Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Predicting Referrals for Competency Evaluation

As required per Engrossed Substitute Senate Bill 5187 Sec 202 (1)(6)(a)

Chapter 475, Laws of 2023

December 1, 2023

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Washington State Department of Social & Health Services
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RDA Report Number 3.56

Executive Summary

Engrossed Substitute Senate Bill (ESSB) 6032 (Chapter 299, Laws of 2018) directed the Department of Social and Health Services (DSHS) to develop and implement a predictive modeling tool to identify persons with behavioral health needs who are at high risk of future involvement with the criminal court system. In response to this directive, a predictive modeling tool was developed, as described in the legislative report[1] submitted in 2018. This report describes the subsequent operational enhancement of the predictive modeling approach, its implementation and use.

The operationalized approach reflects several considerations including:

- The predominance of Medicaid beneficiaries in the population of persons with behavioral health needs involved in the criminal court system;
- The potential for Medicaid-contracted integrated managed care plans and Behavioral Health Administrative Services Organizations (ASOs) to implement behavioral health interventions to reduce the likelihood of arrest for their high-risk enrollees; and
- The urgency to improve outcomes for Trueblood class members who are at risk of further involvement in the forensic mental health system.[2]

The original predictive model was developed using a machine-learning methodology applied to risk factors derived from several data sources to predict the target outcome of a referral for competency evaluation within the following six months. Following exploration of model performance in a validation sample, an alternative method was developed for operational use. The alternative approach provides:

- Higher predictive accuracy in validation samples;
- More equitable risk scoring for persons without prior enrollment in medical, food, or cash assistance programs;
- More timely data for operational use; and
- More accurate identity management in a programmatic context where it is highly desirable to avoid “false positives” that might arise through inaccurate linkage of individual-level information from multiple data systems.

In the model currently in place, the DSHS Research and Data Analysis Division (RDA) identifies individuals with two or more competency evaluation orders in the last two years – a population at relatively high risk of future interaction with the criminal court system. Lists of these clients are then matched with contact information to support

[1] Available at https://www.dshs.wa.gov/ffa/rda/research-reports/predicting-referrals-competency-evaluation-required-engrossed-substitute-senate-bill-6032-chapter-299-laws-2018

[2] In April 2015, a federal court found in the case of Trueblood v DSHS that DSHS was taking too long to provide competency evaluation and restoration services. As a result, the State has been ordered to provide court-ordered competency evaluation and restoration services within specified timeframes. The Trueblood class includes individuals detained in local jails awaiting competency evaluation and restoration services, and individuals previously receiving competency evaluation or restoration services who are released and at-risk for re-arrest or re-hospitalization.

targeted outreach and engagement in a service model called “Forensic Projects for Assistance in Transition from Homelessness (FPATH).”

Under this approach:

- RDA identifies clients at high risk for involvement with the criminal court system and for future forensic competency evaluation referrals;
- RDA creates monthly datasets of names and contact information for these clients, by Managed Care Organization (MCO) and ASO region;
- RDA transfers the datasets to the Health Care Authority (HCA), which then distributes them to MCO and ASO staff;
- MCOs and ASOs conduct outreach activities and employ other methods of improving care coordination for these individuals at high risk.

This report will provide a description of the processes currently in place, as well as details about the numbers of clients identified for outreach and a description of how MCOs and ASOs use this information to improve care coordination.

Scope and Purpose

Engrossed Substitute Senate Bill (ESSB) 6032 (Chapter 299, Laws of 2018) directed the Department of Social and Health Services to develop and implement a predictive modeling tool which identifies persons with behavioral health needs who are at high risk of future involvement with the criminal court system. This report is in accordance with the budget proviso *(ESSB 5187, Chapter 475, Laws of 2023)*:

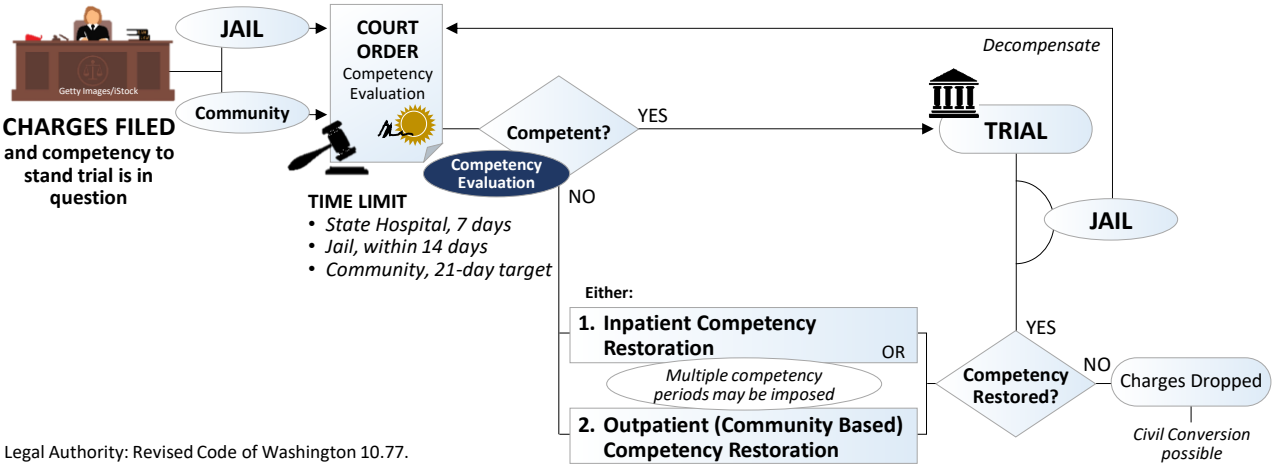
> (i) By the first day of each December during the biennium, the department, in coordination with the health care authority, must submit a report to the office of financial management and the appropriate committees of the legislature which summarizes how the predictive modeling tool has been implemented and includes the following: (A) The numbers of individuals identified by the tool as having a high risk of future criminal justice involvement; (B) the method and frequency for which the department is providing lists of high-risk clients to contracted managed care organizations and behavioral health administrative services organizations; (C) a summary of how the managed care organizations and behavioral health administrative services organizations are utilizing the data to improve the coordination of care for the identified individuals; and (D) a summary of the administrative data to identify whether implementation of the tool is resulting in increased access and service levels and lower recidivism rates for high-risk clients at the state and regional level.

