



Support Act §1003 Current State Assessment Report 4: Comparison of Physical Health and Social Outcomes among Medicaid Beneficiaries with and without Behavioral Health Diagnoses

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IN SEPTEMBER 2019, the Centers for Medicare and Medicaid Services (CMS) awarded the Washington State Health Care Authority (HCA) \$3.8 million under the §1003 SUPPORT ACT.¹ Under this Phase 1 Planning Grant, HCA is developing an implementation strategy for improving treatment and recovery services, including developing an alternative payment model for SUD treatment and recovery services.² An understanding of the current utilization of behavioral health treatment and recovery support services is crucial to identifying both strengths and gaps in the existing behavioral health system in Washington. A current state assessment was conducted to gain insight into the prevalence of substance use disorder (SUD) diagnoses, utilization of treatment services, and physical health and social outcomes among Medicaid beneficiaries with behavioral health diagnoses. The SUPPORT ACT is primarily focused on the experience of all Medicaid beneficiaries with SUDs and opioid use disorders (OUDs). However, it also identifies target populations, such as pregnant and postpartum women, and persons experiencing homelessness, which are included as populations of interest in the current state assessment. The current state assessment consists of four reports, each addressing a core question about existing behavioral health treatment and recovery support services in Washington.

PRIOR REPORTS:

- *What is the prevalence of substance use disorder and opioid use disorder among Medicaid beneficiaries? Does the prevalence vary across the Medicaid population? (See Report 9.119-1)*
- *What is the treatment penetration rate for behavioral health treatment? Does the rate vary across the Medicaid population? (See Report 9.119-2)*
- *What types of Substance Use Disorder treatment services are Medicaid beneficiaries using? Does treatment utilization vary across the Medicaid population? (See Report 9.119-3)*

THIS REPORT:

- *How do physical health and social outcomes differ among Medicaid beneficiaries with different types of behavioral health treatment needs?*

To understand how measures of physical health and social outcomes may differ for Medicaid beneficiaries with different behavioral health diagnoses, this report examined 30 metrics across several domains: access to care, quality of care, coordination of care, utilization of high-intensity services, and social outcomes.

¹ More information about the CMS §1003 SUPPORT ACT grant can be found at:

<https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/substance-use-disorder-prevention-promotes-opioid-recovery-and-treatment-for-patients-and-communities-support-act-section-1003/index.html>.

² More information about the SUPPORT ACT implementation in Washington can be found at: <https://www.hca.wa.gov/about-hca/apple-health-medicaid/support-act>.

Metrics are reported for Medicaid beneficiaries with no behavioral health diagnoses and Medicaid beneficiaries with one of five categories of behavioral health diagnoses (SUD diagnosis, OUD diagnosis, mental health (MH) diagnosis, serious mental illness (SMI) diagnosis, and co-occurring SUD and MH diagnosis [COD]).

These analyses show that Medicaid beneficiaries with SUD or OUD³ diagnoses have worse physical health and social outcomes overall. Across measures of physical health and social outcomes, Medicaid beneficiaries with SUD or OUD diagnoses fare worse than those with an MH diagnosis, SMI diagnosis, or no behavioral health diagnoses. In particular, those with a SUD or OUD diagnoses have higher rates of emergency department utilization, and inpatient services utilization. Those with a SUD or OUD diagnosis also have higher rates of unemployment, arrests, and homelessness.

Data and Methods

To understand how measures of physical health and social outcomes differ for Washington State Medicaid beneficiaries with different behavioral health diagnoses, we conducted retrospective, cross-sectional analyses of Washington State administrative data. All data were drawn from the Department of Social and Health Service's Integrated Client Database (ICDB). The ICDB contains data from several state administrative data systems, including the state's ProviderOne data system that contains Medicaid claims and encounter data.⁴

The population of focus in these analyses was Adult Medicaid beneficiaries (ages 18-64 years old) with behavioral health diagnoses. Medicaid beneficiaries with a non-Medicaid primary health care coverage (also referred to as third-party liability) and those who are dually enrolled in both Medicaid and Medicare were excluded from the analyses, as complete health care information may not be available for those individuals.

