaller and less experienced organizations with additional and ongoing support.** If the state plans to add provider organizations to the network, we recommend that less experienced organizations, particularly social service organizations that are new to the Medicaid delivery system, receive more ongoing training and support, particularly around billing.

2. **Consider implementing new processes for continuing to monitor and ensure all provider organizations are implementing similar services.** While the fidelity reviews were described as excellent learning opportunities for participating organizations, key informants reported delivering varied services. There were no mechanisms for ensuring core program elements were implemented consistently across provider organizations.

3. **Examine the ideal program length and consider increasing it to 12 months.** We heard that six months was not enough time for the assessment, search, placement, and maintenance steps. Furthermore, participants often sought renewals to continue maintenance services even when job or housing placement was complete. COVID-19 and the tight housing market also exacerbated the time it took to find housing. Increasing the program length could minimize the renewal process administrative burden and reduce coverage and service lapses. A 12-month program may also better align with Medicaid annual approvals.

4. **Review Amerigroup's processing time for "Exception to the Rule" applications.** While it was beneficial to have a mechanism by which provider organizations could apply to receive more hours for clients who needed them during the six-month period, some "Exception to the Rule" approvals took months, exceeding the six-month limit, leading to service and billing lapses. Provider organizations reported that applying for a renewal was easier than asking for an exception. If the program length remains at six months, providing more education around the use of "Exception to the Rule" and processing applications more quickly may lead to fewer service and billing lapses. If the program length is extended, some clients may still need additional time. It would be beneficial for these applications to be processed more quickly so as not to lose momentum in their housing or employment search.

5. **Simplify billing practices.** The billing system is complex, particularly for housing services. Provider organizations without clinical billing expertise (e.g., social service organizations) struggled to understand the best way to bill and learned by trial and error. Simplifying billing practices would alleviate some of this burden on provider organizations, particularly for organizations unfamiliar with Medicaid billing. This may present an opportunity to explore how a value-based payment arrangement, such as a capitated rate, might benefit these provider organizations with a more stable, flexible, and predictable revenue stream.