The first section of this report introduces the Forensic PATH program and background on the development and refinement of the predictive modeling tool. The following section provides information about numbers of clients identified and related administrative data. The closing section describes the methods of providing information to MCOs and ASOs, and how those organizations use the information.

Background

The forensic mental health system operates at the intersection of the legal and behavioral health care systems, providing competency evaluation services when a court believes a mental health condition may prevent a criminal defendant from assisting in their own defense, and treatment for restoration when the evaluation finds the defendant is not competent. The court will then order the individual to receive competency restoration services. Figure 1 provides a high-level overview of the operation of the forensic mental health system.

FIGURE 1.
Competency Evaluation/Restoration Pathway



Legal Authority: Revised Code of Washington 10.77.

The Trueblood v. DSHS lawsuit challenged unconstitutional delays in competency evaluation and restoration services for people detained in city and county jails. The Trueblood Contempt Settlement Agreement establishes a plan for providing services to those involved in the criminal court system and for providing treatment to people when needed so they are less likely to become involved in the criminal court system.

Forensic Projects for Assistance in Transition from Homelessness (FPATH)

As part of the Trueblood Settlement of Contempt Agreement, the state is funding targeted outreach and engagement to connect identified individuals with behavioral health services using a federal model called Projects for Assistance in Transitions from Homelessness. In the Agreement, this program is called Intensive Case Management for High Utilizers. RDA created a referral list to identify individuals who are at risk of repeat court orders for competency evaluations, which HCA shares with MCOs and ASOs. Each month, RDA identifies individuals with two or more competency evaluation orders in the last two years who are at higher risk of future intersection with the criminal court system. FPATH staff at the MCOs/ ASOs focus outreach and engagement efforts to individuals on the list who are predominately homeless or have had a high volume of competency evaluations.

FPATH teams, within community behavioral health agencies, include certified peer counselors who have experience working with individuals who may be experiencing homelessness or housing instability combined with multiple competency evaluation

orders within the last two years. FPATH teams assertively seek to engage people to help them connect with community supports including housing, transportation, health care, and behavioral health services. People court-ordered for forensic navigator or outpatient competency restoration services may also use FPATH for case management services if they appear on the referral list created by RDA.

Current Status and Areas of Positive Impact

FPATH teams have been providing targeted outreach and engagement to people identified on the referral list since March 2020. Using a model similar to the federal PATH program, teams have been reaching out to eligible individuals with an emphasis on homeless or unstably housed individuals. The goal is to connect people with community resources and services by building relationships and rapport. While most eligible individuals are homeless or unstably housed, some are not. In all instances, teams seek out to engage the individual "where they are at."

FPATH teams are located within community behavioral health agencies with experience providing outreach and engagement services, which allows for warm handoffs to other needed services. This includes services from certified peer counselors who have experience working with individuals involved in the forensic mental health system experiencing homelessness or housing instability.

Teams prioritize outreach and engagement efforts to individuals prioritized by the following criteria: individuals living in rural areas, individuals who have had four or more referrals for competency evaluation in the past 24 months regardless of housing status, and individuals experiencing homelessness. The intent behind prioritization is to assist in connecting those most at risk of additional referrals for competency evaluations to services in hopes of diverting them from further court involvement.

Data – Crisis Triage and Diversion – FPATH

FPATH data in the current report are generated from the Department of Commerce's Homeless Management Information System, as well as monthly Excel trackers submitted by FPATH providers in the Phase 1 regions. Program eligibility is based on a referral list (formerly the "high utilizer list") of individuals with two or more competency evaluation referrals in the past 24 months.

The FPATH program began March 1, 2020 in Phase 1 regions, and April 1, 2022 in the Phase 2 region. Between March 1, 2020 and June 30, 2023, 2,859 people were referred to the program across all regions. HCA has asked providers to focus outreach efforts on a subset of these people based on housing status (prioritizing unstably housed and homeless), number of prior competency referrals (four or more in the past 24 months), and county of residence (prioritizing rural counties). The number of people in the prioritized group was 1,243.

Of all people on the referral list, FPATH providers attempted to contact 1,173 (41 percent), and successfully contacted 869 (30 percent). As of June 20, 2023, a total of 497 people (17 percent of overall referrals) were enrolled in the FPATH program. Of these, the majority were male (77 percent) and between 30 and 49 years old (62 percent). More than two-thirds of enrollees (69 percent) were homeless, while 21

percent were unstably housed, indicating that providers were focused on enrolling those in the priority population.

