State of Washington
Joint Legislative Audit and Review Committee (JLARC)

Basic Health Plan Study: Part 1

Report 06-1

January 4, 2006

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The Joint Legislative Audit and Review Committee (JLARC) carries out oversight, review, and evaluation of state-funded programs and activities on behalf of the Legislature and the citizens of Washington State. This joint, bipartisan committee consists of eight senators and eight representatives, equally divided between the two major political parties. Its statutory authority is established in RCW 44.28.

JLARC staff, under the direction of the Committee and the Legislative Auditor, conduct performance audits, program evaluations, sunset reviews, and other policy and fiscal studies. These studies assess the efficiency and effectiveness of agency operations, impacts and outcomes of state programs, and levels of compliance with legislative direction and intent. The Committee makes recommendations to improve state government performance and to correct problems it identifies. The Committee also follows up on these recommendations to determine how they have been implemented. JLARC has, in recent years, received national recognition for a number of its major studies.

BASIC HEALTH PLAN STUDY: PART 1

REPORT 06-1

REPORT DIGEST

JANUARY 4, 2006

STATE OF WASHINGTON

JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE

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Study Background

In 1987, the Legislature established the Basic Health Plan (BHP) with the intent of making basic health care services available for low-income residents of Washington State. In the current calendar year, the BHP provides state-subsidized health care coverage to an average of **102,400 Washington residents** each month. For the 2005-07 Biennium, the Legislature has appropriated approximately **$500 million** toward BHP benefits and $16 million for BHP administrative costs.

This Joint Legislative Audit and Review Committee (JLARC) study is the first part of a two-part performance audit of the Health Care Authority's (HCA) Basic Health Plan. This study focuses on the extent to which the BHP's policies and procedures promote or discourage the provision of appropriate, high-quality, cost-effective care to enrollees. As directed by the Legislature, JLARC has reviewed the HCA's promotion of:

- Evidence-based health care strategies;
- High-quality providers;
- Treatment of chronic and other high-cost conditions;
- Wellness activities and preventive services; and
- Innovative health care service delivery methods.

Based on our review of these issues, we found:

Lack of BHP-Specific Coordination and Planning

The HCA has a set of strategic goals and objectives, but the focus is on the agency as a whole, rather than specific programs, such as the BHP. In addition, the HCA Medical Director and the Assistant Administrator for the BHP do not appear to have a formal process in place to coordinate their oversight and management roles, although there are indications that additional meetings will be established with the Medical Director to focus specifically on the BHP.

The lack of a BHP strategic plan and strong integration of the clinical and operational components of the program make it difficult to determine whether the specific health needs of the BHP population are being met.

Unclear Expectations and Limited Guidelines for Health Plans

Statute requires the BHP to provide access to good quality basic health care. In general, the HCA's contract directs health plans to provide appropriate, high-quality, cost-effective care. However, such crucial terms are not defined in either statute or contract provisions.

The contract also has specific Quality Improvement Standards. However, these standards generally evaluate the processes and plans in place to ensure quality care. They do not evaluate the actual outcome or quality of the services provided. For example, the standards require health plans to have two disease management programs, but the HCA does not monitor the actual effectiveness or quality of those programs.

Additionally, the HCA requires health plans to report on performance measures, but the focus of these measures is on customer service and administrative functions, not on health outcomes. Without health outcome measures, the HCA cannot evaluate the extent to which enrollees are receiving the care that they need to improve their overall health.

Without clear guidance and direction from the HCA concerning performance expectations, it is difficult to hold health plans accountable for their performance serving BHP enrollees.

Insufficient Monitoring of Health Plans to Ensure Quality Health Care

During annual site visits to health plans, TEAMonitor, an interagency review team, evaluates health plans based on specific Quality Improvement Standards. But, as previously mentioned this standards do not allow HCA to monitor the actual quality of care provided.

Additionally, TEAMonitor reviews data from HEDIS®, a performance measurement tool, to monitor health plans. However, the health plans are not required to separate BHP-specific HEDIS® information from their information on non-BHP commercial enrollees since some of the plans do not serve many BHP enrollees. But if health plans do not submit BHP-specific HEDIS® information, then this data is less effective in evaluating the performance of health plans in providing health care services to BHP enrollees.

The HCA's use of service utilization data is limited. The HCA's actuary uses that data to set rates and TEAMonitor reviews each health plan's utilization data during their annual site visits. This limited use of utilization data does not allow for detailed analysis of service utilization by BHP enrollees, which makes it difficult to determine the quality and specific nature of the care that health plans are providing to enrollees.

Recommendations

In the course of the study, there were indications that the new Health Care Authority administration is in the process of reviewing BHP contractual provisions, and reorganizing the administration of the program to better align the BHP with statutory goals and objectives for the programs. In light of our findings and potential future changes to the program, JLARC's recommendations are designed to support the HCA's improvement initiative.

Recommendation 1: The HCA should develop goals and objectives for the BHP, focused on the statutory requirements to (1) assure quality; (2) use evidence-based treatment; and (3) explore chronic disease management.

Recommendation 2: The HCA should develop more specific guidelines and performance requirements for future contracts, including defining key terms and developing clinical health-related performance measures for the health plans. At a minimum, this should include: specific care guidelines and reporting requirements for chronic conditions; definitions of evidence-based care; and uniform performance outcome measures that are aligned with the statutory requirement to provide quality health care.

Recommendation 3: The HCA should improve its system of monitoring health plans. This should include: the application of quality assessment tools to monitor the level and type of health care provided by the health plans specifically to BHP enrollees; analysis and use of service utilization data to evaluate the quality and type of care provided specifically to BHP enrollees and to minimize costs; and a process for analyzing clinical health-related performance measures collected in new contracts and reporting this information to the Legislature.

