

Managed Medical Care for Persons with Disabilities and Behavioral Health Needs

Preliminary Findings from Washington State

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THE LAST TWO DECADES have seen a trend away from providing Medicaid medical coverage on a fee-for-service basis, with direct state agency payments to providers for services rendered, in favor of the delivery of services through capitated managed care contracts with health plans. Nationally, Medicaid enrollees with disabilities tended to be among the last coverage groups to shift to managed care. In Washington State, with the exception of a few special programs with relatively small enrollment levels, prior to July 2012 persons enrolled in disability-related Medicaid coverage received medical services through a fee-for-service delivery system. In July 2012, the Washington State Health Care Authority began transitioning Medicaid enrollees with disabilities to managed medical care.

Medicaid mental health services for persons with serious mental illness are carved out into a delivery system administered by a geographically based managed care system of Regional Support Networks, while substance use disorder services are currently delivered through county-administered outpatient and state-administered inpatient treatment systems. Outcomes experienced by Medicaid enrollees with behavioral health needs are the shared responsibility of all of these delivery systems.

The shift to managed medical care is motivated by goals of improving access to primary care and care management for persons with complex health conditions. A significant facet of the clinical complexity of the population of Medicaid enrollees with disabilities is the high prevalence of behavioral health needs. About three-quarters of disabled Medicaid adults have mental health needs, and about half are identified through the disability determination process as having a primary disability of mental illness. Further, about 30 percent of disabled Medicaid adults have substance use disorders, usually with co-occurring mental health needs.

The shift from fee-for-service to managed care medical coverage beginning in July 2012 can be viewed as a step towards the future integration of medical and behavioral health care directed by Second Substitute Senate Bill 6312 (Chapter 225, Laws of 2014). This legislation anticipates that aligning Medicaid medical and behavioral health benefits under a single accountable managed care entity will result in better access to care, improved care coordination, better health outcomes, and ultimately slower growth of Medicaid health service expenditures.

This policy brief reviews the experience of Medicaid enrollees with disabilities during the first year of medical managed care implementation. We compare the experience of disabled persons with mental illness and/or substance use disorders, relative to the experience of disabled persons who do not have identified behavioral health disorders. Quality and outcome metrics that are emerging as performance standards for Medicaid delivery systems are used as the lens for assessing clients' experience under managed care, relative to the prior experience in fee-for-service coverage. A second report due in June 2015 will focus on quality and outcome metrics in the second year under managed care.



Key Findings

Several key outcome measures showed positive relative change for disabled persons with behavioral health disorders after the transition to managed care:

- Access to primary care improved and ED utilization declined for disabled persons with behavioral health disorders, relative to clients without behavioral health disorders.
- The all-cause 30-day hospital readmission rate declined for disabled persons with behavioral health disorders, while it increased slightly for clients without behavioral health disorders.
- The employment rate increased for disabled persons with behavioral health disorders, while it decreased for disabled persons without behavioral health disorders.
- The proportion arrested increased slightly for all groups, but at a slower rate for disabled persons with behavioral health disorders than for persons without behavioral health disorders.

Some process-of-care measures related to behavioral health treatment took a step backward in SFY 2013:

- The proportion receiving outpatient follow-up within seven days of discharge from a psychiatric hospitalization declined.
- Although the broader measure of substance use disorder (SUD) treatment penetration improved slightly, the NCQA HEDIS measures of initiation and engagement in SUD treatment declined.
- Antidepressant and antipsychotic medication management quality indicators declined.

Persons with behavioral health disorders—especially those with substance use disorders—scored significantly lower on many quality and outcome measures than other persons with disabilities:

- Persons with behavioral health disorders have higher all-cause readmission rates and are far more likely to experience hospitalizations for ambulatory care sensitive conditions.
- Persons with substance use disorders score significantly lower on diabetes care quality measures such as hemoglobin A1c testing and LDL-C screening.
- Persons with behavioral health disorders—especially those with substance use disorders—are far more likely to be homeless or arrested, and are less likely to be employed.

These findings have implications for the development of performance-based contracts required under Engrossed House Bill (EHB) 1519 (Chapter 320, Laws of 2013). EHB 1519 requires that state agency contracts with Area Agencies on Aging, Regional Support Networks, county agencies, and managed care organizations include performance measures to address a wide range of outcomes, including many outcome areas examined in this report. As the state moves towards outcome-based contracting for services, it is important for policy makers to recognize that client outcomes reflect the combined impact of the care the client receives, the client's risk attributes and other factors.

The impact of behavioral health disorders on quality and outcome measures can be seen in the experience of persons with substance use disorders. For example, the low diabetes quality scores for persons with substance use disorders reflect in part the impact of substance use on a client's ability to engage in an effective diabetes care plan. This is an important issue to consider in constructing performance-based payment models designed to hold managed care entities accountable for the outcomes experienced by the clients they serve. Poorly designed payment models risk creating incentives for health plans to exclude providers from their network who serve patients with higher prevalence of behavioral health disorders. If incentives are passed through health plans to their contracted providers, poorly designed payment models will create incentives for providers to avoid engaging high-risk clients who may adversely impact a provider's performance scores. Given their relatively poor outcomes, the financial disincentives for enrollment and engagement of persons with substance use disorders would be particularly strong.

Background and Approach

Medical Managed Care Implementation

The Washington State Health Care Authority transitioned persons enrolled in disability-related Medicaid coverage from fee-for-service to Apple Health managed care coverage on a phased basis, as illustrated in Figure 1. The main transition phases occurred in July, September and November 2012. An additional population of long-term care clients was moved into managed care in September 2013. Because persons dually eligible for Medicare remained in fee-for-service coverage, this report focuses on Medicaid-only Categorically Needy (CN) Disabled clients.¹ It is important to note that Medicaid-funded mental health services for persons with serious mental illness are carved out into a service system administered by geographically based Regional Support Networks, while substance use disorders treatment services are delivered through county-administered outpatient and state-administered inpatient treatment systems. Outcomes for Medicaid enrollees with behavioral health needs are the shared responsibility of all of these delivery systems.

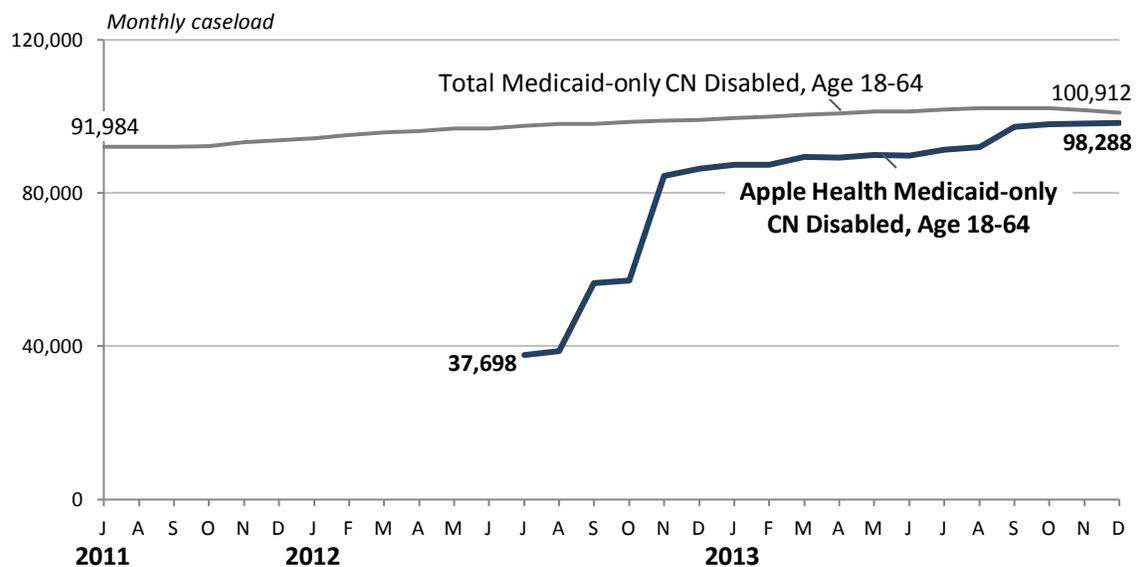
Quality and Outcome Metrics

The analyses that follow use health care quality and outcome metrics that are emerging as performance standards for Medicaid delivery systems as the lens for assessing clients' experience under managed care, relative to prior experience in fee-for-service coverage. These metrics are derived from two sources. The first source is the CMS Initial Core Set of health care quality measures for adults enrolled in Medicaid. Metrics were also sourced from the measurement areas specified by Second Substitute Senate Bill 5732 (Chapter 338, Laws of 2013) and Engrossed House Bill 1519 (Chapter 320, Laws of 2013). These bills directed the Department of Social and Health Services and the Health Care Authority to develop a comprehensive strategy to improve the adult behavioral healthcare system, and to better integrate physical and behavioral healthcare and long term supports and services, to improve outcomes for their shared clients. With our focus on measures developed for adult populations, we generally limited analyses to persons aged 18 to 64, although some metrics are defined over more restrictive age ranges.

FIGURE 1.

Medicaid-only CN Disabled Caseload Trends

Washington State Age 18-64



¹ The state is developing a pilot integrated managed care demonstration project for persons dually eligible for Medicare, scheduled to be implemented in King and Snohomish counties in 2015.

Background and Approach

EHB 1519 mandated that state agency contracts with Area Agencies on Aging, Regional Support Networks, county agencies coordinating substance use disorder services, and Medicaid managed care organizations include performance measures to address:

- Improvement in health status.
- Increased participation in employment, education, and meaningful activities.
- Reduced involvement in criminal justice systems.
- Reduced avoidable use of hospital, emergency rooms, and crisis services.
- Increased housing stability in the community.
- Improved client satisfaction with quality of life.
- Decreased disparities in access to treatment and treatment outcomes

These common outcome and performance measures are designed to move the public healthcare and social service systems towards a model of shared accountability. The quality and outcome measures examined in this report touch on many of the measurement areas called out in this legislation.