Predictive Model Development

Engrossed Substitute Senate Bill (ESSB) 6032 (Chapter 299, Laws of 2018) directed the Department of Social and Health Services (DSHS) to develop and implement a predictive modeling tool to identify persons with behavioral health needs who are at high risk of future involvement with the criminal court system. In response to this directive, a predictive modeling tool was developed, as described in the legislative report submitted in 2018.[3] In consultation with legislative staff, the target population for the predictive model was focused on referrals for competency evaluation, to align with the Trueblood objectives. Among the key lessons learned and included in the legislative report:

- "Prior experiences in the forensic mental health system are by far the most important information in predicting future competency evaluation referrals."
- "Rapid-cycle linkage of managed care enrollment with data from the recently implemented Forensic Data System (FDS) offers the most timely opportunity for identifying enrolled Medicaid beneficiaries who are at high risk of a future competency evaluation referral."
- "We dropped arrest history, adjudication history, and behavioral health diagnosis variables from our final model due to data timeliness limitations in an operational context, with minimal loss of predictive accuracy in the validation sample."

Subsequent analysis of the validation sample developed for the legislative report (described further below) led RDA to make the following recommendations for operationalizing client lists to support the Forensic PATH program:

- Target the Forensic PATH program to persons with two or more prior competency evaluation referrals in the past 24 months.
- Use rapid-cycle linkage of FDS data, ACES social service data, and ProviderOne Medicaid eligibility, managed care enrollment, and behavioral health data to identify the target population, measure risk factors, and create client lists to be updated on a monthly basis.
- Create distinct client lists for different user groups and populations to align with privacy requirements and care management responsibilities (e.g., separate lists for Medicaid MCOs, ASOs, state agency staff, and Forensic PATH program staff).
- To support triage, outreach/engagement, and intervention planning, supplement client lists with client-level risk factors including homelessness, prior psychiatric hospitalization, and volume/result of prior evaluation/restoration referrals.

The advantages of the proposed approach included:

[3] Available at https://www.dshs.wa.gov/ffa/rda/research-reports/predicting-referrals-competency-evaluation-required-engrossed-substitute-senate-bill-6032-chapter-299-laws-2018.

- Higher predictive accuracy in validation samples relative to the original model;
- More equitable risk scoring for persons without prior enrollment in medical, food, or cash assistance programs;
- More timely data for operational use; and
- More accurate identity management (in a programmatic context where it is highly desirable to avoid “false positives”) by providing a far more focused set of cases where manual identity linkage is required.

These recommendations were presented to Plaintiff’s Counsel and the Court Monitor involved in Trueblood litigation in January 2020, with consensus support for proceeding in the proposed direction.

Validation Sample Analysis

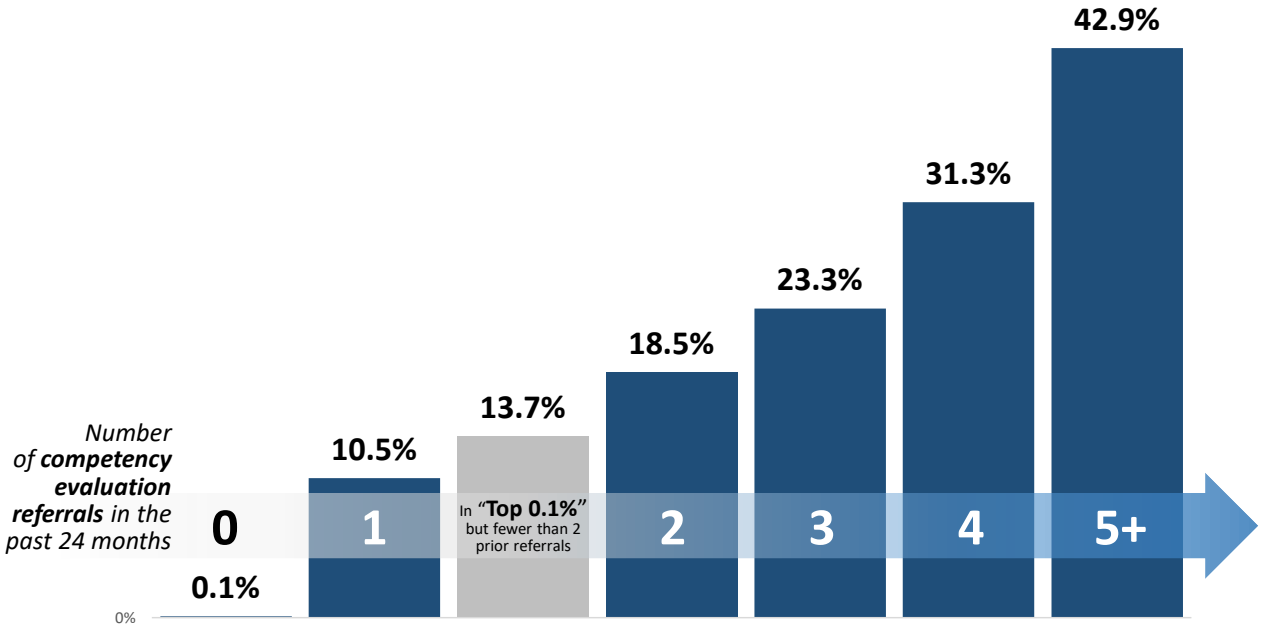
Figure 2 illustrates the efficacy of the implemented approach, relative to the results of the original predictive model, in the validation sample developed for the predictive modeling reflected in the 2018 legislative report. The implemented approach targets the population with 2+ referrals for eligibility for Forensic PATH program services. As shown in the figure below, the population receiving a high-risk score via the original predictive model (defined as those in the top 0.1% of the risk pool) who do not meet the 2+ referral criterion has a significantly lower rate of subsequent occurrence of the target outcome (a competency evaluation referral within the next 6 months), relative to persons meeting the 2+ referral criterion.