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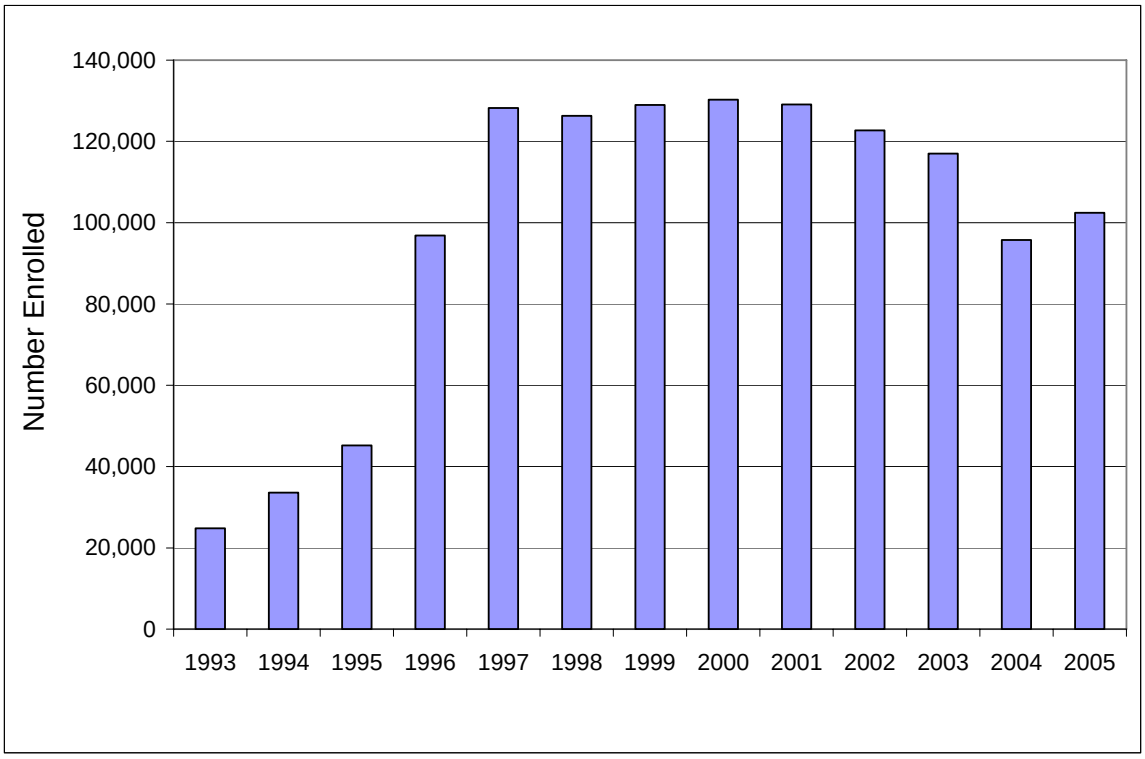
CHAPTER ONE: INTRODUCTION

BACKGROUND ON THE BASIC HEALTH PLAN

In 1987, the Legislature established the Basic Health Plan (BHP) with the intent of making basic health care services available for low-income residents of Washington State. The program began as a five-year demonstration project with openings for 4,000 King and Spokane County residents. In 1993, the Legislature made the BHP a statewide program. **Exhibit 1**, below, shows the average yearly enrollment for the BHP since it was established statewide.

Enrollment in the BHP fluctuates monthly. As of October 2005, the average monthly enrollment for 2005 is approximately **102,400 Washington residents**. For the 2005-07 Biennium, the Legislature has appropriated approximately **$500 million** toward BHP benefits and $16 million for BHP administrative costs.

Exhibit 1 - Average Yearly Enrollment for Basic Health Plan



Source: Health Care Authority.
Note: 2005 data includes January through October enrollment figures.

STUDY MANDATE

The 2005-07 Operating Budget directs the Joint Legislative Audit and Review Committee (JLARC) to conduct a two-part study of the Basic Health Plan. Part 1 of the study, addressed in this report, examines the extent to which BHP policies and procedures promote or discourage the

provision of appropriate, high-quality, cost-effective care to BHP enrollees. Additionally, the Legislature asked JLARC to review the HCA's promotion of:

- Evidence-based health care strategies;
- High-quality providers;
- Treatment of chronic and other high-cost conditions;
- Wellness activities and preventive services; and
- Innovative health care service delivery methods.

Part 2 of the JLARC study, to be completed by July 2006, will examine the characteristics of individuals enrolled in the BHP and their use of health care services.

STUDY APPROACH

JLARC evaluated the Health Care Authority's policies and procedures for the Basic Health Plan to determine the extent to which they are aligned with the roles and responsibilities of the HCA provided in statute. Additionally, we reviewed the HCA's contract with health plans to determine what kind of guidance related to appropriate, high-quality, cost-effective care the HCA provides the plans. We also reviewed how the HCA monitors the performance of health plans.

REPORT OVERVIEW

Chapter 2 describes the Health Care Authority's administration of the Basic Health Plan, including its budget, statutory direction, administration, and performance measures.

Chapter 3 describes the health plans and benefits available to BHP enrollees. Additionally, for each of the issues that the Legislature asked JLARC to review, we examine statutory and contract provisions relating to those issue areas.

Chapter 4 describes models from other states to demonstrate other methods that can be used to manage and monitor the BHP program in Washington State.

Chapter 5 presents the report's findings and recommendations.