Approach

This policy brief examines the experience of Medicaid enrollees with disabilities during the first year of medical managed care implementation in SFY 2013. We compare the experience of disabled persons with mental illness and/or substance use disorders, relative to the experiences of other persons enrolled in disability-related coverage who do not have identified behavioral health disorders. We use an approach analogous to an “intent-to-treat” design, where we compare the outcomes experienced in SFY 2013 with the outcomes experienced in the prior two fiscal years when medical care was provided on a fee-for-service basis. We note that even with the phased implementation of managed care in SFY 2013, managed care enrollment comprised 75 percent of all coverage months for persons aged 18 to 64 with Medicaid-only CN Disabled coverage in that fiscal year. We also note that this report looks at experiences in the first year of implementation of managed care, and the transition to outcomes measured using reported encounter data rather than paid claims could also affect measured outcomes independently of any underlying changes in client care experiences.

Defining Behavioral Health Risk Groups

The analyses that follow compare the experience of disabled persons with mental illness and/or substance use disorders, relative to the experience of other persons enrolled in disability-related coverage who do not have identified behavioral health disorders. Behavioral health needs were identified using data available in the ProviderOne payment system. Mental health service needs were identified if any of the following criteria were met in the measurement year or the year prior to the measurement year: (1) receipt of any health care service with a mental illness diagnosis (including Regional Support Network services or services provided through the medical benefit), or (2) receipt of psychotropic medication including antipsychotic, antimania, antianxiety, antidepressant or ADHD therapy classes. Substance use disorders were identified by the presence of a substance use disorder diagnosis on any health service claim or encounter in the measurement year or the year prior to the measurement year, including treatment or detox events, mental health service events, or medical service events such as emergency department or office visits. We note that several metrics are relevant only to persons with behavioral health disorders (for example, outpatient follow-up after psychiatric hospitalization), in which case information is only presented for client subgroups with the relevant behavioral health disorder. We also note that the experience of clients with co-occurring mental health needs or substance use disorders are also reflected in the separate results reported for the broader groups with these conditions.

Findings

Most of the discussion that follows is based on examination of the trends in quality and outcome measures charted on pages 8 to 12. Supplemental detail tables on pages 13 to 24 provide numerator and denominator counts by subpopulation for each measure. The supplemental tables also contain data for additional metrics from the CMS Initial Core Set that are measureable using claims and encounter data (i.e., without chart review).

Hospital readmissions, page 8

- The all-cause 30-day hospital readmission measure showed positive relative change in SFY 2013 for persons with behavioral health disorders. The readmission rate declined from SFY 2012 to SFY 2013 for disabled persons with behavioral health disorders, while increasing slightly for disabled persons without behavioral health disorders.

Employment, page 8

- Employment rates showed positive relative change in SFY 2013 for persons with behavioral health disorders. The employment rate increased from SFY 2012 to SFY 2013 for disabled persons with behavioral health disorders, while decreasing for disabled persons without behavioral health disorders.

Homelessness, page 8

- The rate of homelessness is significantly higher for persons with behavioral health needs – particularly those with substance use disorders. The proportion of persons who were homeless for at least part of the fiscal year increased for all groups at about the same proportional rate from SFY 2012 to SFY 2013. We note that the rate of homelessness had been growing more slowly for persons with behavioral health needs in the year prior to the transition to managed care. That is, the relative change in the rate of homelessness from SFY 2011 to SFY 2012 was lower for persons with mental health needs or substance use disorders than for the balance of the Medicaid-only CN Disabled adult population.

Arrests, page 8

- The arrest rate is significantly higher for persons with behavioral health needs – particularly those with substance use disorders. The proportion arrested increased slightly from SFY 2012 to SFY 2013 for all groups, but at a slightly slower proportional rate for disabled persons with behavioral health disorders than for persons without behavioral health disorders.

Outpatient follow-up after psychiatric hospitalization, page 9

- Measures are presented for 7-day and 30-day post discharge follow-up windows. The 7-day metric showed a decline in performance from SFY 2012 to SFY 2013, while the 30-day follow-up measure showed slight improvement. Given the importance of timely post-discharge engagement in outpatient follow-up treatment, we would place greater importance on the decline in performance in SFY 2013 on the 7-day follow-up metric.

Initiation and engagement in alcohol and other drug treatment, page 9

- Both metrics declined significantly in SFY 2013, breaking from the trend observed over the prior 2 fiscal years.

Substance use disorder treatment penetration, page 12

- This state-defined measure improved slightly in SFY 2013, in contrast to the decline observed in the HEDIS initiation and engagement metrics.

Mental health treatment penetration, page 12

- This state-defined measure stabilized in SFY 2013, after declining from SFY 2011 to SFY 2012.

Antidepressant medication management, page 10

- Both acute phase and continuation phase metrics declined from SFY 2012 to SFY 2013. This decline was largely consistent with the declining trend experienced from SFY 2011 to SFY 2012.

Antipsychotic medication adherence, page 10

- Adherence rates decline significantly in 2013, following a pattern of improvement from SFY 2011 to SFY 2012. The improvement from SFY 2011 to SFY 2012 likely reflects the impact of a series of initiatives led by the Health Care Authority and the Washington Community Mental Health Council to improve prescribing practice. These initiatives included prescribing provider learning collaboratives, a clinician support phone line provided through the University of Washington, provider feedback reports, and piloting of direct provider access to client-level adherence data through the PRISM application. The decline in adherence from SFY 2012 to SFY 2013 may reflect the disruptive effect of the initial carve out of antipsychotic medications from the managed care benefit for persons with disabilities. Beginning in January 2014, antipsychotic medications were integrated into the pharmacy benefit provided under managed care. This area merits close attention to see whether outcomes return to SFY 2012 levels.

Diabetes care, page 10

- The comprehensive diabetes care hemoglobin A1c testing metric showed improvement across all groups. Persons with substance use disorders score significantly lower on the hemoglobin A1c testing and LDL-C screening metrics (reported in the supplemental data tables).

Hospitalizations for ambulatory care sensitive conditions, page 11

- Persons with behavioral health disorders are far more likely to experience hospitalizations for “avoidable” ambulatory care sensitive conditions such as diabetes complications, COPD, asthma, or congestive heart failure. In fact, persons with behavioral health disorders account for the vast majority of all ambulatory care sensitive condition hospitalizations among persons with disabilities. Relative trends in this area are generally positive for persons with behavioral health disorders, with relative rates of change from SFY 2012 to SFY 2013 that are more favorable in most cases for persons with behavioral health disorders than for the balance of the disabled adult population.

Adult access to primary care, page 12

- Access to primary care improved in SFY 2013 for disabled persons with behavioral health disorders, relative to clients without behavioral health disorders.

Outpatient emergency department visits, page 12

- ED utilization declined in SFY 2013 for disabled persons with behavioral health disorders, relative to clients without behavioral health disorders. The pace of decline in ED utilization for disabled persons with behavioral health disorders was slower in SFY 2013, relative to the decline in utilization observed from SFY 2011 to SFY 2012.

In summary, the results paint a predominantly positive picture. Inpatient hospitalization and outpatient ED utilization metrics are generally moving in a positive direction, as are measures of employment and quality of diabetes care. Rates of homelessness and criminal justice involvement increased for persons with behavioral health disorders, but relative changes were similar to those experienced by other disabled Medicaid adults. Some HEDIS behavioral health care quality metrics declined, but key measures of access to primary care, substance use disorder treatment and mental health treatment were stable or improved in SFY 2013.

Implications for Outcome-Based Contracting

These findings have implications for the development of performance-based contracts required under Engrossed House Bill (EHB) 1519 (Chapter 320, Laws of 2013). EHB 1519 requires that state agency contracts with Area Agencies on Aging, Regional Support Networks, county agencies, and managed care organizations include performance measures to address a wide range of outcomes, including many outcome areas examined in this report. As the state moves towards performance-based contracting for services, it is important for policy makers to recognize that client outcomes reflect the combined impact of the care the client receives, the client's risk attributes and other factors.

The impact of behavioral health disorders on quality and outcome measures can be seen in the experience of persons with substance use disorders:

- Persons with substance use disorders score significantly lower on diabetes care quality measures such as hemoglobin A1c testing and LDL-C screening.
- Persons with substance use disorders have far higher rates of hospitalizations for “avoidable” ambulatory care sensitive conditions including diabetes complications.

Low diabetes quality scores for persons with substance use disorders reflect in part the impact of substance use on a client's ability to engage in an effective diabetes care plan.

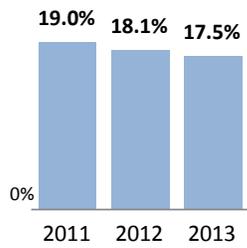
This is an important issue to consider in constructing performance-based payment models designed to hold managed care entities accountable for the outcomes experienced by the clients they serve. Poorly designed payment models risk creating incentives for health plans to exclude providers from their network who serve populations with higher prevalence of behavioral health disorders, in favor of “higher value” providers who serve a lower risk client population with whom it is possible to achieve higher quality scores.

A poorly designed performance-based payment system will reinforce the existing incentives for managed care organizations to achieve a favorable risk pool. Furthermore, if incentives are passed through health plans to their contracted providers, poorly designed payment models will create incentives for providers to avoid engaging high-risk clients who may adversely impact their performance scores. Given the relatively low quality and outcome scores observed for persons with substance use disorders, the disincentives for engagement are likely to be particularly strong for this risk group.