In part this is an illustration of the overwhelming importance of historical referral patterns in the original predictive model. Most clients who scored in the top 0.1% based on the original predictive model had two or more competency evaluation referrals in the prior 24 months. But among those who did not meet this criterion, observed rates of the target outcome in the validation sample were relatively low. This observation, along with the significant operational considerations previously noted (timeliness of data, identity management implications, and equity for persons not connected to public assistance programs), formed the rationale for RDA’s proposed and subsequently implemented approach.

FIGURE 2.

Assessing Predictive Accuracy: Proportion with an Evaluation Referral in the Following 6 Months, by Number of Previous Referrals

Supplemental analysis of proviso report validation sample data



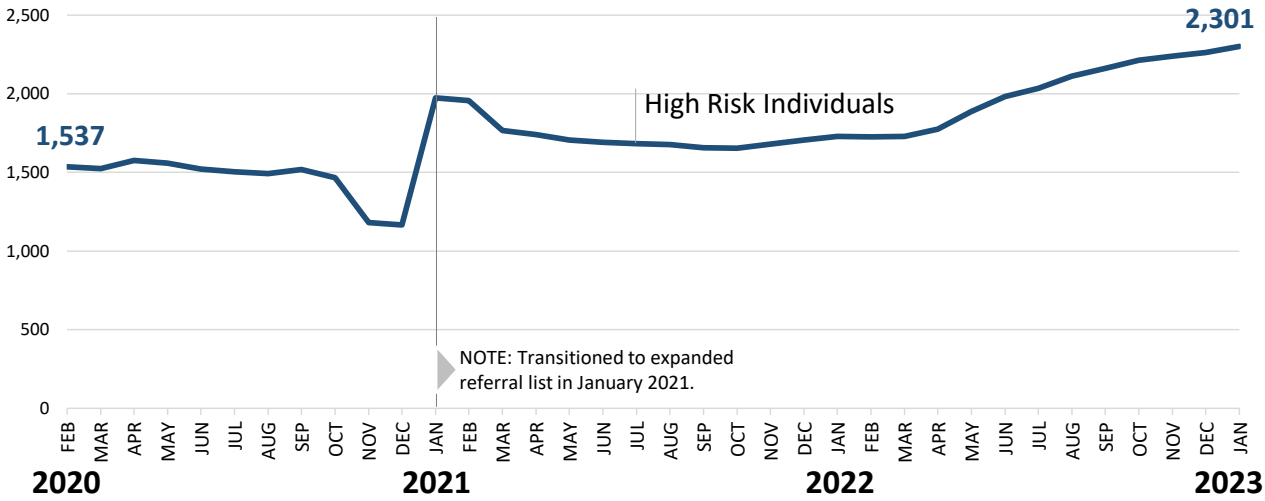
SOURCE: DSHS Research and Data Analysis Division.

The Number of Individuals Identified for the Referral List

Figure 3 shows the trend in the statewide aggregate referral list size. The list was originally restricted to persons with recent participation in food, cash, or medical assistance. The increase in January 2021 reflects the removal of this restriction.

FIGURE 3.

Statewide Monthly Trend in Individuals at High Risk



SOURCE: ProviderOne, Monthly FPATH referral lists.

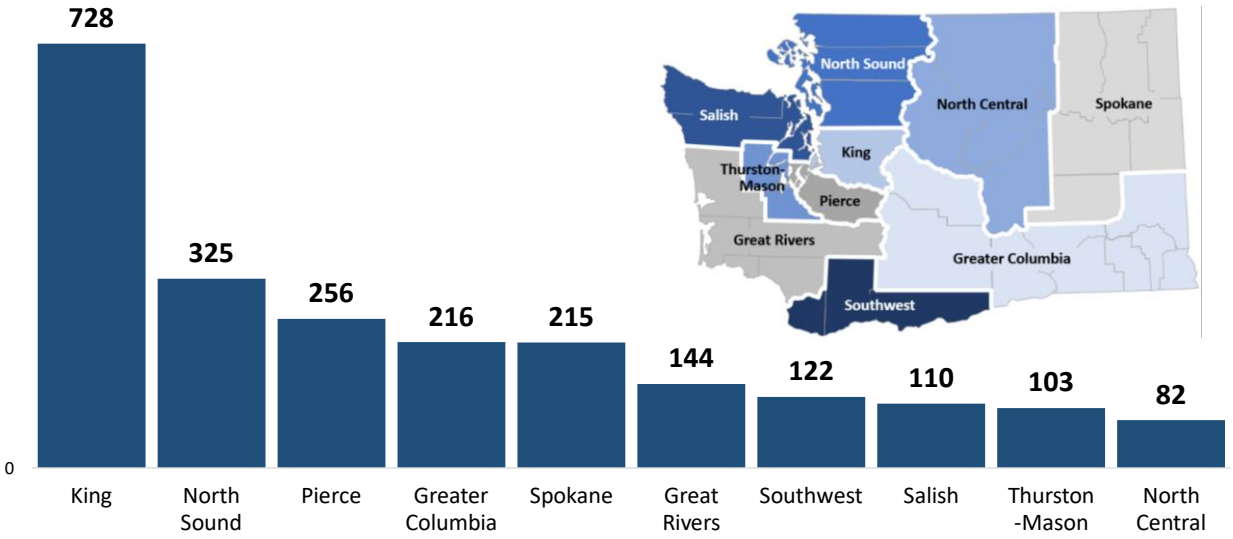
Figure 4 provides the distribution of the January 2023 referral list by Apple Health region, excluding four persons for whom the region could not be assigned. King County represents 32 percent of the statewide target population.