CHAPTER TWO: THE HEALTH CARE AUTHORITY'S ADMINISTRATION OF THE BASIC HEALTH PLAN

BACKGROUND

The Basic Health Plan was originally created as an independent state agency with its own administrator and staff. In 1993, the BHP was merged with the Health Care Authority, which had been established in the same year as the BHP.

In addition to the BHP, the HCA administers the following health care programs:

- Community Health Services, which promotes access to quality and affordable health care for the uninsured, underinsured, and tribes, through grants to community clinics;
- The Washington State Prescription Drug Program, which uses bulk purchasing of drugs to provide discounts to Washington residents;
- The Public Employees Benefits Board (PEBB); and
- The Uniform Medical Plan, a self-insured medical plan that provides two options to PEBB enrollees in addition to privately managed health plans.

HEALTH CARE AUTHORITY BUDGET

The BHP is funded by the statutorily established Basic Health Plan Trust Account and Health Services Account. The HCA also receives some federal reimbursement for administrative services related to managing pass-through funds for two related Medicaid programs. For the 2005-07 Biennium budget, approximately $500 million was appropriated for BHP benefits and $16 million for BHP administrative costs.

STATUTORY DIRECTION FOR THE BHP

The primary elements of the BHP are set in statute, including the intent of the program and eligibility requirements for the program. The intent of the Basic Health Plan is "to provide or make more readily available necessary basic health care services in an appropriate setting to working persons and others who lack coverage, at a cost to these persons that does not create barriers to the utilization of necessary health care services."[1] To qualify for the BHP, enrollees must meet specified criteria, including the following: (1) be a resident of Washington State; (2) not be eligible for Medicare; and (3) have a gross family income at or below 200 percent of the federal poverty level.

Statute also defines the roles and responsibilities of the HCA in administering the program. The HCA Administrator is to design a schedule of covered basic health care services and a structure of enrollee premiums and cost-sharing, as well as accept applications for enrollment in the BHP.

[1] RCW 70.47.010.

However, enrollment levels depend on the amount of funding provided in the budget each biennium.

The Administrator is also charged with soliciting and accepting applications from managed health care systems for participation in the BHP and determining the rate to be paid to each participating managed health care system.[2] Managed health care systems (commonly referred to as health plans) participating in the BHP must do so by contract with the Administrator.[3]

Currently, five managed health care systems contract to deliver the BHP. The HCA is to monitor the health plans and the services they provide to "assure enrollee access to good quality basic health care."[4] This topic is covered in more detail in Chapter 3.

BASIC HEALTH PLAN ADMINISTRATION

Each of the Health Care Authority's programs, including the Basic Health Plan, is overseen by an **Assistant Administrator**. Each of the Assistant Administrators reports to the Deputy Administrator, who reports to the Administrator of the HCA. In the case of the BHP, the Assistant Administrator is focused on the day-to-day operations of the program and the overall strategic direction of the BHP. The HCA employs one **Medical Director** with responsibility for all HCA programs.

Both the Assistant Administrator and the Medical Director have responsibility for the quality of care provided to BHP enrollees. The Assistant Administrator and the Medical Director meet monthly one-on-one, but it is not clear that they have a formal process in place to coordinate the oversight and management of the BHP. Through our interviews, there were indications that additional monthly meetings will be established with the Medical Director to focus specifically on the BHP.

HCA Structure for Monitoring Health Plans

The Health Care Authority monitors the quality of participating health plans through **TEAMonitor,** an interagency contract review team that includes the Health Care Authority, the Health and Recovery Services Administration (HRSA) within the Department of Social and Health Services, and the Department of Health. The HCA Medical Director is the lead for the joint monitoring of health plans that contract with the HCA and the HRSA.

For its evaluation of health plans, TEAMonitor uses **Quality Improvement Standards**, which are incorporated into the HCA's contract with health plans. These standards are based on National Committee for Quality Assurance (NCQA) standards. NCQA is a non-profit organization that accredits and evaluates health plans for quality.

Generally, the Quality Improvement Standards establish a base level of processes and plans that should be in place to ensure quality health care. The standards do not provide a tool for evaluating the actual quality of the services provided. For example, one of the standards is that the health plans have two disease management programs. By using the Quality Improvement Standards TEAMonitor can verify that two disease management programs are

[2] RCW 70.47.060.
[3] RCW 70.47.100.
[4] RCW 70.47.060.

in place, but they could not evaluate or measure the actual quality of care or the outcomes of the programs.

The Quality Improvement Standards are organized into the following topics:

- Quality Management and Improvement
- Utilization Management
- Credentialing and Recredentialing
- Members' Rights and Responsibilities
- Preventive Health Services

Each year, TEAMonitor conducts a two-day site visit of each health plan. Health plans are also required to submit information and documentation before the site visit. TEAMonitor reviews whether each health plan has met, partially met, or not met each of the Quality Improvement Standards. The standards are very specific. For example, when TEAMonitor reviews that health plans have a performance measure for each of the disease management programs, they check to see that the measurement: (1) addresses a relevant process or outcome; (2) produces a quantitative result; (3) is population based; (4) uses data and methodology that are valid for the process or outcome measured; and (5) has been analyzed in comparison to a benchmark or goal. TEAMonitor does not review whether the performance for each measure is acceptable or needing improvement.

Based on this evaluation, TEAMonitor may develop a Corrective Action Plan with recommendations for how the health plan can improve in the areas where it has partially met or not met standards. However, we found that the HCA does not provide sanctions or incentives for health plan compliance with Corrective Action Plans or contract requirements.