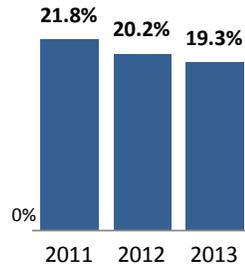
All-Cause 30-Day Hospital Readmission Rate

AGES 18 – 64 • PCR

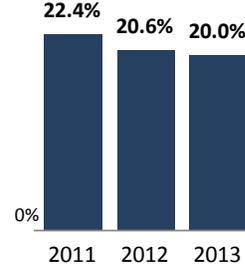
With Mental Health Need



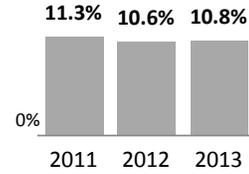
With Substance Use Disorder (SUD)



With Co-Occurring Mental Health and SUD



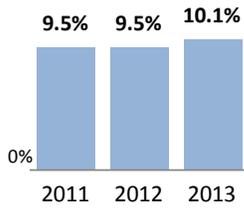
Without Behavioral Health Disorder



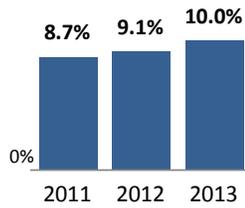
Percent with Earnings

AGES 18 – 64

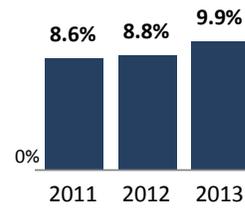
With Mental Health Need



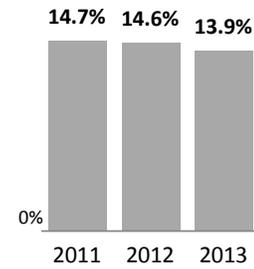
With Substance Use Disorder (SUD)



With Co-Occurring Mental Health and SUD



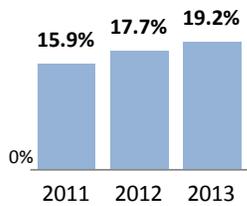
Without Behavioral Health Disorder



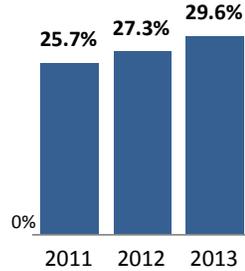
Percent Homeless

AGES 18 – 64

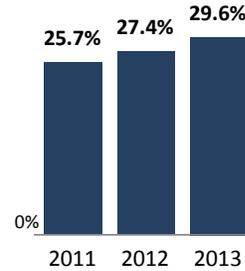
With Mental Health Need



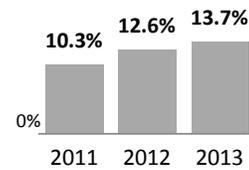
With Substance Use Disorder (SUD)



With Co-Occurring Mental Health and SUD



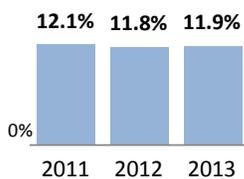
Without Behavioral Health Disorder



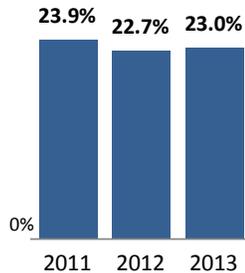
Percent with Arrests

AGES 18 – 64

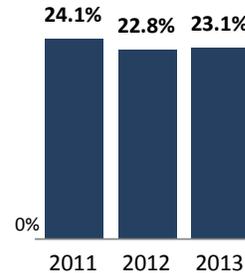
With Mental Health Need



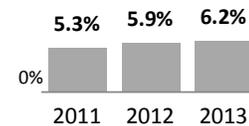
With Substance Use Disorder (SUD)



With Co-Occurring Mental Health and SUD



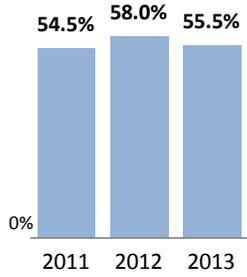
Without Behavioral Health Disorder



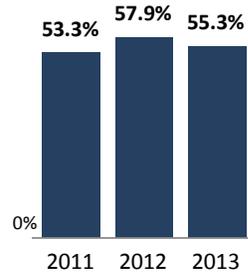
Follow-Up After Hospitalization for Mental Illness – 7 Day

AGES 21 – 64 • FUH-7D

With Mental Health Need



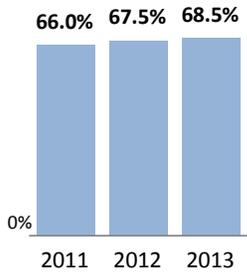
With Co-Occurring Mental Health and SUD



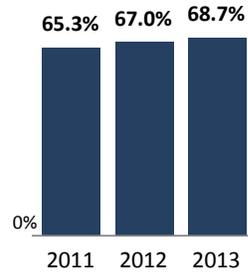
Follow-Up After Hospitalization for Mental Illness – 30 Day

AGES 21 – 64 • FUH-30D

With Mental Health Need



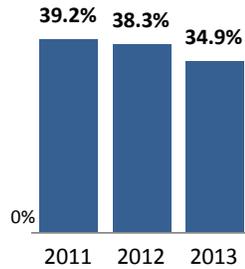
With Co-Occurring Mental Health and SUD



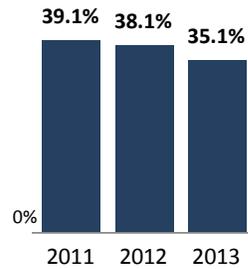
Initiation of Alcohol and Other Drug Dependence Treatment

AGES 18 – 64 • IET-INI

With Substance Use Disorder (SUD)



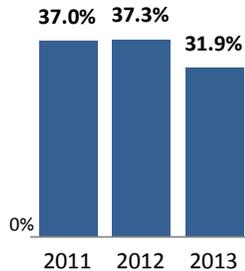
With Co-Occurring Mental Health and SUD



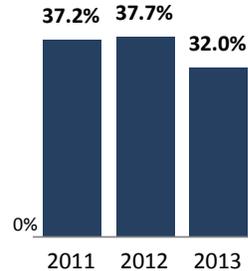
Engagement in Alcohol and Other Drug Dependence Treatment

AGES 18 – 64 • IET-ENG

With Substance Use Disorder (SUD)



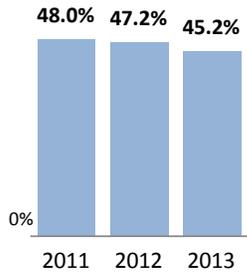
With Co-Occurring Mental Health and SUD



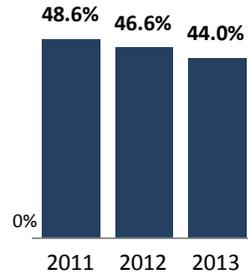
Antidepressant Medication Management – Effective Acute Phase Treatment

AGES 18 – 64 • AMM-84D

With Mental Health Need



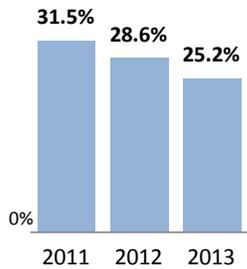
With Co-Occurring Mental Health and SUD



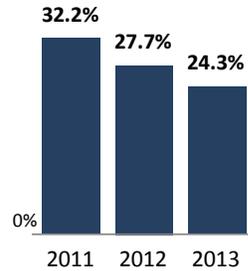
Antidepressant Medication Management – Effective Continuation Phase Treatment

AGES 18 – 64 • AMM-180D

With Mental Health Need



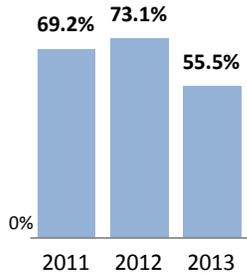
With Co-Occurring Mental Health and SUD



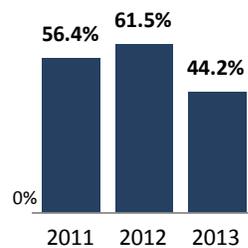
Adherence to Antipsychotic Medications for Individuals with Schizophrenia

AGES 19 – 64 • SAA

With Mental Health Need



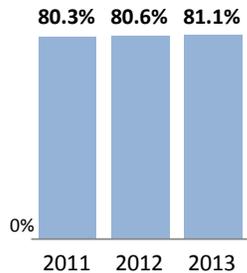
With Co-Occurring Mental Health and SUD



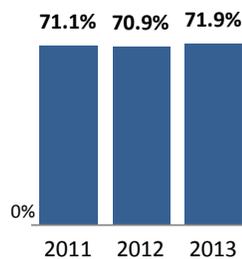
Comprehensive Diabetes Care, Hemoglobin A1c Testing

AGES 18 – 64 • CDC-HBA1C

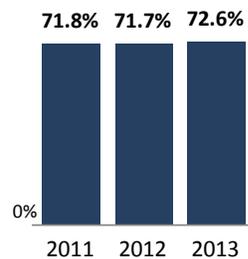
With Mental Health Need



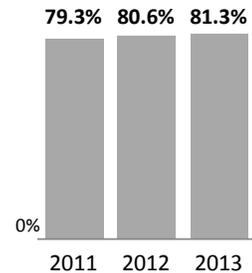
With Substance Use Disorder (SUD)



With Co-Occurring Mental Health and SUD

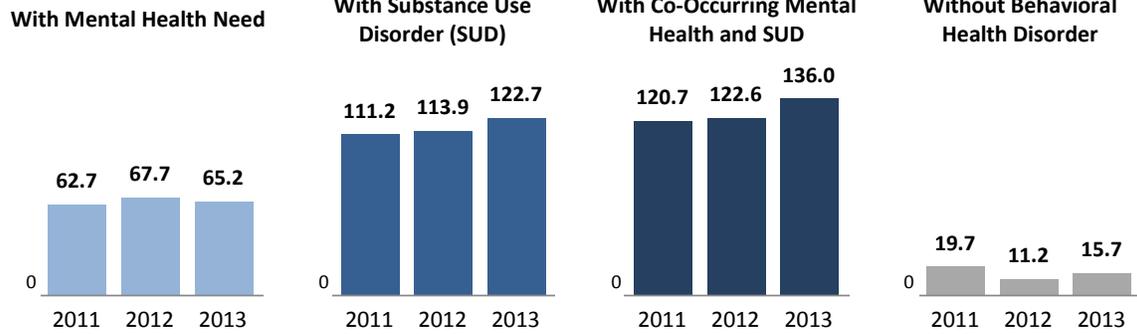


Without Behavioral Health Disorder



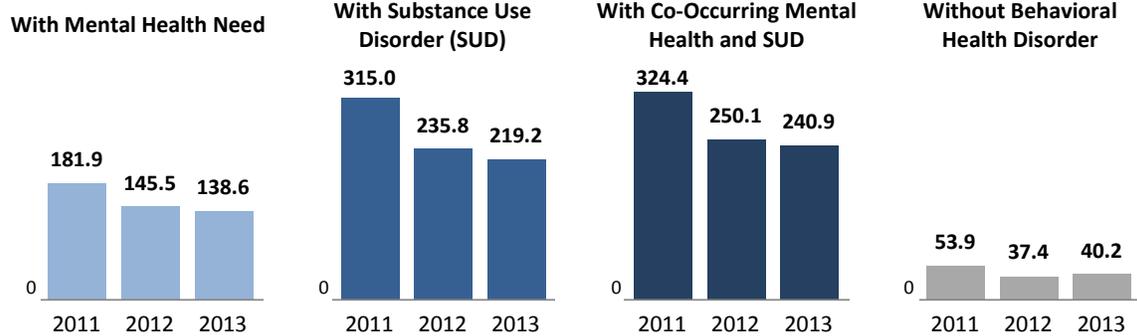
PQI 01: Diabetes Short-Term Complications Admission Rate

