WASHINGTON STATE

Guidance for Interpreting Cross-System Measures

December 2016

Overview

With the 2013 passage of Engrossed House Bill 1519 (Chapter 320, Laws of 2013) and Second Substitute Senate Bill 5732 (Chapter 338, Laws of 2013), the Washington State Legislature directed that contracts executed by the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) with service contracting entities (Managed Care Organizations, Behavioral Health Organizations, and Area Agencies on Aging) include measures related to shared outcomes in the following areas:

- Health and wellness
- Participation in meaningful activities
- Involvement with criminal justice systems
- Reductions in avoidable costs in hospitals, emergency rooms, crisis services and criminal justice systems
- Stable housing in the community
- Client satisfaction with quality of life
- Population-level health disparities

Candidate measures were identified by workgroups created by the 5732/1519 Cross-System Steering Committee convened by DSHS and the HCA. Workgroups ranged in size from approximately 20 members to as many as nearly 40 members, with a combined membership that included at least 60 community organizations, state agencies, and Tribes.

Engrossed House Bill 1519 also directed the phased implementation of public reporting of outcome measures in a form that allows for comparison between geographic regions of Washington State. This document provides guidance to aid in the interpretation of measure results. **Note that data tables available from the public reporting site include both (1) measures selected for use in contracting and (2) measures that are provided for informational purposes that are not part of agency contracts with Behavioral Health Organizations, Area Agencies on Aging, or Managed Care Organizations.**

Guide to Interpretation

- Measures are calculated separately for three different types of service contracting organizations:
    - Area Agencies on Aging
    - Behavioral Health Organizations
    - Medicaid Managed Care Organizations
- Key to the creation of measures is determining which clients are associated with which service contracting entity, a process that is generally referred to as attribution. Different partially overlapping groups of clients qualify for attribution to the three different types of service contracting organizations reflected in this reporting:
    - Clients receiving in-home personal care services funded through the DSHS Aging and Long-Term Supports Administration (ALTSA) are attributed to Area Agencies on Aging.
    - Clients with mental health and substance use disorder treatment needs (who may or may not be receiving treatment services) are attributed to Behavioral Health Organizations. Measure results are reported separately for persons with mental health or substance use disorder treatment needs. The experiences of persons with co-occurring disorders are included in both the "mental health" and "substance use disorder" reports.
    - Clients enrolled with HCA managed care organizations (MCOs), including fully integrated managed care plans, are attributed to HCA MCOs.
    - See the "Measure Attribution of Clients to Service Contracting Entities" section in the measure specification documentation for more detailed information about the attribution process.
- Measures are aggregated across Regional Service Areas. Engrossed House Bill 1519 directed the phased implementation of public reporting of outcome measures in a form that allows for comparison of measures across geographic regions of Washington. The public reporting website provides results by Regional Service Areas defined under the requirements of Second Substitute Senate Bill 6312 (Chapter 225, Laws of 2014).
- In addition to producing measures for the overall adult Medicaid population, measures are produced separately for 4 major adult Medicaid coverage groups:
    - New adults covered under the Affordable Care Act (ACA)
    - Disabled adults
    - Classic non-disabled adults
    - Elders (age 65+)

Key Questions

Q. *Why are measures produced separately by major Medicaid coverage groups?*

- Different coverage groups have significantly different characteristics and experiences. Regions vary in the share of their caseloads comprised of different coverage groups. Reviewing trends and regional differences by major coverage group supports more valid comparisons of client experiences across regions.
- Medicaid Expansion under the ACA has significantly changed the composition of the adult Medicaid caseload. For example, New Adults are more likely to be employed, and New Adults with substance use disorders are more likely to be unstably housed or arrested, compared to the peers in other Medicaid coverage groups. Reporting information by major coverage group allows for more valid comparisons of adult Medicaid enrollee experiences over time.
- Medicaid Expansion has had complex effects on the composition of the adult Medicaid caseload, beyond simply expanding coverage to new populations. For example, the "classic non-disabled adult" coverage group experienced a "welcome mat" caseload increase that tended to be associated with healthier new enrollees. Also, some pre-existing high-risk coverage groups (Presumptive SSI, Disability Lifeline and ADATSA coverage groups) transitioned into New Adult coverage upon implementation of the ACA, creating an initial New Adult population in CY 2014 with a relatively high prevalence of physical and behavioral health risk factors, compared to the composition of the New Adult population in CY 2015 and future years.