In addition to the TEAMonitor site visits, the HCA also reviews **performance measures** that health plans are required by contract to submit to the HCA. Although the contract requires participating health plans to ensure quality and cost-effectiveness of care, the contract only requires the reporting of *administrative* performance measures focused on *process* functions. Specifically, the contract stipulates that the health plan agrees to comply with performance measures relating to:

- Claim turnaround time;
- Distribution of the Member Handbook;
- Enrollment processing; and
- Identification card issuance.

The health plan must self-report compliance with these standards. However, if the HCA determines that it is not feasible for the health plan to report compliance with a measure on a basis specific to BHP enrollees, then the health plan may report compliance with that measure for their total book of business, which may include individuals covered under Medicaid or other commercial plans.

Another performance assessment tool that the HCA's contract requires health plans to submit is audited Health Plan Employer Data and Information Set (**HEDIS®**) information.

HEDIS® is maintained by the National Committee on Quality Assurance as a performance measurement tool used in the managed care industry. HEDIS® can track performance data, such as the percentage of eligible diabetic adults who received an eye screening for diabetic retinal disease.

HCA staff stated that they use HEDIS® to assess health plans. However, the health plans are not required to separate BHP-specific HEDIS® information from their information on non-BHP commercial enrollees. This is primarily because some of the plans do not serve many BHP enrollees. Separating out a small number of BHP enrollees may not provide an accurate reflection of a plan's overall performance, but without BHP-specific HEDIS® information, this data is less effective for evaluating performance for BHP enrollees.

Finally, an additional type of data useful for monitoring health plans is **health care service utilization data**. The Administrator of the HCA is required by statute to collect data reports concerning the utilization of health care services rendered to enrollees in the BHP in order to provide adequate information for evaluation.[5] However, in the course of our review, we found that the HCA's use of utilization data is limited. It is used by the actuary to set rates, as discussed further below, and it is reviewed during TEAMonitor's two-day site visits.

This limited use of utilization data does not allow for detailed analysis of service utilization by BHP enrollees. Without a meaningful analysis of service utilization for the BHP, it is difficult to determine the quality and specific nature of the care that health plans are providing to enrollees.

STRATEGIC PLANNING AND PERFORMANCE MEASURES

The Health Care Authority has developed an agency-wide set of strategic **goals and objectives** for the 2005-07 Biennium. For the most part, this document relates to the activities of the HCA as a whole rather than to its specific programs. The agency's five goals are to:

- Make cost-effective, high-quality benefits accessible for all our enrollees;
- Provide excellent service to all customers;
- Reduce the rate of growth in health care costs;
- Improve, simplify, and streamline operational efficiencies across all divisions; and
- Promote a performance-based culture of mutual respect, open communication, accountability, and employee development.

Under these overarching goals, we found one BHP-specific objective, which states, "Basic Health provides essential access to basic quality benefits, administered comparably to commercial lines of business, striving to contain costs." Within a second, more detailed draft document, which identifies further objectives and strategies for each of the five agency goals, a number of those objectives and strategies relate specifically to the BHP. However, the focus remains largely on agency-wide functions.

The HCA has program-wide **performance measures** for the BHP, but, like the performance measures for individual health plans required under the HCA's contract, they are focused on customer satisfaction and process outcomes, rather than health outcomes. For example,

[5] RCW 70.47.060.

performance measures for the BHP reported to the Office of Financial Management (OFM) as part of the HCA's activity inventory include:

- Percentage of Basic Health and PEBB customer service telephone calls answered within five minutes;
- Percent of Basic Health clients recertified to confirm membership eligibility; and
- Average monthly enrollment in subsidized Basic Health Plan.

Although these statistics are useful to track for other purposes, the BHP performance measures reported to OFM do not demonstrate whether the BHP program is meeting the statutory intent of the program to provide quality health care.

CHAPTER THREE: BENEFITS AND REQUIREMENTS OF THE BASIC HEALTH PLAN

CHAPTER OVERVIEW

This chapter provides information on the health plans that contract with the Health Care Authority to deliver the Basic Health Plan and the benefits available to enrollees in the Basic Health Plan. This chapter then addresses the statutory and contract provisions for each of the six issues that the Legislature asked JLARC to examine: (1) high-quality, cost-effective treatment; (2) evidence-based treatment; (3) high-quality providers; (4) chronic and other high-cost conditions; (5) preventive care; and (6) innovative health care service delivery methods.

HEALTH PLANS AND BENEFITS

The Health Care Authority contracts with health plans to provide health care coverage under the Basic Health Plan to qualified Washington State residents. Currently, there are five health plans that contract with the HCA for participation in the BHP. **Exhibit 2** illustrates the distribution of BHP members across the five plans and the enrollees' percentage of each plan's total market as of October 2005. As shown in Exhibit 2, Molina and Community Health Plan of Washington enroll about 85 percent of the total number of BHP enrollees.

