



As the External Quality Review Organization (EQRO) for Washington, Acumentra Health performs outside review of services provided to Medicaid enrollees by managed care organizations that contract with the Medicaid Purchasing Administration (MPA) and the Division of Behavioral Health and Recovery (DBHR). This newsletter updates EQR activities for the health plans and community stakeholders.

ANNUAL REPORT RECOMMENDS PROGRAM IMPROVEMENTS

The 2010 EQR Annual Report for DSHS updates the status of quality issues related to health care services for Medicaid enrollees in Washington. Building on the findings of previous annual reports since 2005, the report reviews mental health services delivered by the state's 13 Regional Support Networks (RSNs) and physical health services delivered by seven Healthy Options managed care organizations (MCOs).

To evaluate Medicaid managed care services, Acumentra Health analyzed data on a variety of performance measures and compliance criteria. High-level results are summarized below.

State-level strengths

- The Healthy Options MCOs generally are complying with federal and state standards for coverage, authorization, and availability of services, and have strengthened their compliance with access standards for enrollees with special health care needs.
- The MCOs significantly outperform the national Medicaid average in providing child immunizations, and in several measures of diabetes care: administering blood glucose testing and retinal examinations, and maintaining good blood-pressure levels among enrollees with diabetes. Two-thirds of Medicaid children in Washington are receiving the Combo 2 package of immunizations, and this percentage has climbed steadily since 2002.

- All MCOs use evidence-based practice guidelines in decision making for utilization management and service coverage.
- The RSNs typically provide timely access to outpatient mental health care, and most deploy well-developed crisis and stabilization resources. All RSNs have access to child mental health specialists, and RSNs in some areas of the state have ethnic-specific service providers.
- The RSNs use diverse strategies to monitor the quality and appropriateness of care delivered by mental health providers.
- Interviews with local law enforcement officials indicate that Crisis Intervention Training (CIT) at the RSN level is a successful strategy to help ensure that law enforcement can intervene effectively with consumers in mental health crisis. Designated mental health professionals report a positive working relationship with law enforcement as a consequence of CIT programs.

The annual report offers the following high-level recommendations for DBHR and MPA, which oversee managed mental and physical health care, respectively. Severe resource constraints facing the state Medicaid program are likely to affect the feasibility of many of these recommendations.

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FOCUS ON MENTAL HEALTH QUALITY

Acumentra Health conducted a focused quality study for DBHR, examining the degree to which the mental health services provided by the 13 RSNs

- are age-appropriate
- are culturally and linguistically competent
- are driven by and incorporate enrollee and family voice
- are provided in the least restrictive environment (LRE)
- assist enrollees' progress toward recovery and resilience
- promote service continuity and integration with other formal or informal systems and settings

The primary data for this study came from the results of 2008–2010 EQR activities, including a review of clinical records at each RSN. Acumentra Health also conducted focus groups with consumers and consumer advocates; interviews with local law enforcement, community hospital, and evaluation and treatment facility staff; and a teleconference with designated mental health professionals.

The review identified many system-wide strengths and outstanding practices by individual RSNs and CMHAs, as well as significant gaps and barriers in the system, primarily related to resource shortages. Most recommendations associated with the priority standards appear in the 2010 EQR Annual Report (see below). In addition, Acumentra Health recommended that DBHR

- *require all RSNs to submit quality management (QM) plans and annual evaluations for review by DBHR*
- *guide the RSNs in focusing their QM program evaluations on how each RSN uses its collected data, monitoring results, and service verification to advance DBHR's priority standards*
- *to minimize unnecessary hospitalizations, work with the RSNs on using their limited resources effectively to provide LRE treatment and to promote consumer recovery and resilience*

MENTAL HEALTH CARE DELIVERED BY RSNs

These recommendations arose from Acumentra Health's focused quality study, in conjunction with the 2010 EQR site reviews.

Mental health specialists. The RSN system struggles with lack of access to minority mental health specialists. Most RSNs lack adequate access to geriatric mental health specialists, and to specialists in cultures that are not ethnic or age-related (e.g., sexual minorities). Some need specialists to work with Russian-speaking consumers and recent immigrants from Eastern Europe, and/or with consumers who are deaf or hearing-impaired.

- *DBHR needs to work with the RSNs to ensure access to mental health specialists for enrollees in special populations, or work to revise the certification requirements to facilitate certification of additional specialists.*

Culturally and linguistically appropriate services. Most RSNs report a shortage of bilingual and bicultural staff among their regional community mental health agencies (CMHAs).