To identify whether the Medicaid beneficiaries had any behavioral health diagnoses, we looked for any SUD, OUD, MH, or SMI⁵ diagnoses in SFY 2019 or SFY 2018. If a Medicaid beneficiary had both an SUD or OUD and MH or SMI, they were categorized as having a COD. Medicaid beneficiaries were categorized as having no behavioral health diagnoses only if no SUD, OUD, MH, or SMI diagnoses were present in SFY 2019 or SFY 2018. Analyses were further restricted to individuals who met minimum Medicaid enrollment criteria (11 out of 12 months in the measurement year) to meet eligibility requirements for the physical health and social outcome metrics.

Additional details are included in the Technical Notes section at the end of the report.

Table 1 shows the distribution of behavioral health diagnoses among Medicaid beneficiaries who met the inclusion criteria in SFY 2019. Sixty-two percent of eligible Medicaid beneficiaries had no behavioral health diagnoses in the measurement period, 38 percent had at least one behavioral health diagnosis and 9 percent had COD (any MH and SUD diagnosis). COD is also further broken down into subcategories giving more detail of specific combinations types of MH or SUD diagnoses.

³ Medicaid beneficiaries with OUD are a subset of Medicaid beneficiaries with SUD.

⁴ See, [DSHS Integrated Client Databases](#), DSHS Research and Data Analysis Division, Mancuso, March 2020.

⁵ Medicaid beneficiaries with SMI are a subset of Medicaid beneficiaries with MH.

TABLE 1.

Behavioral Health Diagnoses among Medicaid Beneficiaries, SFY 2019

	NUMBER	PERCENT
Any Behavioral Health Diagnoses	594,917	38%
Mental Health Diagnosis	553,694	36%
Serious Mental Illness Diagnosis	311,507	20%
Substance Use Disorder Diagnosis	179,581	12%
Opioid Use Disorder Diagnosis	69,182	4%
Co-Occurring Mental Health + Substance Use Disorder Diagnosis	138,358	9%
Mental Health + Substance Use Disorder	81,075	6%
Mental Health + Opioid Use Disorder	57,283	4%
Serious Mental Illness + Substance Use Disorder	93,544	6%
Serious Mental Illness + Opioid Use Disorder	38,338	2%
No Behavioral Health Diagnoses	963,342	62%
TOTAL	1,558,259	100%

To understand how measures of physical health and social outcomes differ for Medicaid beneficiaries with different behavioral health diagnoses, we examined 30 metrics across several domains. Metrics examined include nationally stewarded Healthcare Effectiveness Data and Information Set (HEDIS) metrics from the National Committee for Quality Assurance (NCQA).⁶ Selected HEDIS metrics in these analyses measure access to care, quality of care, and coordination of care. Additionally, we examined state-developed metrics of utilization of high intensity services, and social outcomes. The purpose of these analyses is to highlight and describe the variation in social- and health-metric outcomes across Medicaid populations with different behavioral health diagnoses. It is important to note that while these analyses describe outcomes, they are not sufficient to indicate whether having a behavioral health diagnosis *caused* the outcomes on the metrics.

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

The rates reported in Table 2 are the percentage of individuals in that population (column) who met the criteria for that metric. Rates are reported for each of the six behavioral health categories: SUD, OUD, MH, SMI, COD⁷, and no behavioral health diagnoses. For example, the numbers reported in the “Access to Ambulatory and Preventive Care” row represent the percentage of persons who received ambulatory or preventive care service in that year. Of the Medicaid beneficiaries without a behavioral health diagnosis, 64 percent received a qualifying service. Of those with a diagnosis of SUD, 86 percent received a qualifying service.

When a higher rate for a specific metric would be indicative of a more favorable outcome, metrics are denoted with a ↑ (up arrow). Metrics where a lower rate is indicative of a more favorable outcome are marked by a ↓ (down arrow). Additional information about the measures used in these analyses is available in the Technical Notes section at the end of this report.