FIGURE 4.

Forensic PATH Target Population by Apple Health Region

January 2023, Total = 2,301

Note: Data on the January 2023 referral list were pulled on 12/20/2022.



SOURCE: ProviderOne, Monthly FPATH referral lists.

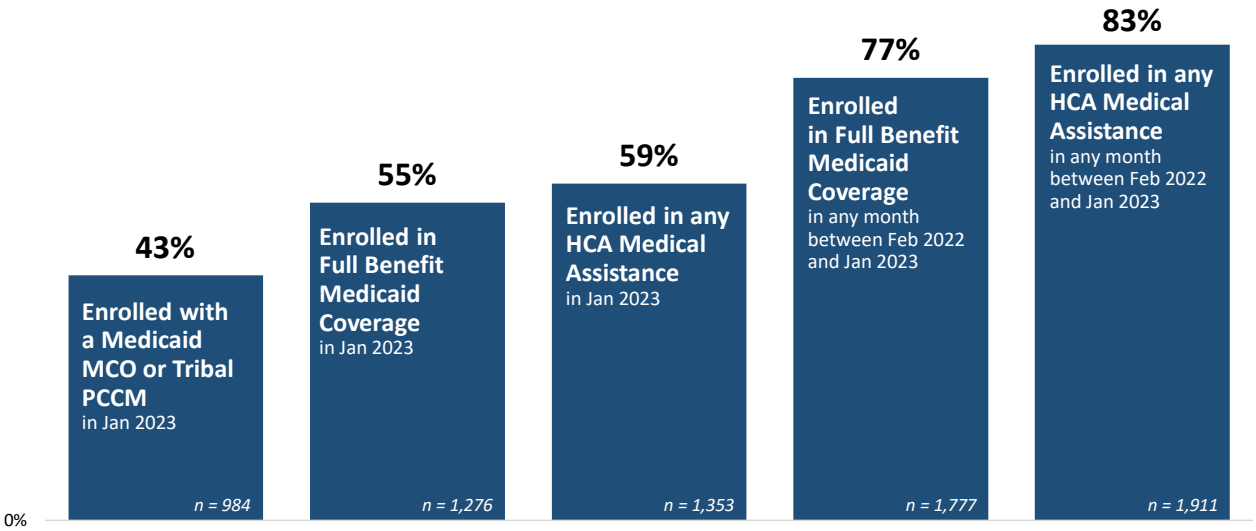
Figure 5 provides information about the medical coverage status of the January 2023 referral list in that month (first three columns) or over the 12-month period ending in January 2023.

FIGURE 5.

Forensic PATH Target Population by Coverage Status

On Referral January 2023, Total = 2,301

Note: Data on the January 2023 referral list were pulled on 12/20/2022.



SOURCE: ProviderOne, Monthly FPATH referral lists.

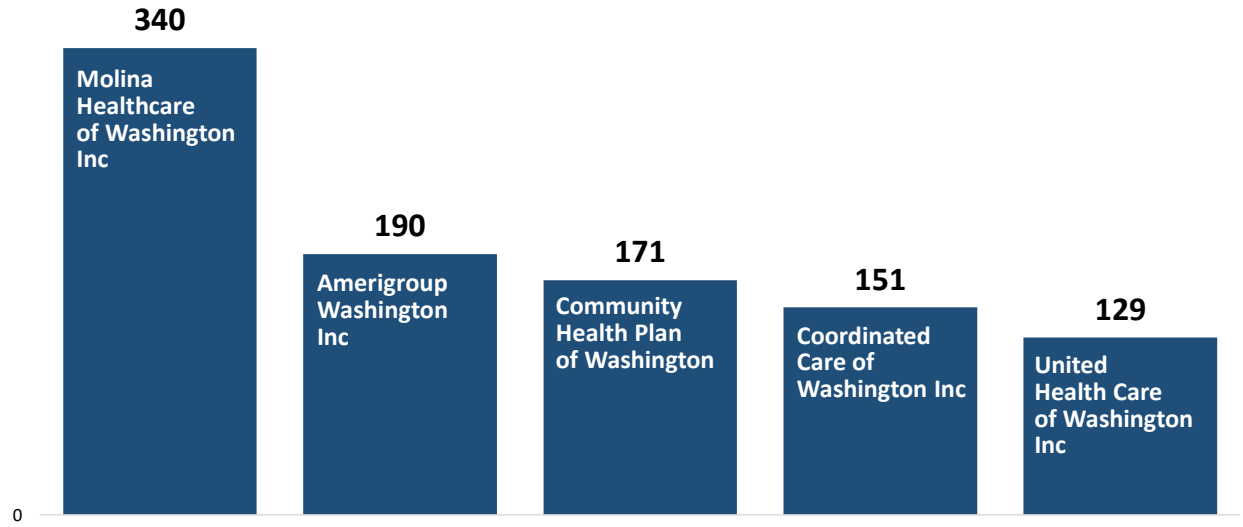
Figure 5 shows there is significant Medicaid coverage churn in this population, likely driven by high rates of incarceration and homelessness. For example, among persons on the January 2023 list, 55 percent had full benefit Medicaid coverage in that month, while 77 percent had full benefit Medicaid coverage at some time over the 12-month period spanning February 2022 through January 2023.