- *DBHR needs to work with the RSNs to build capacity for services delivered by minority-specific providers who are bilingual and/or bicultural.*

Services for children. Most RSNs report a lack of respite services and limited access to acute care services for children.

- *DBHR needs to work with the RSNs and CMHAs to provide adequate community-based services as an alternative to acute care for children in the RSN system.*

Services for transition-age youth. Most RSNs lack programs designed to meet the needs of transition-age youth (age 18–21), especially young people aging out of the foster care system.

- *DBHR needs to encourage RSNs to develop resources for transition-age youth.*

Services for geriatric consumers. A scarcity of step-down resources for geriatric enrollees with dementia and co-occurring medical conditions leads to long stays in acute care settings.

- *DBHR needs to coordinate with other agencies and with geriatric facilities to ensure that enrollees discharged from state and community hospitals receive long-term care.*

Consumer voice in system planning. Some RSNs struggle with recruiting and keeping Quality Review Team (QRT) members. Several described the need to restructure, redirect, and revitalize their QRTs. A few RSNs find it hard to balance QRT members' independence with ensuring constructive input. The majority of QRTs seek more involvement and influence in RSN meetings and system decisions. Some QRT members advocate strengthening the RSN contract provisions related to QRT functions.

- *DBHR needs to facilitate discussion between the RSNs and their QRTs to determine how to incorporate QRT input into the RSN delivery system.*

Several RSNs' boards and committees provide little representation for consumers and family advocates. Most RSNs' advisory boards

do not represent all age groups, and most do not represent the ethnic and minority enrollee populations in their service area. One RSN's board includes no representation from allied agencies, making it difficult to ensure coordination and continuity of care.

- *DBHR needs to work with the RSNs to ensure that RSN advisory boards represent all enrollees and, as needed, represent allied agencies.*

Least restrictive environment. While the RSNs are financially responsible for psychiatric inpatient care for enrollees of the Healthy Options medical plans, the RSNs are not always involved in authorizing hospital stays before admission, and thus cannot intervene to offer alternatives to hospitalization, if appropriate.

- *DBHR needs to work with RSNs and Healthy Options MCOs to improve collaboration between physical and behavioral plans serving Medicaid-eligible consumers.*

Some RSNs struggle to keep the state hospital bed days for their enrollees below the approved allocation. Penalties for exceeding the census caps reduce revenue that RSNs could use to develop less restrictive local resources.

- *DBHR needs to work with the RSNs to establish and maintain a continuum of community-based services and alternatives to acute care or long-term hospitalization.*

Only about half of the consumers in the study focus groups had crisis plans, and most of those consumers did not feel that their plans were helpful during crises.

- *DBHR needs to work with RSNs, providers, and consumers to build consensus regarding effective crisis plans.*

A few RSNs have not implemented Crisis Intervention Training (CIT) for law enforcement.

- *DBHR needs to encourage all RSNs to implement CIT to help ensure that law enforcement officers can intervene effectively with consumers in crisis.*

Recovery and resilience. Budget constraints have forced several RSNs to cut back on supported employment programs and peer-run services, which are highly valued by consumers.

- *DBHR is encouraged to identify creative solutions, such as cross-system funding, to ensure the availability of supported employment, job coaching, and adult vocational training.*

PHYSICAL HEALTH CARE DELIVERED BY MCOs

The annual report presented these “priority” recommendations.

Performance measure feedback to clinics. Clinical performance reports for providers can identify Medicaid enrollees who do not have claims in the system but who need services—i.e., those without access to care.

- *MPA needs to require the MCOs to provide performance measure feedback to clinics and providers on a frequent and regular schedule.*

Technical assistance for providers. Training providers in quality improvement principles will help them improve enrollee outcomes.

- *MPA should encourage MCOs to identify providers that need technical assistance with quality improvement and to implement training at the clinic level.*

Care coordination. MCO compliance scores fell for Primary Care and Coordination and for Emergency and Post-stabilization Services in 2010. Most MCOs needed to refine their care coordination/case management programs, or failed to document program outcomes sufficiently.