With the exception of access to care measures, Medicaid beneficiaries with behavioral health diagnoses tended to fare worse than Medicaid beneficiaries who did not have behavioral health diagnoses across all metrics examined. Medicaid beneficiaries with behavioral health diagnoses, individuals with SUD diagnoses, and particularly those with OUD diagnoses or co-occurring SUD and MH diagnoses, had substantially worse outcomes than those with MH or SMI diagnoses across measures of quality of care, care coordination, utilization of high intensity services, and social outcomes.

⁶See <https://www.ncqa.org/hedis/> for more information.

⁷Appendix Table 1 reports rates for each of the more detailed breakouts of COD shown in Table 1.

TABLE 2.

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

		Medicaid Beneficiaries without any Behavioral Health Diagnoses	Medicaid Beneficiaries with a diagnosis of...					
			Any BH	SUD	OUD	MH	SMI	COD
ACCESS	Access to Ambulatory and Preventive Care (↑)	64%	89%	86%	87%	91%	93%	90%
	Breast Cancer Screening (↑)	44%	55%	46%	43%	55%	54%	47%
	Cervical Cancer Screening (↑)	47%	53%	48%	43%	54%	54%	50%
	Chlamydia Screening (↑)	53%	56%	62%	60%	56%	57%	63%
	Colorectal Cancer Screening (↑)	33%	48%	44%	45%	49%	50%	47%
QUALITY	Antidepressant Medication Management (Acute) (↑)	N/A*	54%	51%	52%	54%	55%	51%
	Antidepressant Medication Management (Continuation) (↑)	N/A*	38%	37%	36%	38%	39%	37%
	Asthma Medication Ratio (↑)	47%	48%	38%	34%	48%	49%	39%
	Comprehensive Diabetes Care – Eye Exam (↑)	44%	46%	38%	37%	47%	47%	39%
	Comprehensive Diabetes Care – HbA1C Testing (↑)	83%	83%	76%	74%	83%	83%	76%
	Comprehensive Diabetes Care – Nephropathy Screening (↑)	82%	86%	85%	86%	86%	86%	85%
	Plan All Cause Readmissions (↓)	7%	14%	16%	18%	14%	15%	16%
	Psychiatric Inpatient Readmissions (↓)	N/A*	13%	14%	16%	13%	14%	14%
	Adherence to Antipsychotics for Persons with Schizophrenia (↑)	N/A*	64%	54%	50%	64%	64%	54%
	Received Statin Therapy (↑)	38%	47%	43%	41%	49%	49%	44%
Statin Therapy Adherence – 80% (↑)	38%	47%	43%	41%	49%	49%	44%	
COORDINATION	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (↑)	N/A*	80%	83%	86%	80%	80%	83%
	Follow-Up After ED Visit for Alcohol or Other Drug Dependence (AOD) – Within 7 Days (↑)	N/A*	18%	18%	29%	19%	21%	19%
	Follow-Up After ED Visit for AOD – Within 30 Days (↑)	N/A*	29%	29%	43%	30%	32%	30%
	Follow-Up After Hospitalization for Mental Illness – Within 7 Days (↑)	N/A*	53%	51%	45%	53%	54%	51%
	Follow-Up After Hospitalization for Mental Illness – Within 30 Days (↑)	N/A*	72%	70%	62%	72%	73%	70%
	Follow-Up After ED Visit for Mental Illness – Within 7 Days (↑)	N/A*	54%	53%	51%	54%	58%	53%
	Follow-Up After ED Visit for Mental Illness – Within 30 Days (↑)	N/A*	66%	64%	64%	66%	71%	64%
UTILIZATION	High Emergency Department Utilization (3+ visits in year) (↓)	3%	14%	22%	23%	15%	17%	25%
	Inpatient Utilization (any visits within year) (↓)	4%	13%	20%	22%	13%	15%	21%
	Home and Community Based Services Utilization (any visits within year) (↑)	1%	3%	3%	4%	4%	5%	4%
SOCIAL OUTCOME	Homeless (↓)	3%	8%	16%	20%	8%	16%	16%
	Unstably Housed (↓)	7%	18%	32%	37%	17%	32%	32%
	Employed (↑)	49%	44%	40%	35%	44%	40%	39%
	Arrested (↓)	3%	10%	21%	26%	9%	21%	21%