Figure 6 shows the distribution of the MCO-enrolled January 2023 referral list by organization. At 35 percent, Molina Healthcare of Washington had the largest share of Medicaid beneficiaries on the January 2023 referral list.

FIGURE 6.

Forensic PATH Target Population by MCO Enrollment

January 2023, Total = 984



SOURCE: ProviderOne, Monthly FPATH referral lists.

Analysis of Impacts on Access to Services and Recidivism

The budget proviso asks the Department to provide "a summary of the administrative data to identify whether implementation of the tool is resulting in increased access and service levels and lower recidivism rates for high-risk clients at the state and regional level." Data are not yet available to evaluate impacts of Forensic PATH program operations, but an evaluation design has been developed and shared with the Trueblood Plaintiff's Counsel and Court Monitor as part of the State's Trueblood Settlement Agreement activities. In this section we describe the planned evaluation approach, along with potential measurement challenges.

The ability to evaluate a specific Trueblood program component such as the Forensic PATH program, and evaluation design options, depends on factors including:

- Availability of encounter (or similar) data identifying when clients engage in services,
- A sufficient number of persons served by the program component to detect likely effect sizes,

- The extent of overlap with services provided through other Settlement Agreement components, and
- The extent to which the FPATH target population in regions not yet implementing Trueblood Settlement Agreement programs was prioritized for intervention by MCOs and ASOs, impacting the "natural experiment" of phased Trueblood program implementation.

The target population for the Forensic PATH program is defined through processes maintained by RDA, with target populations generated monthly on a statewide basis for all regions. This data resource could support an intent-to-treat, difference-of-difference evaluation design based on the populations identified in the monthly lists, assuming that the rate of engagement in Forensic PATH program services is relatively high. An intent-to-treat approach is desirable because it would help mitigate the threat that selection bias poses to measurement validity (discussed further below). To date, engagement has been relatively modest due to the relatively high number of eligible clients, and the challenges associated with building provider capacity and engaging a population with high rates of homelessness and co-occurring serious mental illness and substance use disorders. With currently observed engagement rates, an intent-to-treat approach would likely wash out any effect of the Forensic PATH program on "treated" beneficiaries, by including their experience with the larger number of untreated persons in the target population.

Given currently observed engagement rates, we will consider a propensity score matching approach to identify an untreated comparison group whose experiences will be contrasted with the experiences of persons engaging in the program. This simulates the treatment/control structure of a clinical trial. The comparison group would be defined through a matching process comprised of the following steps:

- Comparison frames for matching would be identified by criteria that align with the targeting criteria used by program, outside of the regions where FPATH is operating. This initial stage of the process identifies all person-months for persons not engaging in the Forensic PATH program where the person meets the targeted risk criteria in the relevant time period. The comparison matching frame may exclude non-participants from the implementing regions to mitigate the impact of selection bias (see internal validity discussion below).
- Key predictors of engagement within the pooled intervention and comparison matching frame would be examined to ensure inclusion of appropriate measurement dimensions in the propensity score model. This includes creating an extensive set of "engagement predictors" that are determined, ex ante, to be potentially relevant to the matching process. This set of predictors is expected to span a wide range of the measurement domains contained within RDA's integrated client data environment.
- Application of machine-learning techniques (e.g., stepwise logistic or lasso regression) would be used to determine the final propensity score model. Exact matching may be required for key variables (e.g., race, gender, prior evaluation referral count).

Impact analyses generally would be conducted using a difference-of-difference design, where the pre-to-post change in experiences for treatment group members would be compared against the pre-to-post change experienced by the matched comparison group. For analyses using a difference-of-difference design, the pre-post boundary for the treatment group will be based on the point at which they engage in the Forensic PATH program. The pre-post boundary for the comparison group would be defined through the matching process, which uses a person-month matching frame for matching against the "person-months" associated with entry into the intervention by the treatment group. This approach leverages the richness of RDA's integrated analytical data infrastructure, which supports data management techniques that scan all relevant persons at all relevant points in time when they might be a "best" match to a person at the time they entered the FPATH program.

Analyses will likely focus on the following outcome areas:

- Arrests,
- Subsequent referrals for competency evaluation,
- Changes in housing status (e.g., becoming stably housed),
- Enrollment in Medicaid, and
- Use of Medicaid-funded mental health or SUD treatment services.