AGES 18 – 64 • Admissions per 100,000 Member Months



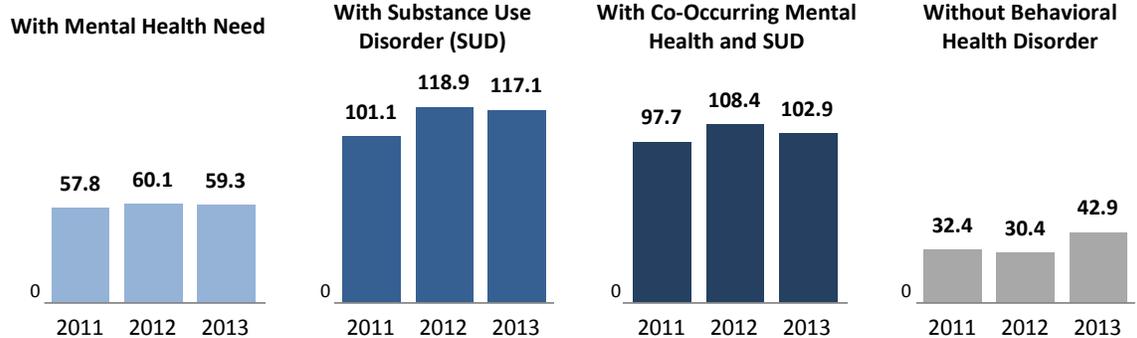
COPD/Asthma in Older Adults Admission Rate

AGES 40 – 64 • Admissions per 100,000 Member Months



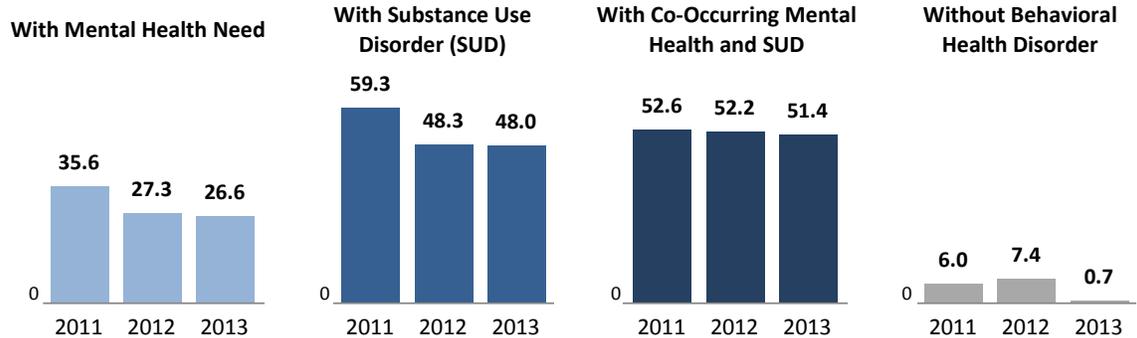
Congestive Heart Failure (CHF) Admission Rate

AGES 18 – 64 • Admissions per 100,000 Member Months



Asthma in Younger Adults Admission Rate

AGES 18 – 39 • Admissions per 100,000 Member Months

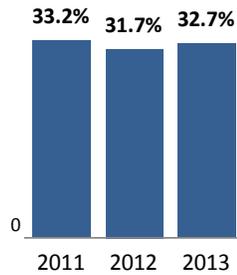


Substance Use Disorder Treatment Penetration

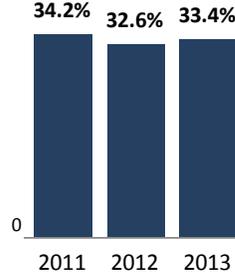
AGES 18 – 64 • SUPPL-AOD

With Mental Health Need

With Substance Use Disorder (SUD)



With Co-Occurring Mental Health and SUD

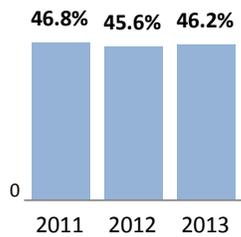


Without Behavioral Health Disorder

Mental Health Treatment Penetration

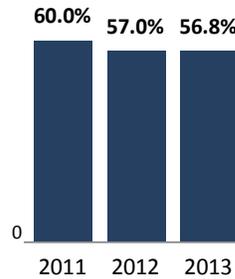
AGES 18 – 64 • SUPPL-MH-B

With Mental Health Need



With Substance Use Disorder (SUD)

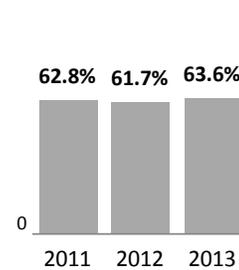
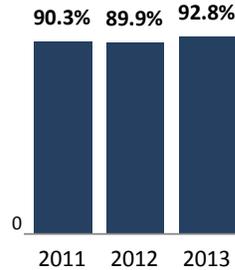
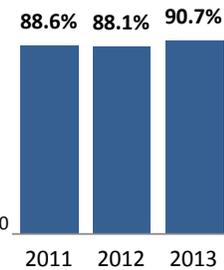
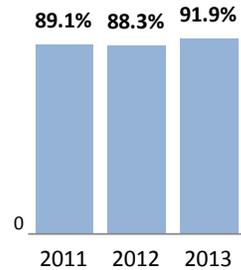
With Co-Occurring Mental Health and SUD



Without Behavioral Health Disorder

Adult Access to Primary Care

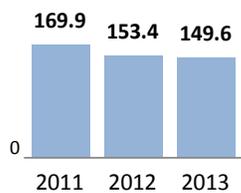
AGES 20 – 64 • AAP



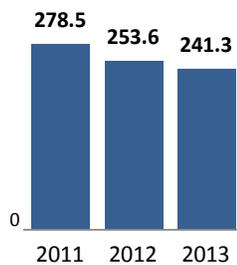
Outpatient Emergency Department Visits

AGES 18 – 64 • Visits per 1,000 Member Months

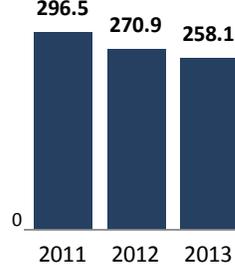
With Mental Health Need



With Substance Use Disorder (SUD)



With Co-Occurring Mental Health and SUD



Without Behavioral Health Disorder

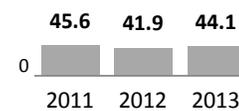


TABLE 1

NCQA-HEDIS and State-Defined Quality Measures by Fiscal Year

SOURCE: DSHS Research and Data Analysis Division, Integrated Client Database

1A. All Medicaid-only CN Disabled Adult Clients

MEASURE	ABBREVIATION	AGE GROUP	SFY	NUMERATOR	DENOMINATOR	RATE
Adult Body Mass Index (BMI) Assessment	ABA	18-64	2011	1,912	57,118	3.3%
			2012	3,670	59,319	6.2%
			2013	4,676	62,399	7.5%
Antidepressant Medication Management – Effective Acute Phase Treatment	AMM-84D	18-64	2011	1,375	2,866	48.0%
			2012	1,404	2,972	47.2%
			2013	1,406	3,114	45.2%
Antidepressant Medication Management – Effective Continuation Phase Treatment	AMM-180D	18-64	2011	903	2,866	31.5%
			2012	849	2,972	28.6%
			2013	785	3,114	25.2%
Breast Cancer Screening	BCS	42-64	2011	10,147	24,487	41.4%
			2012	10,315	25,180	41.0%
			2013	10,424	25,776	40.4%
Cervical Cancer Screening	CCS	24-64	2011	15,315	37,026	41.4%
			2012	14,783	36,802	40.2%
			2013	14,439	37,389	38.6%
Comprehensive Diabetes Care, Hemoglobin A1c Testing	CDC-HBA1C	18-64	2011	11,222	14,064	79.8%
			2012	11,680	14,567	80.2%
			2013	12,129	15,026	80.7%
Comprehensive Diabetes Care, LDL-C Screening	CDC-LDLC	18-64	2011	9,683	14,064	68.8%
			2012	9,859	14,567	67.7%
			2013	10,074	15,026	67.0%
Chlamydia Screening	CHL	21-24	2011	744	1,708	43.6%
			2012	711	1,679	42.3%
			2013	722	1,684	42.9%
Follow-Up After Hospitalization for Mental Illness – 7 Day	FUH-7D	21-64	2011	1,684	3,108	54.2%
			2012	1,651	2,851	57.9%
			2013	1,605	2,904	55.3%
Follow-Up After Hospitalization for Mental Illness – 30 Day	FUH-30D	21-64	2011	2,037	3,108	65.5%
			2012	1,923	2,851	67.5%
			2013	1,983	2,904	68.3%
Annual HIV/AIDS Medical Visit - 90 Day	HIV-90D	18-64	2011	774	900	86.0%
			2012	770	908	84.8%
			2013	770	904	85.2%
Annual HIV/AIDS Medical Visit - 180 Day	HIV-180D	18-64	2011	661	900	73.4%
			2012	672	908	74.0%
			2013	660	904	73.0%
Initiation of Alcohol and Other Drug Dependence Treatment	IET-INI	18-64	2011	5,527	14,471	38.2%
			2012	5,595	14,906	37.5%
			2013	5,492	16,122	34.1%
Engagement in Alcohol and Other Drug Dependence Treatment	IET-ENG	18-64	2011	1,967	5,527	35.6%
			2012	2,001	5,595	35.8%
			2013	1,677	5,492	30.5%
Annual Monitoring for Patients on Persistent Medications - ACE or ARB	MPM-ACE	18-64	2011	8,293	9,737	85.2%
			2012	8,844	10,356	85.4%
			2013	5,990	7,132	84.0%