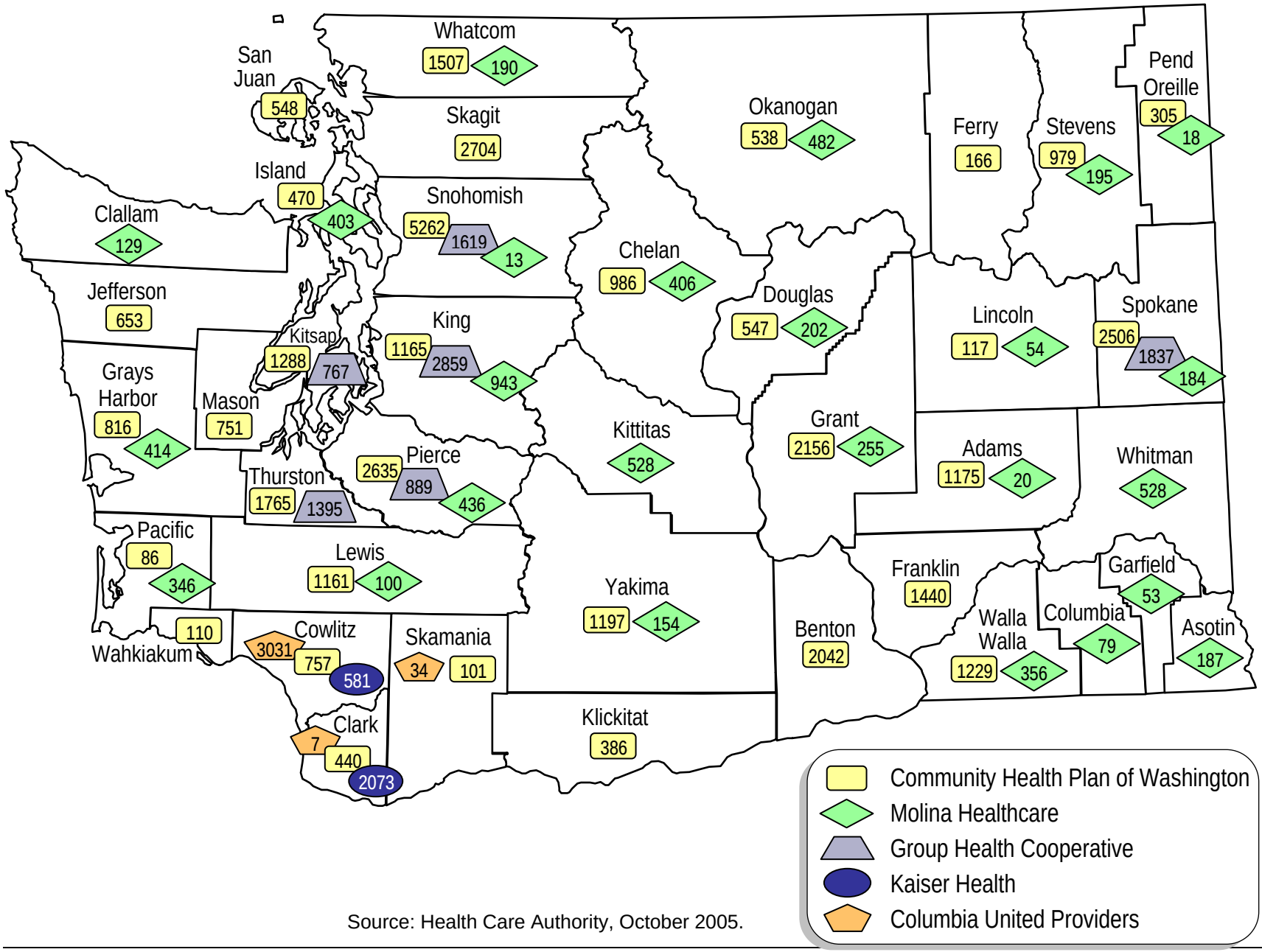
Exhibit 2 - Basic Health Plan Enrollment Market by Health Plan as of October 2005

Health Plan	# of BHP Enrollees Served by the Plan	% of BHP Enrollees Served by the Plan	# of Counties Covered	BHP's % of Plan's Total Business	Other Customers
Community Health Plan of Washington	59,250	60%	33	26.5%	PEBB, Medicaid
Molina Healthcare	25,035	25%	25	12.0%	Medicaid
Group Health Cooperative	9,367	9%	6	1.8%	PEBB, Medicaid, Commercial Business
Kaiser Health	2,655	3%	2	0.6%	PEBB, Medicaid, Commercial Business
Columbia United Providers	2,072	3%	3	8.5%	Medicaid

Source: Health Care Authority and individual health plans.

Exhibit 3 shows health plans by county and number of enrollees as of October 2005. As illustrated by the map, of Washington's 39 counties, 15 are covered by only one health plan, 18 are covered by two health plans, and six are covered by three health plans.

Exhibit 3 - Basic Health Subsidized Enrollees by Health Plan as of October 2005



Source: Health Care Authority, October 2005.

As directed in statute—and within budget constraints—BHP benefits are determined by the HCA Administrator. All health plans that participate in the BHP offer the same base benefits, but monthly premiums, providers, and some details of coverage, such as whether the plan offers any additional preventive services, vary.

To help set premiums, the HCA contracts with an actuary. The actuary receives utilization data from each of the plans and uses this data to negotiate premiums depending on the plan and the county being served. For example, the actuary may set two different rates for one health plan, negotiating a higher premium for care in remote rural areas where providers are scarce and a lower premium for urban areas where providers are plentiful.

The HCA pays negotiated premiums directly to the health plans participating in the BHP, with BHP enrollees reimbursing the HCA for a portion of the premium. The amount that enrollees pay is determined on a sliding scale based on their age, family size, gross family income, county of residence, and the particular health plan that they choose.

STATUTORY AND CONTRACT PROVISIONS

The Health Care Authority's contracts with health plans define the character and functioning of the Basic Health Plan. The 2005 contracts incorporate supporting documents, including the Basic Health Member Handbook, which details the services, benefits, exclusions, and limitations applicable to enrollees in the BHP, and the Quality Improvement Standards.

The following section provides a discussion of the statutory and contract provisions for each of the six issues raised by the Legislature for this study: (1) high-quality, cost-effective treatment; (2) evidence-based treatment; (3) high-quality providers; (4) chronic and other high-cost conditions; (5) preventive care; and (6) innovative health care service delivery methods.