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

Access to Care. Medicaid beneficiaries with behavioral health diagnoses had higher rates of service utilization associated with access to care when compared to Medicaid beneficiaries with no behavioral health diagnoses. For example, for Access to Ambulatory and Preventive Care, which measures use of primary care-type services, 64 percent of Medicaid beneficiaries with no behavioral health diagnoses accessed ambulatory/preventive care. However, 86 percent of Medicaid beneficiaries with a SUD diagnosis and 93 percent of Medicaid beneficiaries with an SMI diagnosis accessed ambulatory/preventive care. Medicaid beneficiaries with COD had similar or higher measures of access to care compared to those with no behavioral health diagnoses (Table 2).

Quality of Care. Measures of quality of care varied by behavioral health diagnosis category. For some metrics, there were minor differences between behavioral health diagnoses (Antidepressant Medicaid Management, Nephropathy Screening, and Psychiatric Inpatient Readmissions). For other metrics, Medicaid beneficiaries with SUD, OUD, or co-occurring diagnoses fared worse than those with no behavioral health diagnoses, but those with MH or SMI diagnoses fared better (Asthma Medication Ratio, Eye Exam, HbA1C Testing). For two metrics, Statin Therapy and Statin Therapy Adherence, Medicaid beneficiaries with behavioral health diagnoses had higher rates than those with no behavioral health diagnoses. However, one measure showed substantially worse outcomes for Medicaid beneficiaries with behavioral health diagnoses (Plan All Cause Readmissions). Individuals with no behavioral health diagnoses had a 7 percent rate of readmission. Those with behavioral health diagnoses had a readmission rate between 14 and 18 percent (Table 2).

Coordination of Care. Follow-up after an emergency department visit for SUD at 7 and 30 days was higher for Medicaid beneficiaries with an OUD diagnosis than for those with an SUD diagnosis (29 and 43 percent compared to 18 and 29 percent). Conversely, follow-up after hospitalization for mental illness was lower for individuals with an OUD diagnosis compared to all other behavioral health diagnoses. Follow-up after an emergency department visit for mental illness at 7 and 30 days was highest for those with a serious mental illness diagnosis. Diabetes screening for people with schizophrenia was slightly higher for Medicaid beneficiaries with an SUD, OUD, or COD compared to MH or SMI diagnoses (Table 2).

Utilization of High Intensity Services. Across all three types of services, Medicaid beneficiaries with behavioral health diagnoses had higher rates of utilization compared to Medicaid beneficiaries with no behavioral health diagnoses. The rate of high emergency department utilization (defined as three or more emergency department visits in a year) was at 3 percent for Medicaid beneficiaries with no behavioral health diagnoses and 14 percent or more for those with a behavioral health diagnosis. Twenty-five percent of individuals with COD were high ED utilizers. Inpatient utilization was 4 percent for those with no behavioral health diagnoses and 13-22 percent for those with behavioral health diagnoses. Use of home and community based services (HCBS) followed the same pattern as the other services examined, however utilization rates were much lower across all populations. One percent of Medicaid beneficiaries with no behavioral health diagnosis used HCBS compared to 3-5 percent of those with behavioral health diagnoses.

Social Outcomes. For all social outcomes reported, Medicaid beneficiaries with behavioral health diagnoses fared substantially worse than Medicaid beneficiaries with no behavioral health diagnoses. Those with OUD diagnoses fared worst of all; 20 percent were homeless, 37 percent were unstably housed, 35 percent were employed (second lowest Employment rate compared, MH was lower at 4%), and 26 percent had been arrested in the past year.