Q. *Why do measures vary across regions?*

- Regional variation in measured outcomes reflects the influence of a variety of factors including (but not limited to):
    - The impact of the quality of activities conducted by organizations with care management responsibilities for clients
    - The impact of the quality of services provided by Medicaid-contracted direct care providers
    - The impact of the quality of services provided by other providers of formal or informal health or social services and supports
    - The impact of client characteristics and behavior
    - Factors affecting the availability and accessibility of services
    - Factors affecting the need for services, such as variation in regional economic conditions
    - Random variation

Q. *Can I use reported outcome measure trends to evaluate the impact of specific initiatives in my region?*

- No – evaluation of the impact of specific initiatives or policy changes requires a valid evaluation design that controls for other factors affecting regional differences in outcome trends. The information presented here should be considered descriptive and not a resource for evaluation.

Q. *Why are the mental health service and substance use disorder treatment penetration measures case-mix adjusted for BHO reporting?*[1]

- Client outcomes reflect the combined impact of many factors beyond the quality of care provided by managed care organizations or their contracted direct care providers.
- Most of the variation across regions in the reported behavioral health penetration measures is accounted for by client characteristics and residential population density – variables that are not directly influenced by service contracting entity actions.
- For example, residential population density is a powerful predictor of the likelihood that a client accesses behavioral health care, with lower residential density associated with lower likelihood of accessing care. In other words, rural and frontier regions experience predictably lower rates of access to behavioral health care. This may reflect the impact of greater distance between clients and providers and systematic challenges in building provider networks in rural and frontier regions. The case-mix adjustment process accounts for this difference in calculating the "expected" level of performance by Regional Service Area.

Q. *How do I interpret the "observed" and "expected" values for the case-mix adjusted mental health service and substance use disorder treatment penetration measures?*

- The "observed" value reflects the actual experience of the population attributed to the region in the reporting period. The "expected" value reflects the expected experience of the population attributed to the region in the reporting period, given their demographics and risk factors, and given the population density of the region.
- If the "observed" rate is "higher" than the expected rate, it means that performance in the region is better than expected.
- The case-mix adjustment process uses a regression model relating client outcomes on the specified measure to a set of variables reflecting client demographics, client risk factors, and the population density of the client's zip code of residence. Case-mix models were calibrated using experience over a prior three-year period.

[1] For more detail, see: https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-3.43_0.pdf

Q. *How can I tell if differences in outcomes across client subgroups are meaningful?*

- Compare statewide and regional trends by major coverage group. Because regions can differ in their coverage group composition, and because coverage groups can have widely varying experiences, users are encouraged to consider focusing on regional differences at the major coverage group level (that is, comparing New Adults in region A to New Adults in region B, rather than focusing on the overall Medicaid adult experience).
- Consider the degree of stability of the measure. Some measures are more variable than others. For example, because the Psychiatric Inpatient Readmissions measure is based on a far smaller number of hospital discharges, it is inherently less stable than the All-Cause Inpatient Readmissions metric. Consequently, the Psychiatric Inpatient Readmissions metric is more variable across regions and over time than the All-Cause Inpatient Readmissions metric. Users should be cautious in interpreting the significance of differences across regions and over time. We have provided numerator and denominator counts to allow the user to determine whether the differences they are observing in any specific comparison are statistically significant.
- More generally, because users may want to make a wide range of comparisons across regions, across coverage groups or over time, we have not embedded statistical tests into the reporting workbooks. However, we have provided numerator and denominator counts to allow the user to determine whether the differences they are observing in any given comparison are statistically significant, using standard formulas.

Q. *How do the 5732/1519 employment measures relate to the measures in the Employment Monitoring Data Project (EMDP) reports that RDA produces for persons receiving mental health or substance use disorder treatment services?*

- The EMDP reports generally contain quarterly employment rates for specific cohorts of clients receiving treatment services through Behavioral Health Organizations. The 5732/1519 reports contain annual employment rates for Medicaid enrollees with mental health or substance use disorder treatment needs.
- This means that the 5732/1519 reports represent the experience of a much broader population of Medicaid enrollees than are reflected in the EMDP reports. In general, employment rates in the 5732/1519 reports will be higher than the rates observed in the EMDP reports, because the underlying population has a higher level of functioning.
- In addition, the annual employment measure used in the 5732/1519 reports will be associated with a higher rate than EMDP measures of quarterly employment, due to the longer time period used to identify instances of employment.