Assessment of Data Limitations and Threats to Validity

In the context of quasi-experimental evaluation of programs such as Forensic PATH, in the absence of randomized design for program implementation the key potential threat to the validity of measured impacts is selection bias. Selection bias refers to the presence of uncontrolled differences between treatment and comparison group members that may account for observed differences in outcomes between the two groups. Although propensity score matching (often combined with second-stage regression adjustment) is recognized as a valid evaluation design and frequently accepted in the peer-reviewed literature, this approach may not fully mitigate the threat of selection bias. It will be critical to understand the processes associated with engagement in Forensic PATH services and to use this knowledge to define a credible "matching frame" and set of engagement predictors in creating the matched comparison group. The richness of the administrative data available to the RDA evaluation team would help reduce the threat of selection bias to the validity of measured impacts.

MCO and ASO Activities

The Health Care Authority requires both the Managed Care Organizations (MCOs) and Behavioral Health Administrative Service Organizations (ASOs) to engage in care coordination for high-risk clients, including those involved with the forensic system. To support those efforts, HCA has provided the RDA-generated lists of FPATH-eligible clients to MCOs, ASOs, and the FPATH providers, including information on clients in highest need of outreach and assistance.

Managed Care Organizations

The Health Care Authority contracts with five MCOs across the State of Washington. MCO contracts include language requiring them to develop and implement plans for improving access to timely and appropriate treatment for individuals with behavioral health needs and current or prior criminal justice involvement[4]. HCA received reports about the MCOs' use of prioritized lists and other activities related to criminal justice-involved clients. Some examples of these activities follow.

A typical process for use of the monthly Trueblood High Utilizer (FPATH) Report was described in detail by Community Health Plan of Washington (CHPW). Once the report is received from HCA:

- A Complex Discharge Case Manager is assigned to all members on the report in an inpatient behavioral health or medical facility to coordinate care for a safe discharge. The Complex Discharge Case Manager will coordinate with the facility and local and state agency staff to ensure a safe discharge to the community setting. The Case Manager coordinates the placement to ensure the member's needs are met.
- A Jail Transitions Case Manager is assigned to all incarcerated members on the Trueblood High Utilizer Report, to coordinate care for the member as they transition into a correctional facility. The MCO provides information on the member's health conditions and needed services, including medication history.
- Upon the release of the member from the correctional facility, Case Managers will coordinate with the facility to ensure a safe transition to the community setting. MCOs meet with individual members before release to provide information on benefits, including finding a primary care provider, and how to access services such as transportation to appointments, follow-up medical and behavioral health appointments, housing and employment assistance, and other support services.

Similar descriptions of how the MCO staff aid members were received from all the MCOs. Case Managers attempt to contact all members on the Trueblood High Utilizer Report to offer care coordination or case management. Coordinated Care of Washington provided this list of services offered once the client is reached:

[4] See Appendix 1 for excerpts from the Apple Health Integrated Managed Care contract related to clients involved in the criminal justice system. Found at https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf

- Find doctors, dentists, behavioral health providers, telehealth, and treatment services that are culturally and linguistically appropriate.
- Schedule appointments and court-ordered assessments such as those required for Least Restrictive Alternative placements, conditions of probation, or Trueblood cases.
- Schedule transportation to appointments.
- Apply for and follow up on community resources such as employment, housing, food, disability benefits, cell phone services, and other benefits and resources.
- Connect to culturally appropriate care and resources, including Indian Health Care Providers and tribal-specific resources for American Indian/Alaska Native populations.
- Receive timely access to care by making sure eligibility is active after release.
- Coordinated Care has policies in place to cover emergency prescription fills without prior authorization for members being released from correctional facilities. Coordinated Care also guarantees authorization and payment after an emergency fill is dispensed by a contracted pharmacy. This includes prescriptions filled on the day of release from a correctional facility to allow for continuity of care.

United Healthcare reports, “Our team is geographically dispersed so as needed they can meet face to face with members.” Molina reports that several staff on their dedicated team have previous corrections experience. Each day, Molina’s team outreaches to members in custody based on the coordination plan that was developed with jail leadership. This could include in-person visits to the jail, video visits, phone calls, emails, or letters. In addition, Molina provides outreach to 100% of members who were booked and released.

Coordinated Care of Washington (CCW) reported that special efforts are made to connect with facilities, jails, courts, and other reentry release planners working with juvenile offenders, including the development of a Juvenile Rehabilitation Administration workgroup. CCW reports that the JRA workgroup was able to build relationships and create workflows that assist Juvenile Detention staff with identifying each member’s MCO and making email referrals for care management, which has improved care coordination with Juvenile Detention facilities and helps ensure members are receiving needed resources.

Several other collaborative activities began this year. For example, Molina reports that they have developed a collaborative relationship with the Pierce County Public Defenders’ office, which assisted them to implement a mental health sentencing alternative for an enrollee, and with the Washington State Sheriffs and Police Chiefs. Molina worked with the Health Services re-entry Administrator at the Department of Corrections to create the protocol of how MCO’s and DOC should work together on re-entry planning for extraordinary medical releases.

The MCOs also collaborate with the Behavioral Health Administrative Service Organizations (ASOs) across the state. For example, Amerigroup described participation in King County’s monthly clinical case rounds, in which the cases are

selected by King County by matching the FPATH list with other utilization data. King County reports that participants include outpatient behavioral health care providers (including Trueblood diversion programs and FPATH/FHARPS providers), administrators for PACT and other outpatient services, and forensic navigators. These collaborative meetings are used by MCOs to determine roles for coordinating services and to ensure necessary referrals are in place, especially for clients making transitions into or out of managed care.