Annual Monitoring for Patients on Persistent Medications - Anticonvulsants	MPM-ANT	18-64	2011	2,435	4,032	60.4%
			2012	2,250	3,883	57.9%
			2013	1,741	3,101	56.1%
Annual Monitoring for Patients on Persistent Medications - Digoxin	MPM-DIG	18-64	2011	241	299	80.6%
			2012	242	289	83.7%
			2013	196	238	82.4%
Annual Monitoring for Patients on Persistent Medications - Diuretic	MPM-DIU	18-64	2011	6,175	7,255	85.1%
			2012	6,404	7,539	84.9%
			2013	4,398	5,195	84.7%
Annual Monitoring for Patients on Persistent Medications - Total	MPM-TOT	18-64	2011	17,144	21,323	80.4%
			2012	17,740	22,067	80.4%
			2013	12,325	15,666	78.7%
Plan All-Cause Readmission	PCR	18-64	2011	3,277	17,909	18.3%
			2012	3,000	17,136	17.5%
			2013	2,800	16,814	16.7%
Post-Partum Care Rate	PPC	18-64	2011	222	782	28.4%
			2012	229	751	30.5%
			2013	210	790	26.6%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	SAA	19-64	2011	3,313	4,791	69.2%
			2012	3,524	4,821	73.1%
			2013	2,644	4,765	55.5%
Adult Access to Primary Care	AAP	20-64	2011	65,615	79,929	82.1%
			2012	66,540	82,049	81.1%
			2013	71,925	85,734	83.9%
30-Day Psychiatric Readmission Rate [State-Defined]	PCR-P	18-64	2011	297	2,045	14.5%
			2012	233	1,797	13.0%
			2013	209	1,815	11.5%
Substance Use Disorder Treatment Penetration [State-Defined]	SUPPL-AOD	18-64	2011	7,338	22,112	33.2%
			2012	7,545	23,781	31.7%
			2013	7,858	24,023	32.7%
Mental Health Treatment Penetration [State-Defined]	SUPPL-MH-B	18-64	2011	30,217	64,526	46.8%
			2012	30,593	67,155	45.6%
			2013	31,651	68,499	46.2%

1B. Medicaid-only CN Disabled Adult Clients with Mental Health Need

MEASURE	ABBREVIATION	AGE GROUP	SFY	NUMERATOR	DENOMINATOR	RATE
Adult Body Mass Index (BMI) Assessment	ABA	18-64	2011	1,691	44,056	3.8%
			2012	3,220	45,791	7.0%
			2013	4,013	47,401	8.5%
Antidepressant Medication Management – Effective Acute Phase Treatment	AMM-84D	18-64	2011	1,375	2,866	48.0%
			2012	1,404	2,972	47.2%
			2013	1,406	3,114	45.2%
Antidepressant Medication Management – Effective Continuation Phase Treatment	AMM-180D	18-64	2011	903	2,866	31.5%
			2012	849	2,972	28.6%
			2013	785	3,114	25.2%
Breast Cancer Screening	BCS	42-64	2011	8,572	19,792	43.3%
			2012	8,711	20,180	43.2%
			2013	8,643	20,383	42.4%
Cervical Cancer Screening	CCS	24-64	2011	12,774	28,742	44.4%
			2012	12,363	28,377	43.6%
			2013	11,886	28,501	41.7%

Comprehensive Diabetes Care, Hemoglobin A1c Testing	CDC-HBA1C	18-64	2011	9,118	11,357	80.3%
			2012	9,344	11,597	80.6%
			2013	9,587	11,826	81.1%
Comprehensive Diabetes Care, LDL-C Screening	CDC-LDLC	18-64	2011	7,854	11,357	69.2%
			2012	7,845	11,597	67.6%
			2013	7,957	11,826	67.3%
Chlamydia Screening	CHL	21-24	2011	595	1,263	47.1%
			2012	569	1,254	45.4%
			2013	540	1,220	44.3%
Follow-Up After Hospitalization for Mental Illness – 7 Day	FUH-7D	21-64	2011	1,681	3,082	54.5%
			2012	1,647	2,841	58.0%
			2013	1,604	2,891	55.5%
Follow-Up After Hospitalization for Mental Illness – 30 Day	FUH-30D	21-64	2011	2,034	3,082	66.0%
			2012	1,919	2,841	67.5%
			2013	1,979	2,891	68.5%
Annual HIV/AIDS Medical Visit - 90 Day	HIV-90D	18-64	2011	669	762	87.8%
			2012	670	782	85.7%
			2013	661	759	87.1%
Annual HIV/AIDS Medical Visit - 180 Day	HIV-180D	18-64	2011	578	762	75.9%
			2012	588	782	75.2%
			2013	575	759	75.8%
Initiation of Alcohol and Other Drug Dependence Treatment	IET-INI	18-64	2011	4,926	12,946	38.1%
			2012	4,963	13,253	37.4%
			2013	4,849	14,136	34.3%
Engagement in Alcohol and Other Drug Dependence Treatment	IET-ENG	18-64	2011	1,771	4,926	36.0%
			2012	1,803	4,963	36.3%
			2013	1,492	4,849	30.8%
Annual Monitoring for Patients on Persistent Medications - ACE or ARB	MPM-ACE	18-64	2011	6,368	7,386	86.2%
			2012	6,645	7,689	86.4%
			2013	4,559	5,326	85.6%
Annual Monitoring for Patients on Persistent Medications - Anticonvulsants	MPM-ANT	18-64	2011	2,032	3,276	62.0%
			2012	1,874	3,185	58.8%
			2013	1,473	2,574	57.2%
Annual Monitoring for Patients on Persistent Medications - Digoxin	MPM-DIG	18-64	2011	157	184	85.3%
			2012	156	175	89.1%
			2013	131	147	89.1%
Annual Monitoring for Patients on Persistent Medications - Diuretic	MPM-DIU	18-64	2011	4,835	5,633	85.8%
			2012	4,958	5,798	85.5%
			2013	3,450	4,024	85.7%
Annual Monitoring for Patients on Persistent Medications - Total	MPM-TOT	18-64	2011	13,392	16,479	81.3%
			2012	13,633	16,847	80.9%
			2013	9,613	12,071	79.6%
Plan All-Cause Readmission	PCR	18-64	2011	3,034	15,927	19.0%
			2012	2,776	15,297	18.1%
			2013	2,583	14,787	17.5%
Post-Partum Care Rate	PPC	18-64	2011	170	584	29.1%
			2012	179	559	32.0%
			2013	157	587	26.7%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	SAA	19-64	2011	3,313	4,791	69.2%
			2012	3,524	4,821	73.1%
			2013	2,644	4,765	55.5%

Adult Access to Primary Care	AAP	20-64	2011	51,306	57,561	89.1%
			2012	51,924	58,798	88.3%
			2013	55,466	60,372	91.9%
30-Day Psychiatric Readmission Rate [State-Defined]	PCR-P	18-64	2011	297	2,045	14.5%
			2012	233	1,797	13.0%
			2013	209	1,815	11.5%
Substance Use Disorder Treatment Penetration [State-Defined]	SUPPL-AOD	18-64	2011			
			2012			
			2013			
Mental Health Treatment Penetration [State-Defined]	SUPPL-MH-B	18-64	2011	30,217	64,526	46.8%
			2012	30,593	67,155	45.6%
			2013	31,651	68,499	46.2%

1C. Medicaid-only CN Disabled Adult Clients with Substance Use Disorder

MEASURE	ABBREVIATION	AGE GROUP	SFY	NUMERATOR	DENOMINATOR	RATE
Adult Body Mass Index (BMI) Assessment	ABA	18-64	2011	630	14,558	4.3%
			2012	1,256	15,733	8.0%
			2013	1,588	16,572	9.6%
Antidepressant Medication Management – Effective Acute Phase Treatment	AMM-84D	18-64	2011	552	1,136	48.6%
			2012	556	1,194	46.6%
			2013	535	1,217	44.0%
Antidepressant Medication Management – Effective Continuation Phase Treatment	AMM-180D	18-64	2011	366	1,136	32.2%
			2012	331	1,194	27.7%
			2013	296	1,217	24.3%
Breast Cancer Screening	BCS	42-64	2011	1,939	5,425	35.7%
			2012	2,127	5,957	35.7%
			2013	2,208	6,262	35.3%
Cervical Cancer Screening	CCS	24-64	2011	3,845	8,256	46.6%
			2012	3,751	8,450	44.4%
			2013	3,744	8,791	42.6%
Comprehensive Diabetes Care, Hemoglobin A1c Testing	CDC-HBA1C	18-64	2011	2,295	3,227	71.1%
			2012	2,548	3,596	70.9%
			2013	2,692	3,746	71.9%
Comprehensive Diabetes Care, LDL-C Screening	CDC-LDLC	18-64	2011	1,901	3,227	58.9%
			2012	2,031	3,596	56.5%
			2013	2,156	3,746	57.6%
Chlamydia Screening	CHL	21-24	2011	184	316	58.2%
			2012	172	274	62.8%
			2013	177	285	62.1%
Follow-Up After Hospitalization for Mental Illness – 7 Day	FUH-7D	21-64	2011	1,076	2,029	53.0%
			2012	1,063	1,838	57.8%
			2013	1,073	1,946	55.1%
Follow-Up After Hospitalization for Mental Illness – 30 Day	FUH-30D	21-64	2011	1,318	2,029	65.0%
			2012	1,231	1,838	67.0%
			2013	1,333	1,946	68.5%
Annual HIV/AIDS Medical Visit - 90 Day	HIV-90D	18-64	2011	376	436	86.2%
			2012	407	466	87.3%
			2013	381	438	87.0%
Annual HIV/AIDS Medical Visit - 180 Day	HIV-180D	18-64	2011	325	436	74.5%
			2012	360	466	77.3%
			2013	320	438	73.1%