Summary

Overall, these descriptive analyses highlight variation in social and health outcomes among Medicaid beneficiaries. Across measures of physical health and social outcomes, Medicaid beneficiaries with SUD or OUD diagnoses fare worse compared to those with a mental health diagnosis, serious mental illness diagnosis, or no behavioral health diagnoses. In particular, those with SUD or OUD diagnoses have higher rates of emergency department utilization, and inpatient services utilization. Rates of unemployment, arrest, and homelessness are much higher for individuals with SUD or OUD compared to those with MH diagnosis (MH (4% employed) vs SUD or OUD (40 and 35% employed, respectively). It is important to note that these while these analyses describe outcomes, they are not sufficient to indicate whether having a behavioral health diagnosis *causes* the outcomes on the metrics. Additional research is needed to determine if these outcomes are significantly different across behavioral health diagnoses or to determine if having a behavioral health diagnosis directly causes poorer outcomes on the selected metrics.

This report also does not include Medicaid beneficiaries who are dually eligible for Medicare, or Medicaid beneficiaries who did not meet the minimum eligibility requirements. These populations may have different results on these measures of social and health outcomes.

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

APPENDIX

TABLE A1.

Physical and Social Outcomes in SFY 2019 among Medicaid Beneficiaries with Co-Occurring Behavioral Health Diagnoses

Medicaid Beneficiaries with Co-Occurring Behavioral Health Diagnoses			Medicaid Beneficiaries with diagnosis of...			
			MH + SUD	MH + OUD	SMI + SUD	SMI + OUD
ACCESS	Access to Ambulatory and Preventive Care (↑)	90%	89%	91%	92%	93%
	Breast Cancer Screening (↑)	47%	50%	44%	48%	46%
	Cervical Cancer Screening (↑)	50%	54%	45%	51%	47%
	Chlamydia Screening (↑)	63%	63%	61%	64%	62%
	Colorectal Cancer Screening (↑)	47%	47%	47%	48%	49%
QUALITY	Antidepressant Medication Management (Acute) (↑)	51%	51%	52%	53%	53%
	Antidepressant Medication Management (Continuation) (↑)	37%	37%	36%	38%	38%
	Asthma Medication Ratio (↑)	39%	41%	35%	41%	37%
	Comprehensive Diabetes Care – Eye Exam (↑)	39%	40%	38%	40%	38%
	Comprehensive Diabetes Care – HbA1C Testing (↑)	76%	78%	75%	78%	76%
	Comprehensive Diabetes Care – Nephropathy Screening (↑)	85%	85%	86%	85%	86%
	Plan All Cause Readmissions (↓)	16%	14%	18%	17%	18%
	Psychiatric Inpatient Readmissions (↓)	14%	12%	16%	14%	16%
	Adherence to Antipsychotics for Persons with Schizophrenia (↑)	54%	56%	50%	54%	50%
	Received Statin Therapy (↑)	44%	47%	43%	46%	44%
	Statin Therapy Adherence – 80% (↑)	44%	47%	43%	46%	44%
COORDINATION	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (↑)	83%	82%	86%	83%	86%
	Follow-Up After ED Visit for Alcohol or Other Drug Dependence (AOD) – Within 7 Days (↑)	19%	9%	29%	21%	30%
	Follow-Up After ED Visit for AOD – Within 30 Days (↑)	30%	17%	43%	32%	44%
	Follow-Up After Hospitalization for Mental Illness – Within 7 Days (↑)	51%	55%	46%	52%	46%
	Follow-Up After Hospitalization for Mental Illness – Within 30 Days (↑)	70%	76%	62%	72%	63%
	Follow-Up After ED Visit for Mental Illness – Within 7 Days (↑)	53%	54%	51%	56%	53%
	Follow-Up After ED Visit for Mental Illness – Within 30 Days (↑)	64%	65%	64%	68%	68%
UTILIZATION	High Emergency Department Utilization (3+ visits in year) (↓)	25%	23%	26%	27%	30%
	Inpatient Utilization (any visits within year) (↓)	22%	21%	24%	24%	27%
	Home and Community Based Services Utilization (any visits within year) (↑)	4%	4%	4%	5%	5%
SOCIAL OUTCOME	Homeless (↓)	16%	14%	19%	18%	20%
	Unstably Housed (↓)	32%	29%	37%	35%	39%
	Employed (↑)	39%	42%	35%	38%	34%
	Arrested (↓)	21%	17%	26%	21%	25%

TECHNICAL NOTES

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

This report focuses on differences in outcomes among Medicaid beneficiaries with different behavioral health diagnoses.