Appropriate, High-Quality, Cost-Effective Care

This fundamental issue of the extent to which BHP policies and procedures promote or discourage the provision of appropriate, high-quality, cost-effective care provides the framework for each of the subsequent, more specific, issues. This first issue is required by statutory provisions and called out in the contracts with health plans.

Statutory Requirements

As provided in statute, the purpose of the Basic Health Plan is "to provide or make more readily available necessary basic health care services in an appropriate setting to working persons and others who lack coverage, at a cost to these persons that does not create barriers to the utilization of necessary health care services."[6] The Administrator of the HCA is charged with monitoring the provision of covered services to enrollees by participating health plans in order to assure enrollee *access to good quality basic health care*.[7]

In addition, the Administrator of the HCA is charged with requiring periodic data reports concerning the utilization of health care services rendered to enrollees in order to provide

[6] RCW 70.47.010.
[7] RCW 70.47.060.

adequate information for evaluation, and inspecting the books and records of participating health plans to assure compliance with statute.[8]

Contract Provisions

The contract stipulates that the health plan must provide evidence that it has and uses a plan to *improve* its quality, care delivery and satisfaction scores, and other standard measures.

The contract stipulates that the health plan must provide evidence that it has and uses a plan to hold all components of the delivery system accountable for the *appropriateness of care* delivered to enrollees, for *patient outcomes*, and for *enrollee satisfaction*.

The HCA's contract with health plans stipulates that in its demonstration of fiscal accountability to the HCA, enrollees, and providers, the health plan must provide for and ensure that the health plan has and uses the following:

- Financial contracts and agreements with providers that focus on *efficiency and effectiveness of health care*;
- A plan to improve administrative systems that promote health plan's *performance and efficiencies*, including information management systems to support the HCA's expectations and objectives and, in particular, the ability of the health plan to monitor and promote *continuous quality improvements*;
- Financial arrangements with providers that are designed to ensure that enrollees receive *appropriate and cost-effective care*;
- A risk management plan that is designed to anticipate and reduce threats to continued enrollee *access to care*;
- A system to incorporate *disease management*, use of *clinical guidelines*, and *evidence-based medicine*; and
- Policies and procedures to *prevent and detect fraud and abuse* activities related to the BHP.

The contract does not include definitions of critical terms used in each of these provisions, such as "appropriate and cost-effective care," "disease management," "clinical guidelines," and "evidence-based medicine."

The HCA's contract with health plans also stipulates that the health plan must maintain a quality improvement program that meets or exceeds the requirements of the HCA's Quality Improvement Standards, which is a subset of the National Committee for Quality Assurance (NCQA) standards. The Quality Improvement Standards, which are incorporated into the contract as a supporting document, address the basic areas relating to the promotion of appropriate, high-quality, cost-effective care, but do not include specific definitions for these terms. The contract does provide specific guidance, in an additional incorporated document, relating to the requirement for a cardiovascular disease quality initiative in meeting the Quality Improvement Standards.

[8] RCW 70.47.060.

Evidence-Based Treatment Strategies

The HCA's identification and promotion of evidence-based treatment strategies in the BHP is required by statutory provisions. The HCA also addresses the use of evidence-based treatment strategies in its contracts with health plans and the policies in the Member Handbook.

Statutory Requirements

The HCA is required by statute to coordinate state agency efforts to develop and implement uniform policies across state-purchased health care programs. The policies adopted by the HCA should be based, to the extent possible, upon the best available *scientific and medical evidence*.[9]

Contract Provisions

The HCA's contract with health plans stipulates that health plans must provide for and ensure that the health plan has and uses a system to incorporate *disease management*, use of *clinical guidelines*, and *evidence-based medicine*. However, no definitions are provided for these terms.

The contract also stipulates, as discussed in more detail in the section on preventive services below, that primary and secondary preventive care services must be provided in accordance with the current edition of the U.S. Preventive Services Task Force's "Guide to Clinical Preventive Services." The U.S. Preventive Services Task Force conducts rigorous, impartial assessments of the scientific evidence for the effectiveness of a broad range of clinical preventive services, including screening, counseling, and preventive medications.

The Member Handbook, which supplements the contract, specifies services to be covered under the BHP when they are medically necessary. The following conditions must be met for qualification of covered services as "medically necessary:"

- The service, supply, or intervention is the *most appropriate* level of service, supply, or intervention considering the potential benefits and harm to the patient.
- The level of service, supply, or intervention is *known to be effective in improving health outcomes*.
- The level of service, supply, or intervention recommended for this condition is *cost-effective* compared to alternative interventions, including no intervention.
- For new interventions, effectiveness is determined by *scientific evidence*. For existing interventions, effectiveness is determined first by *scientific evidence*, then by *professional standards*, then by *expert opinion*.

Specific definitions are provided for the following terms in the Member Handbook: "effective," "health outcomes," "new interventions," "scientific evidence," "existing interventions," and "cost-effective."

High-Quality Providers

The issues of whether enrollees in the BHP are encouraged to use high-quality providers, and what criteria the HCA uses to determine the quality of providers are not specifically required in

[9] RCW 41.05.013.

statute, but the more general question of access to quality health care is. Numerous provisions of the contract call out issues relating to provider access and quality.