Initiation of Alcohol and Other Drug Dependence Treatment	IET-INI	18-64	2011	5,233	13,350	39.2%
			2012	5,276	13,792	38.3%
			2013	5,162	14,805	34.9%
Engagement in Alcohol and Other Drug Dependence Treatment	IET-ENG	18-64	2011	1,938	5,233	37.0%
			2012	1,969	5,276	37.3%
			2013	1,647	5,162	31.9%
Annual Monitoring for Patients on Persistent Medications - ACE or ARB	MPM-ACE	18-64	2011	1,386	1,575	88.0%
			2012	1,529	1,770	86.4%
			2013	1,113	1,300	85.6%
Annual Monitoring for Patients on Persistent Medications - Anticonvulsants	MPM-ANT	18-64	2011	419	653	64.2%
			2012	405	638	63.5%
			2013	286	467	61.2%
Annual Monitoring for Patients on Persistent Medications - Digoxin	MPM-DIG	18-64	2011	31	36	86.1%
			2012	41	45	91.1%
			2013	39	43	90.7%
Annual Monitoring for Patients on Persistent Medications - Diuretic	MPM-DIU	18-64	2011	1,083	1,241	87.3%
			2012	1,184	1,378	85.9%
			2013	899	1,022	88.0%
Annual Monitoring for Patients on Persistent Medications - Total	MPM-TOT	18-64	2011	2,919	3,505	83.3%
			2012	3,159	3,831	82.5%
			2013	2,337	2,832	82.5%
Plan All-Cause Readmission	PCR	18-64	2011	2,067	9,460	21.8%
			2012	1,901	9,408	20.2%
			2013	1,819	9,439	19.3%
Post-Partum Care Rate	PPC	18-64	2011	53	224	23.7%
			2012	64	243	26.3%
			2013	68	265	25.7%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	SAA	19-64	2011	934	1,655	56.4%
			2012	1,019	1,656	61.5%
			2013	760	1,721	44.2%
Adult Access to Primary Care	AAP	20-64	2011	17,498	19,755	88.6%
			2012	18,337	20,813	88.1%
			2013	20,114	22,180	90.7%
30-Day Psychiatric Readmission Rate [State-Defined]	PCR-P	18-64	2011			
			2012			
			2013			
Substance Use Disorder Treatment Penetration [State-Defined]	SUPPL-AOD	18-64	2011	7,338	22,112	33.2%
			2012	7,545	23,781	31.7%
			2013	7,858	24,023	32.7%
Mental Health Treatment Penetration [State-Defined]	SUPPL-MH-B	18-64	2011			
			2012			
			2013			

1D. Medicaid-only CN Disabled Adult Clients with Co-Occurring Mental Health Need and SUD

MEASURE	ABBREVIATION	AGE GROUP	SFY	NUMERATOR	DENOMINATOR	RATE
Adult Body Mass Index (BMI) Assessment	ABA	18-64	2011	598	13,134	4.6%
			2012	1,189	14,215	8.4%
			2013	1,478	14,809	10.0%
Antidepressant Medication Management – Effective Acute Phase Treatment	AMM-84D	18-64	2011	552	1,136	48.6%
			2012	556	1,194	46.6%
			2013	535	1,217	44.0%

Antidepressant Medication Management – Effective Continuation Phase Treatment	AMM-180D	18-64	2011	366	1,136	32.2%
			2012	331	1,194	27.7%
			2013	296	1,217	24.3%
Breast Cancer Screening	BCS	42-64	2011	1,857	5,077	36.6%
			2012	2,031	5,514	36.8%
			2013	2,084	5,752	36.2%
Cervical Cancer Screening	CCS	24-64	2011	3,646	7,679	47.5%
			2012	3,570	7,819	45.7%
			2013	3,540	8,093	43.7%
Comprehensive Diabetes Care, Hemoglobin A1c Testing	CDC-HBA1C	18-64	2011	2,116	2,949	71.8%
			2012	2,356	3,286	71.7%
			2013	2,444	3,367	72.6%
Comprehensive Diabetes Care, LDL-C Screening	CDC-LDLC	18-64	2011	1,757	2,949	59.6%
			2012	1,875	3,286	57.1%
			2013	1,948	3,367	57.9%
Chlamydia Screening	CHL	21-24	2011	175	302	57.9%
			2012	162	259	62.5%
			2013	157	258	60.9%
Follow-Up After Hospitalization for Mental Illness – 7 Day	FUH-7D	21-64	2011	1,075	2,016	53.3%
			2012	1,063	1,837	57.9%
			2013	1,073	1,940	55.3%
Follow-Up After Hospitalization for Mental Illness – 30 Day	FUH-30D	21-64	2011	1,317	2,016	65.3%
			2012	1,231	1,837	67.0%
			2013	1,333	1,940	68.7%
Annual HIV/AIDS Medical Visit - 90 Day	HIV-90D	18-64	2011	353	404	87.4%
			2012	386	437	88.3%
			2013	357	408	87.5%
Annual HIV/AIDS Medical Visit - 180 Day	HIV-180D	18-64	2011	309	404	76.5%
			2012	341	437	78.0%
			2013	303	408	74.3%
Initiation of Alcohol and Other Drug Dependence Treatment	IET-INI	18-64	2011	4,680	11,981	39.1%
			2012	4,693	12,315	38.1%
			2013	4,570	13,037	35.1%
Engagement in Alcohol and Other Drug Dependence Treatment	IET-ENG	18-64	2011	1,742	4,680	37.2%
			2012	1,771	4,693	37.7%
			2013	1,462	4,570	32.0%
Annual Monitoring for Patients on Persistent Medications - ACE or ARB	MPM-ACE	18-64	2011	1,238	1,402	88.3%
			2012	1,361	1,557	87.4%
			2013	995	1,156	86.1%
Annual Monitoring for Patients on Persistent Medications - Anticonvulsants	MPM-ANT	18-64	2011	395	623	63.4%
			2012	386	608	63.5%
			2013	277	451	61.4%
Annual Monitoring for Patients on Persistent Medications - Digoxin	MPM-DIG	18-64	2011	25	30	83.3%
			2012	31	35	88.6%
			2013	30	34	88.2%
Annual Monitoring for Patients on Persistent Medications - Diuretic	MPM-DIU	18-64	2011	956	1,091	87.6%
			2012	1,049	1,214	86.4%
			2013	788	900	87.6%
Annual Monitoring for Patients on Persistent Medications - Total	MPM-TOT	18-64	2011	2,614	3,146	83.1%
			2012	2,827	3,414	82.8%
			2013	2,090	2,541	82.3%

Plan All-Cause Readmission	PCR	18-64	2011	1,975	8,813	22.4%
			2012	1,807	8,791	20.6%
			2013	1,747	8,752	20.0%
Post-Partum Care Rate	PPC	18-64	2011	50	200	25.0%
			2012	60	213	28.2%
			2013	64	240	26.7%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	SAA	19-64	2011	934	1,655	56.4%
			2012	1,019	1,656	61.5%
			2013	760	1,721	44.2%
Adult Access to Primary Care	AAP	20-64	2011	15,850	17,553	90.3%
			2012	16,621	18,483	89.9%
			2013	18,031	19,422	92.8%
30-Day Psychiatric Readmission Rate [State-Defined]	PCR-P	18-64	2011	218	1,427	15.3%
			2012	170	1,214	14.0%
			2013	157	1,242	12.6%
Substance Use Disorder Treatment Penetration [State-Defined]	SUPPL-AOD	18-64	2011	6,645	19,410	34.2%
			2012	6,787	20,840	32.6%
			2013	6,955	20,800	33.4%
Mental Health Treatment Penetration [State-Defined]	SUPPL-MH-B	18-64	2011	11,823	19,709	60.0%
			2012	12,064	21,181	57.0%
			2013	12,717	22,379	56.8%

1E. Medicaid-only CN Disabled Adult Clients without Behavioral Health Disorders

MEASURE	ABBREVIATION	AGE GROUP	SFY	NUMERATOR	DENOMINATOR	RATE
Adult Body Mass Index (BMI) Assessment	ABA	18-64	2011	189	11,638	1.6%
			2012	383	12,010	3.2%
			2013	553	13,235	4.2%
Antidepressant Medication Management – Effective Acute Phase Treatment	AMM-84D	18-64	2011 2012 2013			
Antidepressant Medication Management – Effective Continuation Phase Treatment	AMM-180D	18-64	2011 2012 2013			
Breast Cancer Screening	BCS	42-64	2011	1,493	4,347	34.3%
			2012	1,508	4,557	33.1%
			2013	1,657	4,883	33.9%
Cervical Cancer Screening	CCS	24-64	2011	2,342	7,707	30.4%
			2012	2,239	7,794	28.7%
			2013	2,349	8,190	28.7%
Comprehensive Diabetes Care, Hemoglobin A1c Testing	CDC-HBA1C	18-64	2011	1,925	2,429	79.3%
			2012	2,144	2,660	80.6%
			2013	2,294	2,821	81.3%
Comprehensive Diabetes Care, LDL-C Screening	CDC-LDLC	18-64	2011	1,685	2,429	69.4%
			2012	1,858	2,660	69.8%
			2013	1,909	2,821	67.7%
Chlamydia Screening	CHL	21-24	2011	140	431	32.5%
			2012	132	410	32.2%
			2013	162	437	37.1%
Follow-Up After Hospitalization for Mental Illness – 7 Day	FUH-7D	21-64	2011 2012 2013			

Follow-Up After Hospitalization for Mental Illness – 30 Day	FUH-30D	21-64	2011 2012 2013			
Annual HIV/AIDS Medical Visit - 90 Day	HIV-90D	18-64	2011 2012 2013	82 79 85	106 97 115	77.4% 81.4% 73.9%
Annual HIV/AIDS Medical Visit - 180 Day	HIV-180D	18-64	2011 2012 2013	67 65 68	106 97 115	63.2% 67.0% 59.1%
Initiation of Alcohol and Other Drug Dependence Treatment	IET-INI	18-64	2011 2012 2013			
Engagement in Alcohol and Other Drug Dependence Treatment	IET-ENG	18-64	2011 2012 2013			
Annual Monitoring for Patients on Persistent Medications - ACE or ARB	MPM-ACE	18-64	2011 2012 2013	1,777 2,031 1,313	2,178 2,454 1,662	81.6% 82.8% 79.0%
Annual Monitoring for Patients on Persistent Medications - Anticonvulsants	MPM-ANT	18-64	2011 2012 2013	379 357 259	726 668 511	52.2% 53.4% 50.7%
Annual Monitoring for Patients on Persistent Medications - Digoxin	MPM-DIG	18-64	2011 2012 2013	78 76 56	109 104 82	71.6% 73.1% 68.3%
Annual Monitoring for Patients on Persistent Medications - Diuretic	MPM-DIU	18-64	2011 2012 2013	1,213 1,311 837	1,472 1,577 1,049	82.4% 83.1% 79.8%
Annual Monitoring for Patients on Persistent Medications - Total	MPM-TOT	18-64	2011 2012 2013	3,447 3,775 2,465	4,485 4,803 3,304	76.9% 78.6% 74.6%
Plan All-Cause Readmission	PCR	18-64	2011 2012 2013	151 130 145	1,335 1,222 1,340	11.3% 10.6% 10.8%
Post-Partum Care Rate	PPC	18-64	2011 2012 2013	49 46 49	174 162 178	28.2% 28.4% 27.5%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	SAA	19-64	2011 2012 2013			
Adult Access to Primary Care	AAP	20-64	2011 2012 2013	12,661 12,900 14,376	20,166 20,921 22,604	62.8% 61.7% 63.6%
30-Day Psychiatric Readmission Rate [State-Defined]	PCR-P	18-64	2011 2012 2013			
Substance Use Disorder Treatment Penetration [State-Defined]	SUPPL-AOD	18-64	2011 2012 2013			
Mental Health Treatment Penetration [State-Defined]	SUPPL-MH-B	18-64	2011 2012 2013			

