

2007 Fact Sheet:

Medicaid integration in Washington

THE BACKGROUND

Nationally, there is an interest in integrating medical, mental health, chemical dependency and long-term care services for Medicaid clients to produce better health outcomes overall and to control costs by reducing duplicative or inappropriate services. The Washington Medicaid Integration Partnership (WMIP) is one such effort. WMIP is a voluntary integration of Medicaid services for adult Snohomish County clients with Supplemental Social Income (SSI) and who are eligible for both Medicaid and Medicare (dual eligible). Their care is coordinated by a single managed care plan, Molina Healthcare, Inc., and services have been phased in -- starting with medical and chemical dependency in January 2005, mental health services in October 2005, and long-term care in October 2006.

LESSONS LEARNED IN THE FIRST TWO YEARS

In the course of implementing WMIP, we learned the following lessons:

1. A disproportionate number of high-cost clients chose fee-for-service, rather than WMIP enrollment.
 - Based upon analysis conducted by DSHS' Research and Data Analysis staff, enrollees' historical fee-for-service (FFS) medical expenditures averaged \$496 per member per month (pmpm) while disenrollees' expenditures averaged \$742 pmpm.
 - Expenditures for LTC show that enrollees' historical utilization cost about \$130 pmpm, while disenrollees average cost was \$209 dollars pmpm.
 - Clients with historical use of LTC services are disproportionately choosing to remain in FFS: 7% of those enrolled have a history of LTC use, while 16% of disenrollees have used LTC services in the past.
2. Clients with a history of chemical dependency have a disproportionate rate of disenrollment from WMIP. This includes clients who have interruptions in eligibility for the program due to lost Medicaid eligibility, incarceration, etc.
 - Enrollees' historical utilization of DASA services averaged around 8.7 percent, while disenrollees used approximately 9.2 percent.
 - Enrollees with Alcohol or Other Drug Treatment (AOD) diagnoses averaged 9.3 percent while disenrollees averaged around 11.5 percent.
 - Assessments and referrals for clients with substance abuse issues continue to remain low, although similar to the rate for the fee-for-service population.
3. Some providers prefer the FFS system and can unintentionally create administrative barriers that result in clients choosing to drop out of WMIP (for example, pharmacists will attempt to use the fee-for-service Point-of-Sale system to charge for a prescription, and when that does not work, they tell the patient the drug is not covered).
4. Preliminary utilization indicators for inpatient and emergency room use show relative reductions, which generally is construed as an indicator of health care being provided in more efficient/effective health settings.
 - Emergency room visits were reduced from 128.6 visits per 1,000 member months to 125.9 visits per 1,000 member months after WMIP enrollment. A comparison group of non-WMIP enrollees (FFS) showed no significant change in emergency room visits over the same period (114.9 vs. 114.5 visits per member months).
 - Inpatient hospital admissions increased in non-WMIP members from 14 admissions per 1,000 member months to 16.8 admissions per 1,000 member months, while WMIP inpatient

hospital admissions only increased from 13.9 admissions per 1,000 member months to 15.5 admissions per 1,000 member months.

6. Molina's 2006 WMIP HEDIS measures showed an improvement over the National Committee for Quality Assurance (NCQA) 2004 Medicaid experience with diabetes.

	WMIP Mean	NCQA Mean
HbA1c tests (% tested)	84.55%	73.9%
Nephropathy monitored	55.91%	43.1%
Eye Exams (% examined)	52.73%	44.1%
Lipid profile (LDL-C) performed	84.09%	74.8%

7. Molina's CAHPS satisfaction data showed some areas of improved customer service compared to non-managed care, and did not reveal surprises in terms of areas that still need attention to client and provider education. The more positive findings are below:

- 57.7% of WMIP members have the same PCP they had when they were on FFS.
- 76.2% of WMIP members marked "Not a Problem" with experiencing delays in getting approval for treatment or tests compared to 55.2% of the FFS members who marked "Not a Problem" with experiencing delays in getting approval for treatment or tests.
- In the area of Plan Communications, 35.0% called WMIP's customer service to get help compared to 21.2% who called DSHS to get help. Of this amount, 62.9% indicated that it was "Not a Problem" getting help from WMIP's customer service compared to 47.7% who indicated it was "Not a Problem" getting help from DSHS.
- Only 28.9% of WMIP members have waited over 8+ days to have their complaint resolved compared to 37.5% FFS members who have waited over 8+ days to have their complaint resolved.
- 97.3% of WMIP members indicated "Not a Problem" with their paperwork compared to 61.9% FFS members who indicated "Not a Problem" with their paperwork.

8. One of the main reasons for low enrollment numbers in WMIP was due to loss or change in eligibility status. This remains true for FFS clients as well.
9. Voluntary enrollment, while favored by both client advocates and clients, is not conducive to growing the program and makes evaluation processes more difficult. While risk adjustment is used to compensate for the loss of clients with previous high utilization of services, it is not a perfect method to address the difference. See Lessons #1 and #2.

Considerations for Future Expansion

There are outstanding evaluation questions that should be answered before a final decision is made on expansion. These include:

1. Does WMIP improve client health status relative to the comparison group by slowing the progression of chronic disease conditions?
2. Does WMIP slow deterioration in functional status, as measured by changes the ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs)?
3. Does WMIP reduce mortality rates?
4. Does WMIP increase the proportion of clients with mental illness who get mental health services?
5. Does WMIP improve continuity of care among providers?
6. Does WMIP reduce the occurrence of avoidable hospitalizations for ambulatory care sensitive conditions?
7. Does WMIP reduce the rate of transition to more restrictive long-term care placements?
8. Does WMIP affect client arrest or conviction rates?
9. Does WMIP increase the proportion of clients with chemical dependency issues who get chemical dependency treatment services?

All of the above questions remain important to the Project Team, and should be answered positively for program expansion to be considered. While we await the complete evaluation, there are certain considerations under discussion.

1. The first two years have shown that the voluntary enrollment method will not result in the most high cost and high risk clients being enrolled. However, mandatory enrollment is not without controversy and system challenges. Among the issues that would arise from mandatory enrollment:

- It would be vitally important to ensure an adequate provider network.
 - Certain long term care providers are reluctant to contract with managed care plans because of stringent credentialing requirements and differences in payment processes.
 - Mandatory enrollment would affect both mental health networks and long term care case management, requiring stakeholder work with the RSN and unions.
 - Long term care clients in community placement are at risk of losing both care and housing if their provider network is disrupted, but they are not the only vulnerable members of the population.
 - It would be preferable to only mandate enrollment in a county with choice of managed care plan, to preserve client choice to a greater extent.
 - For these reasons, mandatory enrollment would have to include a liberal exemption policy, or exclude long term care clients all together.
2. Expansion will require extra staff resources in both HRSA and ADSA for exemptions, programming, rate-setting, quality monitoring, Integrated Provider Network Database programming time, training for HRSA internal staff such as the call centers, transportation, etc. Additional staff time will be needed for contracts, program management, administrative and secretarial duties, publications, IT/operations, accounting, translations, fiscal and budget rates and negotiations, client registry, Research and Data Analysis staff, and others.
 3. Funding will be needed for actuarial work and evaluation and monthly reporting. The current evaluation budget relies partially on external grant funding which is set to expire in 2007. For example, our work to improve risk adjustment methods to address the disproportionate enrollment has been subsidized with grant funds.
 4. As additional counties are added, there will be fixed costs for outreach and other activities, but since much of the groundwork has already been laid, it will only require adjustments.
 5. Provider One will need to be operational before expansion can be finalized, but much of the groundwork, such as bidding, contracting, outreach, site readiness reviews, and education and enrollment activities could be done over the next 18 months. The soonest any expansion could be undertaken, then, is mid-2008.