- *MPA should consider requiring MCOs conduct a performance improvement project (PIP) on Primary Care Coordination and Emergency and Post-stabilization Services.*
- *MPA needs to work with DBHR to ensure that an MCO is notified when a Healthy Options enrollee receives inpatient mental health services through an RSN.*

Data completeness. This issue is relevant when MCOs deliver capitated services or when providers may not submit claims if they perceive the reimbursement to be low. The Healthy Options MCOs should

- *evaluate expected claims or encounter volumes by provider type to help identify missing data*
- *monitor data submitted by vendors for completeness and accuracy, and maintain formal reconciliation processes to ensure the integrity of data transfer between MCOs and their vendors*

MPA requires the Healthy Options MCOs to report race and ethnicity data for all enrollees each year (a HEDIS measure). However, reporting is not consistent among the MCOs, and large gaps remain in the reported data. In 2010, several MCOs categorized large percentages of enrollees as having “unknown” ethnicity and race. MCOs should consider capturing race and ethnicity data from the state's enrollment files or from alternative sources such as member surveys and enrollment applications to help ensure that the HEDIS measure accurately reflects the diversity of MCO enrollees.

- *MPA should institute corrective action for an MCO that fails to report complete race/ethnicity data, or require the MCO to conduct a PIP to improve reporting of complete race/ethnicity data.*

2010 HEDIS RESULTS

MPA uses Healthcare Effectiveness Data and Information Set (HEDIS®) measures to evaluate care delivery for Healthy Options enrollees. The annual Performance Measure Comparative Analysis Report enables MPA to compare the MCOs' performance with national averages for the Medicaid population.

As in past years, the 2010 results show a relatively favorable picture of the care received by enrollees. In the aggregate, the Healthy Options MCOs are performing at levels that are nearly identical to, or better than, the national Medicaid averages for

- seven indicators of childhood immunizations
- four of eight indicators of diabetes care for which comparisons can be made (blood glucose testing, dilated retinal exams, and two indicators of blood pressure control)

The reported service utilization rates for Healthy Options enrollees remain below the national averages—generally considered positive—in all areas of inpatient and ambulatory care except for maternity services. In particular, Healthy Options enrollees visit emergency rooms at significantly lower rates compared with Medicaid enrollees nationwide.

However, the Healthy Options plans as a group continue to lag behind the national average in providing well-child care (WCC) visits for infants, children, and adolescents, as well as in lipid screening and control and in monitoring for diabetic nephropathy.

Five-year trends

Long-term trend analysis shows different trends for the childhood immunization and WCC measures over the past 5 years.

Immunizations: This measure assesses the percentage of continuously enrolled children who turned 2 years old during the measurement year and who received

- four diphtheria, tetanus, and acellular pertussis (DTaP) vaccinations
- three polio (IPV) vaccinations
- one measles, mumps, and rubella (MMR) vaccination
- three Haemophilus influenzae type b (HiB) vaccinations
- three hepatitis B (Hep B) vaccinations
- one varicella-zoster virus (VZV) vaccination
- four pneumococcal conjugate (PCV) vaccinations

Combo 2 includes all antigens in this list except for PCV, and Combo 3 includes all antigens listed.

Figure 1 on page 5 shows the Healthy Options aggregate averages for seven separate immunizations and for Combo 2 and Combo 3 from 2006 to 2010.

The 2010 results indicate a continuing stabilization of statewide immunization rates, except that the rates for Hep B, Combo 2, and Combo 3 rose significantly from 2009. The 2010 statewide rates for Hep B, IPV, PCV, and Combo 2 and 3 were significantly above the 2010 national average, while the statewide rate for VZV was significantly below the national average.

Aggregate rates for all six antigens comprising Combo 2 are at 80 percent or higher, the target set by the federal benchmark report, *Healthy People 2010*, for health plans to achieve by 2010. Four rates are above 90 percent (IPV, MMR, HiB, Hep B). Improvement in the PCV vaccination rate has stalled, leaving this indicator well below the federal benchmark, though still significantly higher than the national Medicaid average.

Increasing use of the CHILD Profile registry, along with contractual incentives for the health plans, have contributed to long-term gains in immunization rates. Ongoing improvement will depend on long-term commitment to strategies that have proved effective.

WCC visits: Infants should receive at least six WCC visits during the first 15 months of life. Children in the 3rd, 4th, 5th, and 6th years of life and adolescents ages 12–21 should receive at least one WCC visit each year.

Figure 2 shows the long-term trends for WCC visits. As a group, the Healthy Options plans continue to lag behind the national Medicaid performance in providing WCC visits—significantly below the national averages for children and adolescents. The long-term improvement in visit rates for infants and children is encouraging, despite the sharp decline in the infant visit rate in 2010. The average number of Healthy Options infants receiving at least *five* WCC visits significantly exceeds the national average, and almost all infants are receiving at least one WCC visit in the first 15 months of life.