TABLE 2

AHRQ Prevention Quality Indicator (PQI) Admission Rates by Fiscal Year

SOURCE: DSHS Research and Data Analysis Division, Integrated Client Database

2A. All Medicaid-only CN Disabled Adult Clients

MEASURE	ABBREVIATION	AGE GROUP	SFY	NUMERATOR	DENOMINATOR	PER 100,000 MM
Diabetes Short-Term Complications Admission Rate	PQI-01	18-64	2011	558	1,106,409	50.4
			2012	585	1,133,594	51.6
			2013	601	1,196,527	50.2
COPD/Asthma in Older Adults Admission Rate	PQI-05	40-64	2011	1,072	696,854	153.8
			2012	858	722,085	118.8
			2013	854	764,307	111.7
Congestive Heart Failure Admission Rate	PQI-08	18-64	2011	585	1,106,409	52.9
			2012	634	1,133,594	55.9
			2013	715	1,196,527	59.8
Asthma in Younger Adults Admission Rate	PQI-15	18-39	2011	113	409,555	27.6
			2012	84	411,509	20.4
			2013	77	432,220	17.8

2B. Medicaid-only CN Disabled Adult Clients with Mental Health Need

MEASURE	ABBREVIATION	AGE GROUP	SFY	NUMERATOR	DENOMINATOR	PER 100,000 MM
Diabetes Short-Term Complications Admission Rate	PQI-01	18-64	2011	486	775,099	62.7
			2012	533	787,142	67.7
			2013	533	817,799	65.2
COPD/Asthma in Older Adults Admission Rate	PQI-05	40-64	2011	925	508,467	181.9
			2012	756	519,651	145.5
			2013	748	539,549	138.6
Congestive Heart Failure Admission Rate	PQI-08	18-64	2011	448	775,099	57.8
			2012	473	787,142	60.1
			2013	485	817,799	59.3
Asthma in Younger Adults Admission Rate	PQI-15	18-39	2011	95	266,632	35.6
			2012	73	267,491	27.3
			2013	74	278,250	26.6

2C. Medicaid-only CN Disabled Adult Clients with Substance Use Disorder

MEASURE	ABBREVIATION	AGE GROUP	SFY	NUMERATOR	DENOMINATOR	PER 100,000 MM
Diabetes Short-Term Complications Admission Rate	PQI-01	18-64	2011	297	267,002	111.2
			2012	318	279,160	113.9
			2013	372	303,069	122.7
COPD/Asthma in Older Adults Admission Rate	PQI-05	40-64	2011	581	184,436	315.0
			2012	468	198,443	235.8
			2013	468	213,532	219.2
Congestive Heart Failure Admission Rate	PQI-08	18-64	2011	270	267,002	101.1
			2012	332	279,160	118.9
			2013	355	303,069	117.1
Asthma in Younger Adults Admission Rate	PQI-15	18-39	2011	49	82,566	59.3
			2012	39	80,717	48.3
			2013	43	89,537	48.0

2D. Medicaid-only CN Disabled Adult Clients with Co-Occurring Mental Health Need and SUD

MEASURE	ABBREVIATION	AGE GROUP	SFY	NUMERATOR	DENOMINATOR	PER 100,000 MM
Diabetes Short-Term Complications Admission Rate	PQI-01	18-64	2011	284	235,319	120.7
			2012	301	245,432	122.6
			2013	357	262,507	136.0
COPD/Asthma in Older Adults Admission Rate	PQI-05	40-64	2011	523	161,225	324.4
			2012	432	172,697	250.1
			2013	440	182,671	240.9
Congestive Heart Failure Admission Rate	PQI-08	18-64	2011	230	235,319	97.7
			2012	266	245,432	108.4
			2013	270	262,507	102.9
Asthma in Younger Adults Admission Rate	PQI-15	18-39	2011	39	74,094	52.6
			2012	38	72,735	52.2
			2013	41	79,836	51.4

2E. Medicaid-only CN Disabled Adult Clients without Behavioral Health Disorders

MEASURE	ABBREVIATION	AGE GROUP	SFY	NUMERATOR	DENOMINATOR	PER 100,000 MM
Diabetes Short-Term Complications Admission Rate	PQI-01	18-64	2011	59	299,627	19.7
			2012	35	312,724	11.2
			2013	53	338,166	15.7
COPD/Asthma in Older Adults Admission Rate	PQI-05	40-64	2011	89	165,176	53.9
			2012	66	176,688	37.4
			2013	78	193,897	40.2
Congestive Heart Failure Admission Rate	PQI-08	18-64	2011	97	299,627	32.4
			2012	95	312,724	30.4
			2013	145	338,166	42.9
Asthma in Younger Adults Admission Rate	PQI-15	18-39	2011	8	134,451	6.0
			2012	10	136,036	7.4
			2013	1	144,269	0.7

TABLE 3

Supplemental Outcomes by Fiscal Year

SOURCE: DSHS Research and Data Analysis Division, Integrated Client Database

3A. All Medicaid-only CN Disabled Adult Clients

SFY	Earnings				Homelessness			Arrests		
	Clients	Percent with Earnings	Average Annual Earnings	Total Annual Earnings	Percent Homeless	Average Months Homeless	Total Months Homeless	Percent with Arrests	Average Annual Arrests	Total Annual Arrests
2011	107,513	11.0%	\$671	\$72,178,437	14.6%	1.16	124,879	10.5%	0.19	20,488
2012	112,315	11.0%	\$681	\$76,468,905	16.5%	1.34	150,396	10.4%	0.19	21,430
2013	113,700	11.2%	\$680	\$77,307,732	18.0%	1.49	169,535	10.7%	0.20	23,011

3B. Medicaid-only CN Disabled Adult Clients with Mental Health Need

SFY	Earnings				Homelessness			Arrests		
	Clients	Percent with Earnings	Average Annual Earnings	Total Annual Earnings	Percent Homeless	Average Months Homeless	Total Months Homeless	Percent with Arrests	Average Annual Arrests	Total Annual Arrests
2011	73,651	9.5%	\$491	\$36,185,123	15.9%	1.26	92,583	12.1%	0.22	16,187
2012	76,039	9.5%	\$505	\$38,435,715	17.7%	1.43	108,382	11.8%	0.22	16,791
2013	76,970	10.1%	\$539	\$41,516,825	19.2%	1.57	120,652	11.9%	0.23	17,528

3C. Medicaid-only CN Disabled Adult Clients with Substance Use Disorder

SFY	Earnings				Homelessness			Arrests		
	Clients	Percent with Earnings	Average Annual Earnings	Total Annual Earnings	Percent Homeless	Average Months Homeless	Total Months Homeless	Percent with Arrests	Average Annual Arrests	Total Annual Arrests
2011	26,227	8.7%	\$409	\$10,736,583	25.7%	2.07	54,344	23.9%	0.46	12,128
2012	27,915	9.1%	\$421	\$11,759,926	27.3%	2.23	62,369	22.7%	0.45	12,452
2013	29,651	10.0%	\$460	\$13,627,555	29.6%	2.42	71,774	23.0%	0.46	13,756

3D. Medicaid-only CN Disabled Adult Clients with Co-Occurring Mental Health Need and SUD

SFY	Earnings				Homelessness			Arrests		
	Clients	Percent with Earnings	Average Annual Earnings	Total Annual Earnings	Percent Homeless	Average Months Homeless	Total Months Homeless	Percent with Arrests	Average Annual Arrests	Total Annual Arrests
2011	22,915	8.6%	\$388	\$8,886,476	25.7%	2.06	47,182	24.1%	0.46	10,655
2012	24,294	8.8%	\$391	\$9,499,316	27.4%	2.22	53,845	22.8%	0.45	11,047
2013	25,468	9.9%	\$436	\$11,092,184	29.6%	2.40	61,051	23.1%	0.46	11,830

3E. Medicaid-only CN Disabled Adult Clients without Behavioral Health Disorders

SFY	Earnings				Homelessness			Arrests		
	Clients	Percent with Earnings	Average Annual Earnings	Total Annual Earnings	Percent Homeless	Average Months Homeless	Total Months Homeless	Percent with Arrests	Average Annual Arrests	Total Annual Arrests
2011	30,550	14.7%	\$1,118	\$34,143,206	10.3%	0.82	25,134	5.3%	0.09	2,828
2012	32,655	14.6%	\$1,095	\$35,772,580	12.6%	1.03	33,490	5.9%	0.10	3,234
2013	32,547	13.9%	\$1,022	\$33,255,537	13.7%	1.17	38,160	6.2%	0.11	3,557

TABLE 4

Outpatient ED Visits and Inpatient Hospital Admissions Per 1000 Member Months

SOURCE: DSHS Research and Data Analysis Division, Integrated Client Database

1A. All SSI Non-Dual Working Age Adult Clients

MEASURE	ABBREVIATION	AGE GROUP	SFY	NUMERATOR	DENOMINATOR	PER 1,000 MEMBER MONTHS
Outpatient ED Visits Per 1000 Member Months	SUPPL-ED	18-64	2011	149,787	1,104,907	135.6
			2012	138,078	1,133,618	121.8
			2013	142,640	1,197,498	119.1
Inpatient Hospital Admissions Per 1000 Member Months	SUPPL-IP	18-64	2011	28,285	1,104,907	25.6
			2012	27,411	1,133,618	24.2
			2013	27,375	1,197,498	22.9