1. **Substance Use Disorder Diagnosis** is defined as the presence of a Substance Use Disorder (SUD) diagnosis within the measurement year (SFY 2019) or the year prior to the measurement year (SFY 2018). Example SUD diagnoses include diagnoses related to alcohol, amphetamines (including methamphetamine), cocaine and other stimulants, heroin and other opioids (including synthetic opioids), and cannabis. It does not include diagnoses related to tobacco use disorder.
2. **Opioid Use Disorder Diagnosis** is defined as the presence of an Opioid Use Disorder (OUD) diagnosis within the measurement year (SFY 2019) or the year prior to the measurement year (SFY 2018). Example OUD diagnoses include diagnoses related to synthetic and non-synthetic opioids, such as heroin and fentanyl. OUD diagnoses are subset of SUD diagnoses (all individuals with an OUD diagnosis will also be identified as having a SUD diagnosis).
3. **Mental Health Diagnosis** is defined as the presence of a Mental Health (MH) diagnosis within the measurement year (SFY 2019) or the year prior to the measurement year (SFY 2018). Example MH diagnoses include depression, anxiety, ADHD, and mania/bipolar.
4. **Serious Mental Illness Diagnosis** is defined as the presence of a Serious Mental Illness (SMI) diagnosis within the measurement year (SFY 2019) or the year prior to the measurement year (SFY 2018). Example SMI diagnoses include schizophrenia, bipolar disorder, and major depressive disorder. SMI diagnoses are a subset of MH diagnoses (all individuals with a SMI diagnosis will also be identified as having a MH diagnosis).
5. **Co-Occurring Substance Use Disorder and Mental Health Diagnosis** is defined as the presence of a SUD or OUD diagnosis AND a MH or SMI diagnosis within the measurement year (SFY 2019) or the year prior to the measurement year (SFY 2018).
6. **No Behavioral Health Diagnosis** is defined as the absence of any SUD, OUD, MH, or SMI diagnosis within the measurement year (SFY 2019) or the year prior to the measurement year (SFY 2018).

Additional variables are used in this analysis:

- **Physical Health and Social Outcomes:** Reported measures adhered to measure steward specifications, including Medicaid eligibility and demographic requirements (e.g. Breast Cancer Screening is only measured for women between the ages of 50 and 64). A list of the measure stewards and the respective measures is below. A link to the specifications is included.
 - [NCQA HEDIS® 2019 Specifications](#): Access to Ambulatory and Preventive Care, Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening, Colorectal Cancer Screening, Antidepressant Medication Management (Acute and Continuation Phases), Asthma Medication Ratio, Comprehensive Diabetes Care (Eye Exam, HbA1C testing, Nephropathy Screening), Plan All Cause Readmission, Adherence to Antipsychotics for Persons with Schizophrenia, Received Statin Therapy, Statin Therapy Adherence – 80 percent, Diabetes Screening for People with Schizophrenia or Bipolar Disorder, Follow-Up After ED Visit for Alcohol or Other Drug Dependence, Follow-Up After Hospitalization for Mental Illness, Follow-Up After ED Visit for Mental Illness.
 - [DSHS-RDA 2019 Specifications](#): Psychiatric Inpatient Readmissions, High Emergency Department Utilization (3+ visits within a year), Inpatient Utilization, Home and Community Based Services Utilization, Homelessness-Narrow, Homelessness-Broad, Arrested, Employed.

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

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