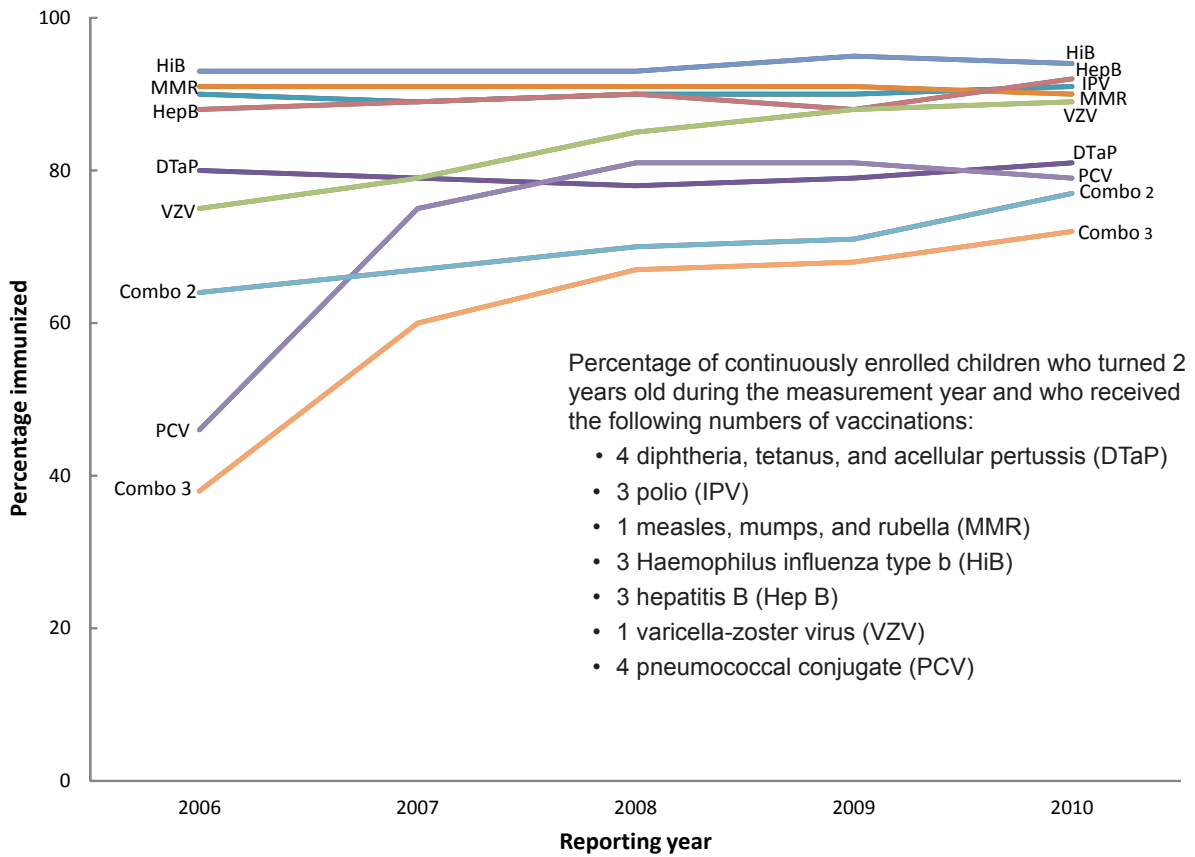


Figure 1. Healthy Options MCO averages for seven immunizations, Combo 2, and Combo 3, 2006–2010.