Statutory Requirements

The Administrator of the HCA is charged with monitoring the provision of covered services to enrollees by participating health plans in order to assure enrollee *access to good quality basic health care.*[10] In addition, in coordinating state agency efforts to develop and implement uniform policies across state-purchased health care programs, the HCA is required to endeavor to address monitoring of *health outcomes*, *adverse events*, *quality*, and *cost-effectiveness of health services.*[11]

Contract Provisions

The HCA's contract with health plans stipulates that the health plan must submit to the HCA a *report of providers* currently under contract with the health plan.

The contract requires that the health plan must provide *access to consistently high-quality, cost-effective care* that is designed to improve the health of enrollees through *efficient, stable networks or delivery systems*.

The contract stipulates that the health plan must provide evidence that it has and uses a plan to *support the efforts of providers to improve quality, service, safety, and effectiveness of care*. The health plan must be able to demonstrate how its efforts incorporate information sharing, provider development programs, and regular feedback on performance.

The contract stipulates that the health plan must ensure that an *adequate network of providers* who deliver *high-quality health care services* is available to enrollees. *Upon request*, the health plan must demonstrate that it ensures the following for the benefit of enrollees:

- A comprehensive, organized system of care that is accountable for delivery, development, and performance;
- Accessible high-quality primary care physicians, specialists, hospitals, and pharmacies;
- Long-term relationships with providers; and
- Adequate and timely access to medically appropriate providers outside the contracted network if there is an insufficient number of participating providers.

The contract stipulates that the health plan must ensure enrollees have access to covered services by the medically appropriate provider.

The contract does not include definitions of critical terms used in each of these provisions. However, the HCA's Quality Improvement Standards, which are incorporated into the contract as a supporting document, provide specific guidance for initial and ongoing assessment of providers by the health plans.

[10] RCW 70.47.060.
[11] RCW 41.05.013.

Chronic and Other High-Cost Conditions

Statute provides basic requirements relating to the care of enrollees with chronic and other high-cost conditions. Provisions of the contract with health plans specifically address the identification of chronic conditions and call out issues relating to disease management programs for those conditions.

Statutory Requirements

In coordinating state agency efforts to develop and implement uniform policies across state-purchased health care programs, the HCA is required by statute to work with other state agencies to explore common strategies for *disease management and demand management programs*. Legislation enacted in 2005 expanded upon this language to provide that the strategies must include management of asthma, diabetes, heart disease, and similar common chronic diseases. In addition, the HCA is required to issue status reports to the Legislature in January 2007 and January 2009, summarizing its results in exploring and coordinating strategies for asthma, diabetes, heart disease, and other chronic diseases.[12]

Contract Provisions

The HCA's contract with health plans stipulates that the health plan must submit data specific to the BHP regarding that health plan's *top-five chronic conditions* by frequency and costs for the prior calendar year. A definition is provided for "chronic condition."[13]

The contract requires health plans to report chronic conditions by frequency *and* costs, but these two ways of identifying chronic conditions result in different lists. Thus, plans are choosing either cost or number of patients. In addition, health plans use their own categorization process to develop their chronic conditions report. For example, some reports from plans break out specific types of cancer (e.g., breast, cervical, colon, etc.) into separate categories, while others combine all types of cancer into one category.

The methodology and categorization used to calculate the top-five chronic conditions can have a significant impact on the information that gets reported and the ease with which that information can be compared across plans. Since this data is not reported consistently, it is difficult for the HCA to use the information to guide the health plan's efforts to improve the health of its chronically ill BHP enrollees. Additionally, since service utilization data is only reviewed by TEAMonitor during their annual two-day site visits and by the actuary in setting rates, the HCA does not conduct ongoing analysis of the top chronic conditions.

The HCA reports that it uses the health plans' reports of the top-five chronic conditions to monitor how BHP enrollees with chronic conditions are identified and treated, and trends in chronic conditions over time. However, the HCA only requires counts of members, annual costs of diagnosis, and annual cost per enrollee. The HCA does not require more detailed information about treatment or outcomes.

[12] RCW 41.05.013.

[13] Chronic condition is defined as any condition lasting three months or longer or a condition classified as chronic regardless of its time of onset (e.g., diabetes, heart conditions, emphysema, and arthritis). Pregnancies and fractures are specifically excluded.

Through the Quality Improvement Standards, the HCA also requires health plans to have disease management programs for two chronic conditions. However, there is no requirement that health plans have disease management programs for the top-five chronic conditions that they report. During its annual site visits, TEAMonitor reviews the health plans' disease management programs on the basis of specific criteria, including program content, identification of eligible members, informing and educating practitioners, and measuring effectiveness.

Wellness Activities and Preventive Services

Both statutory and contract provisions address the extent to which BHP enrollees are encouraged to engage in wellness activities and receive preventive services. However, the focus is on preventive care rather than wellness activities.

Statutory Requirements

As provided in statute, the Administrator of the HCA is charged with designing and periodically revising a schedule of covered basic health care services that emphasizes *proven preventive and primary health care*, including development of a program of *proven preventive health measures*.[14]

Contract Provisions

The HCA's contract with health plans stipulates that primary and secondary preventive care services must be provided in accordance with the current edition of the U.S. Preventive Services Task Force's "Guide to Clinical Preventive Services." The contract divides the services in the Guide into the following categories: (1) services that must be covered and for which the health plan must take active steps to assure their provision; (2) services that must be covered; (3) services that are not to be covered; (4) services that are not to be covered and, if provided, there must be informed consent; and (5) services that are to be provided at the discretion of the health plan. However, the contract allows health plans to substitute generally recognized accepted guidelines as a basis to define coverage of preventive services with the HCA's advance approval. Currently, all the health plans use the "Guide to Clinical Preventive Services."