1B. All SSI Non-Dual Working Age Adult Clients with Mental Health Need

MEASURE	ABBREVIATION	AGE GROUP	SFY	NUMERATOR	DENOMINATOR	PER 1,000 MEMBER MONTHS
Outpatient ED Visits Per 1000 Member Months	SUPPL-ED	18-64	2011	131,572	774,312	169.9
			2012	120,665	786,627	153.4
			2013	122,330	817,842	149.6
Inpatient Hospital Admissions Per 1000 Member Months	SUPPL-IP	18-64	2011	24,265	774,312	31.3
			2012	23,384	786,627	29.7
			2013	22,930	817,842	28.0

1C. All SSI Non-Dual Working Age Adult Clients with Substance Use Disorder

MEASURE	ABBREVIATION	AGE GROUP	SFY	NUMERATOR	DENOMINATOR	PER 1,000 MEMBER MONTHS
Outpatient ED Visits Per 1000 Member Months	SUPPL-ED	18-64	2011	74,309	266,811	278.5
			2012	70,765	279,083	253.6
			2013	73,138	303,147	241.3
Inpatient Hospital Admissions Per 1000 Member Months	SUPPL-IP	18-64	2011	14,708	266,811	55.1
			2012	14,701	279,083	52.7
			2013	15,171	303,147	50.0

1D. All SSI Non-Dual Working Age Adult Clients with Co-Occurring Mental Health Need and SUD

MEASURE	ABBREVIATION	AGE GROUP	SFY	NUMERATOR	DENOMINATOR	PER 1,000 MEMBER MONTHS
Outpatient ED Visits Per 1000 Member Months	SUPPL-ED	18-64	2011	69,726	235,178	296.5
			2012	66,474	245,416	270.9
			2013	67,767	262,568	258.1
Inpatient Hospital Admissions Per 1000 Member Months	SUPPL-IP	18-64	2011	13,433	235,178	57.1
			2012	13,354	245,416	54.4
			2013	13,637	262,568	51.9

1E. All SSI Non-Dual Working Age Adult Clients without Behavioral Health Disorders

MEASURE	ABBREVIATION	AGE GROUP	SFY	NUMERATOR	DENOMINATOR	PER 1,000 MEMBER MONTHS
Outpatient ED Visits Per 1000 Member Months	SUPPL-ED	18-64	2011	13,632	298,962	45.6
			2012	13,122	313,324	41.9
			2013	14,939	339,077	44.1
Inpatient Hospital Admissions Per 1000 Member Months	SUPPL-IP	18-64	2011	2,745	298,962	9.2
			2012	2,680	313,324	8.6
			2013	2,911	339,077	8.6

STUDY POPULATION

In Washington State, with the exception of a few special programs with relatively small enrollment levels, prior to July 2012 persons enrolled in disability-related Categorically Needy (CN) Medicaid coverage received medical health services through a fee-for-service delivery system. In July 2012, the Washington State Health Care Authority began transitioning Medicaid enrollees with disabilities to managed care. Because persons dually eligible for Medicare remained fee-for-service, all analyses presented in this report pertain to Medicaid-only CN Disabled clients.

We use an approach analogous to a difference-of-difference intent-to-treat design, where we compare the outcomes experienced in SFY 2013 with the outcomes experienced in the prior two fiscal years when medical care was provided on a fee-for-service basis. We note that with the phased implementation of managed care in SFY 2013, managed care enrollment comprised 75 percent of all coverage months for persons aged 18 to 64 with Medicaid-only CN Disabled coverage in that fiscal year. The difference-of-difference aspect of the analyses is reflected in the comparison of changes in the experience of disabled persons with mental illness and/or substance use disorders, relative to changes in the experiences of disabled persons who do not have identified behavioral health disorders, where such comparisons are feasible. For quality metrics that are defined only over populations with behavioral health disorders, such comparisons cannot be made, and we focus on changes in measured outcomes relative to prior trends.

BEHAVIORAL HEALTH RISK GROUPS

Behavioral health needs were identified using data available in the ProviderOne payment system. Mental health service needs were identified if any of the following criteria were met in the measurement year or the year prior to the measurement year: (1) receipt of any health care service with a mental illness diagnosis (including Regional Support Network services or services provided through the medical benefit), or (2) receipt of psychotropic medication including antipsychotic, antimania, antianxiety, antidepressant or ADHD therapy classes. Substance use disorders were identified by the presence of a substance use disorder diagnosis on any health service claim or encounter in the measurement year or the year prior to the measurement year, including treatment or detox events, mental health service events, or medical service events such as emergency department or office visits. The experience of clients with co-occurring mental health needs or substance use disorders are also reflected in the separate results reported for the overall subgroups with these conditions.

HEALTH CARE QUALITY AND OUTCOME METRICS

Metrics are derived from two sets of sources. The first source is the CMS Initial Core Set of health care quality measures for adults enrolled in Medicaid. The CMS Initial Core Set is comprised primarily of National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) metrics.² Metrics were also sourced from the measurement areas specified by Second Substitute Senate Bill 5732 (Chapter 338, Laws of 2013) and Engrossed House Bill 1519 (Chapter 320, Laws of 2013). These bills directed the Department of Social and Health Services and the Health Care Authority to develop a comprehensive strategy to improve the adult behavioral healthcare system and to better integrate physical and behavioral healthcare and long term supports and services to improve outcomes for their shared clients.

This report uses the following HEDIS metrics:

- Adult Body Mass Index (BMI) Assessment
- Antidepressant Medication Management – Effective Acute and Continuation Phase Treatment
- Breast Cancer Screening
- Cervical Cancer Screening
- Comprehensive Diabetes Care, Hemoglobin A1c Testing and LDL-C Screening
- Chlamydia Screening
- Follow-Up After Hospitalization for Mental Illness – 7 Day and 30 Day Follow-up
- Annual HIV/AIDS Medical Visit - 90 Day and 180 Day Metrics
- Initiation and Engagement in Alcohol and Other Drug Dependence Treatment
- Annual Monitoring for Patients on Persistent Medications - ACE or ARB, Anticonvulsants, Digoxin and Diuretic
- Plan All-Cause Inpatient Readmission
- Post-Partum Care Rate
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Adult Access to Primary Care

² See <http://www.ncqa.org/HEDISQualityMeasurement.aspx>

The CMS Initial Core Set also includes the following Prevention Quality Indicators (PQIs) developed by the Agency for Healthcare Research and Quality (AHRQ):

- Diabetes Short-Term Complications Admission Rate
- COPD/Asthma in Older Adults Admission Rate
- Congestive Heart Failure Admission Rate
- Asthma in Younger Adults Admission Rate

Technical specifications for the HEDIS and AHRQ-PQI measures are available at:

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf>. SAS code and related reference material to support the implementation of the AHRQ-PQI measures are available at: http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx.

STATE-DEFINED OUTCOME METRICS

Homelessness. Information about homelessness was derived from the DSHS Economic Services Administration (ESA)'s Automated Client Eligibility System (ACES). ACES is used by caseworkers to record information about a client's self-reported living arrangement when determining eligibility for cash and food assistance. A client was identified as homeless in the month if their living arrangement for that benefit month was coded as homeless without housing (e.g., living on the street), homeless with housing (e.g., living temporarily with friends or "couch surfing"), battered spouse shelter, or emergency housing shelter. Clients are reported as ever homeless in the year if they had at least one benefit month in the year coded with one of the specified living arrangements. We note that the final specification of homelessness to meet the requirements of 2SSB 5732 and EHB 1519 will differ somewhat from the specification used in this report.

Arrests. Arrest data from the Washington State Patrol (WSP) identified clients who had been arrested. Local law enforcement agencies are generally required to report only felony and gross misdemeanor offenses into the WSP arrest database. This report therefore somewhat understates the full volume of arrest events in the population because the WSP data excludes arrests for some misdemeanor offenses.

Employment. Outcomes are derived from quarterly wage data maintained by the Washington State Employment Security Department (ESD). A client is counted as employed if they had at least one quarter with positive earnings reported in ESD wage data in the fiscal year. We note that ESD wage data does not include self-employment income, most federal employment income, or unreported earnings.

Substance Use Disorder Treatment Penetration. Substance use disorder treatment *need* is identified using the criteria noted in the Behavioral Health Risk Groups section above. Substance use disorder treatment *receipt* is defined to include the following service modalities: inpatient or residential treatment services, outpatient treatment services, opiate substitution treatment services, other medication-assisted treatment (buprenorphine) and case management services.

Mental Health Treatment Penetration. Mental health treatment *need* is identified using the criteria noted in the Behavioral Health Risk Groups section above. Mental health treatment *receipt* is defined to include receipt of therapy and related services through the RSN system, or receipt of mental health therapy through the Medicaid medical benefit. RSN-funded treatment services are defined to include the following modalities: inpatient or state mental hospital services, residential services, brief intervention treatment, co-occurring treatment, community based wrap-around services, wise services, day support, family treatment, group treatment services, high intensity treatment, individual treatment services, intake, medication management or medication monitoring, mental health clubhouse, peer support, psychological assessment, rehabilitation case management, stabilization services, supported employment, and therapeutic psychoeducation. The following RSN-funded services were excluded from the numerator specification: community transition, crisis services, engagement and outreach, hearing for involuntary treatment, integrated substance abuse and mental health screen, integrated substance abuse and mental health assessment, interpreter services, involuntary treatment investigation, respite care services, special population evaluation, case management and day treatment.

30-Day Psychiatric Readmission Rate. This state-defined measure is modeled after the HEDIS all-cause readmission metric, with the reference discharge and subsequent readmission events limited to psychiatric hospitalization. Hospitalizations included discharges and subsequent admissions to community psychiatric hospital, evaluation and treatment facility, or state mental hospital settings.

Outpatient ED Visits. Outpatient ED visits are identified from paid claim and encounter data based on procedure, revenue and place-of-service criteria.

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Copies of this paper may be obtained at www.dshs.wa.gov/rda/ or by calling DSHS' Research and Data Analysis Division at 360.902.0701. Please request REPORT NUMBER 6.56