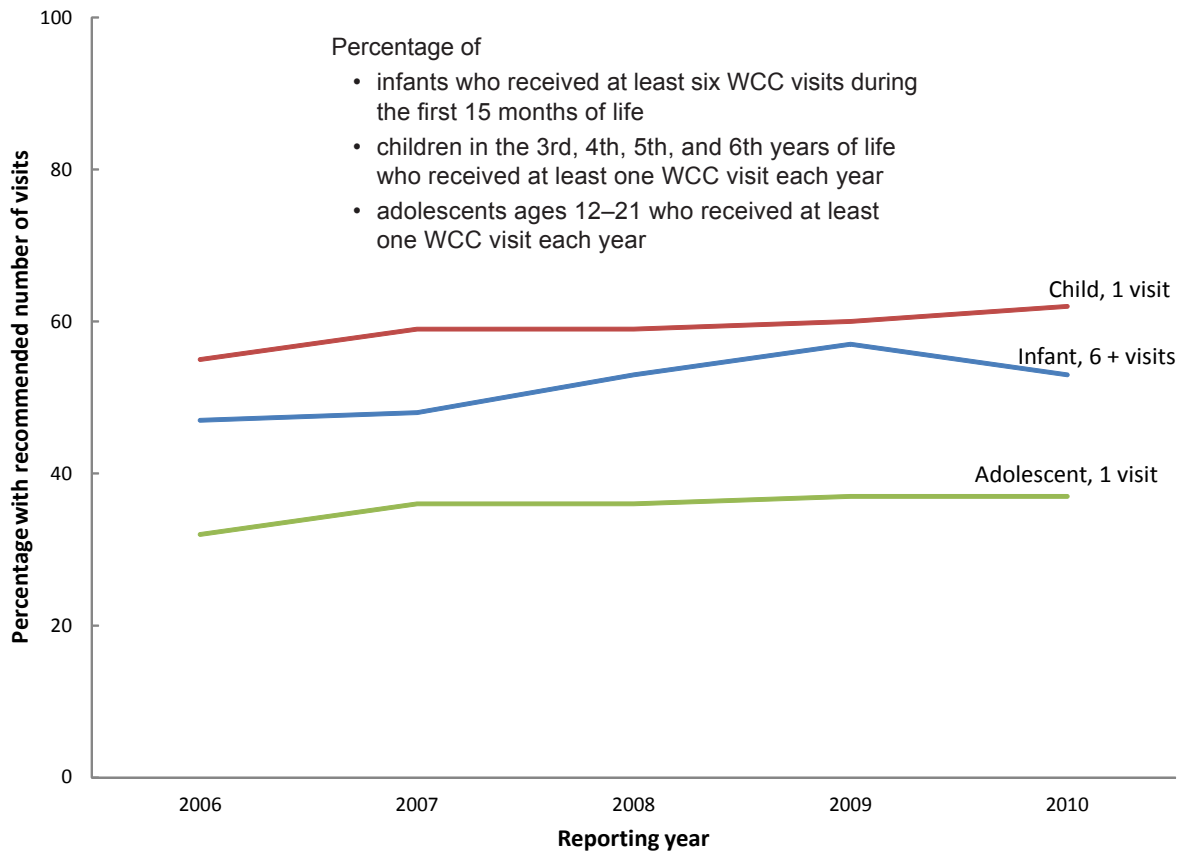


Figure 2. Healthy Options MCO averages for recommended WCC visits for infants, children, and adolescents, 2006–2010.

HEDIS MEASURES FOR WMIP

This year's HEDIS report presents fifth-year performance data for the Washington Medicaid Integration Partnership (WMIP), managed by Molina Healthcare of Washington. The WMIP seeks to integrate medical, mental health, substance abuse, and long-term care services for aged, blind, and disabled clients with complex health conditions—the fastest growing and most expensive segment of DSHS's client base. As of October 2010, nearly 3,000 residents of Snohomish County were enrolled in the program.

For 2010, Molina reported seven HEDIS measures for the WMIP population: comprehensive diabetes care, inpatient care utilization—general hospital/acute care and nonacute care, ambulatory care utilization, anti-depression medication management, follow-up after hospitalization for mental illness, and use of high-risk medications for the elderly.

Because WMIP excludes children under 21 and Healthy Options enrollees, it is not possible to compare WMIP data meaningfully

with data reported by the Healthy Options plans, nor with national data for the Medicaid population. However, it is possible to evaluate changes from the 2006 WMIP baseline measurements for some indicators of diabetes care and service utilization.

In 2010, blood glucose testing rose to its highest rate in four years. However, other measures of diabetes care—including blood pressure control and delivery of eye exams, lipid screening, and nephropathy monitoring—showed declines from 2009. The results for service utilization measures were mixed. Total inpatient acute and nonacute care discharges and days declined from 2009, as did the average length of stay in nonacute care, though the declines were not statistically significant. At the same time, the rate of visits for outpatient care rose significantly.

The WMIP performance measure trends underscore the challenge of managing health care for this population of enrollees, who present more acute episodes and generally require more care.

WASHINGTON EQR CALENDAR

DATE	EVENT
<i>March 2011</i>	
9	HEDIS audits begin
17	TeaMonitor site visits begin
<i>April 2011</i>	
19	RSN training, Olympia: Monitoring Over- and Underutilization; Using Grievance Data for Quality Improvement
20	Medicaid Quality Management Meeting, Olympia