Spokane County Region oversees a quarterly Jail Transitions and Coordination (JTAC) meeting, which was created in 2022 to encourage and support transitions from incarcerated settings. Similar efforts are supported by ASOs across the state.

Behavioral Health Administrative Service Organizations

The Health Care Authority contracts with eight Behavioral Health Administrative Service Organizations in ten regions across the State of Washington. In their role of providing crisis services, the ASOs are frequently the first point of contact for clients who are at risk of criminal justice involvement.

Spokane ASO reports, “As a default entry point into the behavioral health system, our crisis response teams provide a comprehensive response to those experiencing a behavioral health crisis, including engagement with first responders, law enforcement, emergency rooms, and community members. Leveraging existing systems, the crisis response teams provide stabilization and referral services respective of need, to ensure warm handoffs, and provide for coordination of services.”

This year, the ASOs reported increased collaboration and care coordination related to criminal justice-involved individuals. Several ASO programs are funded by targeted funds, such as the Criminal Justice Treatment Account, Jail Transition Services, and Trueblood Enhancement funds. Carelon (serving North Central, Southwest, and Pierce County regions), Spokane, and King ASOs gave these examples of ASO services:

- Substance use disorder treatment and recovery support services to individuals facing charges by a prosecutor or enrolled in drug court;
- Assisted Outpatient Treatment (AOT) uses a court order to provide behavioral health treatment for clients meeting specific criteria;
- Enhanced Mobile Crisis Response and Enhanced Crisis Triage/Stabilization Programs;
- The Recovery Navigator program, which offers peer-lead recovery support, field-based case management, and care coordination.

Spokane Region ASO reports that the Peer Pathfinder - Jail Transitions Program provides peer support services to assist individuals as they prepare for re-entry after incarceration. This program assists individuals through the discharge process to identify necessary services and resources and provide a warm hand-off to long-term behavioral health supports.

Misdemeanor diversion funds within the HCA budget have been leveraged to resource ASOs to provide outpatient treatment services for non-Medicaid individuals on the

FPATH referral list, in outpatient competency restoration, or with other criminal court involvement. Trueblood Misdemeanor Diversion (TMD) Funding and 5177 Diversion funds have been used to provide inpatient substance use disorder treatment, inpatient co-occurring treatment, outpatient substance use disorder treatment, outpatient mental health treatment, and outpatient co-occurring treatment. In addition, funds are used to connect clients with various community resources.

Discussion

This year has seen an evolution in strategies employed by the MCOs and ASOs to provide individual case management and care coordination services for justice-involved clients. They now routinely use lists of individuals who are at high risk of a subsequent competency evaluation referral to identify and provide outreach to members, and in cross-sector case management meetings. In addition, both MCOs and ASOs have formed new partnerships with staff who work with individuals at risk for or who are involved in the criminal justice system across the state. These activities have led to improved policies, communication, and coordination of services, and support the common goal of reducing or preventing incarceration and reducing recidivism.

APPENDIX 1

MCO and ASO Requirements Related to Criminal Justice

Examples of specific contract requirements[5] from the Apple Health Integrated Managed Care contract:

- 14.1.9 The Contractor shall provide for the smooth transition of care for Enrollees who lose Medicaid eligibility while hospitalized in behavioral health inpatient or residential treatment facilities or while incarcerated or in homeless shelters. The Contractor shall include protocols for coordination with the ASO to facilitate referral for state funded or federal block grant services, when such funds are available, in order to maintain Continuity of Care.
- 14.7.15 The Contractor will provide Care Coordination to Enrollees who are named on the HCA Referral List, also known as the "high utilizer list," in the Trueblood, et al., v. Department of Social and Health Services Settlement Agreement. HCA will provide the HCA Referral List to the Contractor monthly. The Contractor will support connecting Enrollees with behavioral health needs and current or prior criminal justice involvement to receive Care Coordination. The Contractor will report semi-annually, using the Semi-Annual Trueblood Misdemeanor Diversion Fund report template.
- 14.22 Transitional Planning for Incarcerated Enrollees. For the purposes of this subsection, "correctional facility" includes city and county jails, Department of Corrections (DOC) facilities, and Juvenile Rehabilitation facilities.

  14.21.1 The Contractor shall coordinate care for Enrollees as they transition into a correctional facility or upon release from a correctional facility. The Contractor shall initiate development of and make progress toward obtaining data sharing agreements with correctional facilities to enable the Contractor and these facilities to share health information about the Enrollees. Transitional care coordination shall be provided for up to the first thirty (30) calendar days of incarceration or as needed and upon the Enrollee's release, including honoring another MCOs prior authorization for admission to SUD residential facility.

ASO contract requirements excerpt[6]:

- 15.1.2 The Contractor will provide Care Coordination to Individuals who are named on the HCA Referral List, also known as the "high utilizer list," in the Trueblood, et al., v. Department of Social and Health Services Settlement Agreement. HCA will provide the HCA Referral List to the Contractor monthly. The Contractor will support connecting Individuals with behavioral health needs and current or prior criminal justice involvement receive Care Coordination.
- 15.1.3 The Contractor will report semi-annually, using the Semi-Annual Trueblood Misdemeanor Diversion Fund Report template. Reports must be submitted to HCA by January 31, for the reporting period of July through December of the previous year, and by July 31, for the reporting period of January through June of the current year.

[5] https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf.

[6] Found at Behavioral health-administrative services organization contract (wa.gov)