The contract requires health plans to provide enrollees with a description of preventive care benefits. In addition, the Member Handbook provides that preventive care requires no co-payment and is not subject to the BHP's deductible or coinsurance. Preventive care is specified in the Member Handbook to include routine physicals, immunizations, PAP tests, mammograms, and other screening and testing when provided as part of the preventive care visit.

Due to cost concerns, the HCA has not included wellness programs as a requirement in its contracts with health plans. However, the HCA has reported that each of the health plans currently offers at least two wellness programs to enrollees.

Innovative Health Care Service Delivery Methods

As cited above, the purpose of the BHP provided in statute is "to provide or make more readily available necessary basic health care services in an appropriate setting to working persons and others who lack coverage, at a cost to these persons that does not create barriers to the utilization

[14] RCW 70.47.060.

of necessary health care services."[15] As such, the issue of innovative health care service delivery methods is not within the intent or scope of the BHP, as currently established. Correspondingly, the provisions of the HCA's contract with health plans do not address this issue. However, the HCA has reported that some health plans offer enrollees innovative service delivery methods.

[15] RCW 70.47.010.

CHAPTER FOUR: OTHER STATE MODELS

As part of our review, JLARC looked at other state models for managing contracted health plans with the goal of identifying other practices that could be incorporated into the management of the BHP and improve the overall quality and effectiveness of the program. JLARC did not conduct a comprehensive review of other states' programs, but focused on state programs that addressed areas in which Washington's BHP could improve.

MASSACHUSETTS – ALIGNING QUALITY GOALS WITH PRACTICE GUIDELINES

Massachusetts provides an example of how states can identify specific interventions to meet quality improvement goals. The Medicaid Program of the Commonwealth of Massachusetts, referred to as MassHealth, recently developed a managed care quality strategy for 2005-2006. As part of that strategy, MassHealth focused on aligning quality improvement goals and evidence-based practices. For example, the 2005-2006 Asthma and Diabetes quality improvement goals specify that improvement interventions must be consistent with the National Heart, Lung and Blood Institute Asthma Guidelines and the Massachusetts Adult Diabetes Guidelines, respectively. In addition, the strategy provides a list of other guidelines endorsed by MassHealth. For example, the guidelines suggest the use of the Massachusetts Health Quality Partners Guidelines for Adult and Child Preventive Care. Health plans are not limited to these guidelines, but the plans are expected to use them as appropriate for their members.

WISCONSIN – COMPARING PERFORMANCE ACROSS PROGRAMS AND HEALTH PLANS

Wisconsin provides an example of how states can use clinical performance data to compare state-funded programs, assess performance of individual health plans over time, and make comparisons among individual health plans. This data can then be used as a tool for program managers to assess quality and performance of plans, by policymakers to make informed decisions about the managed care system, and by consumers to make informed decisions about their care.

Wisconsin uses a set of standardized performance measures for Medicaid and BadgerCare, which is the state's health insurance program for low-income families with children. This performance data is derived directly from monthly health plan encounter data and other state-controlled electronic data sources. Using this data to calculate each health plan's performance on a designated measure assures greater consistency, completeness, and accuracy across the program. It also makes it possible to review, for example, the level of blood sugar control for diabetes in several ways: (1) to compare the performance of Medicaid to BadgerCare; (2) to review trends in performance; and (3) to make comparisons across health plans.

OREGON – GUIDING AND MONITORING CARE THROUGH CONTRACTS

The Oregon Health Plan provides an example of how contracts with health plans can be used to provide greater guidance and monitoring of state-administered health coverage programs. The Oregon Health Plan includes both a Plus and a Standard benefits package. The Plus package is the state's Medicaid program, whereas the Standard package is comparable to Washington's Basic Health Plan.

In its contracts with health plans, the Office of Medical Assistance Programs (OMAP) requires that health plans submit performance measures to OMAP relating to two specific interventions: asthma care and childhood immunization status. The contract provides detailed guidance on the information to be provided and the format in which it is to be provided.

OMAP's contracts with health plans also require that each health plan's quality and performance improvement program must have ongoing performance improvement projects for the covered services that it provides to members. The health plans are required to measure and report to OMAP the results of performance improvement projects for the previous calendar year. Each health plan must use either the performance improvement projects identified in the contract or no less than two pre-approved projects that the health plan has initiated. The projects identified in the contract are tobacco cessation and early childhood cavities prevention. The contract provides detailed guidance on the elements to be included in the projects, as well as reporting requirements for the projects.

Lastly, in their contracts with health plans, OMAP requires each health plan to submit monthly encounter and pharmacy data to OMAP. The contract provides a description of the records that fall under these two categories of data.

Through their contracts, OMAP provides specific and direct guidance to their health plans relating to the care provided to enrollees. Additionally, OMAP ensures that they will have the data necessary to monitor the performance of each health plan in their provision of services to enrollees. With these contract requirements, OMAP is able to meaningfully direct and monitor the Oregon Health Plan.

CHAPTER FIVE: FINDINGS AND RECOMMENDATIONS

FINDINGS

Based on our review of the extent to which the Health Care Authority is ensuring that their health plans are providing appropriate, high-quality, cost-effective care to BHP enrollees, we have the following findings:

Lack of Coordination and Planning for the Basic Health Plan Within the Health Care Authority

The Health Care Authority has developed a set of strategic goals and objectives for the biennium, but the focus is on the agency as a whole, rather than statutory requirements for its specific programs, such as the BHP. Without a strategic plan that includes clearly defined goals and expectations for the BHP, the HCA does not have focused guidance for the health plans.

We also found that the HCA Medical Director and the Assistant Administrator for the BHP do not appear to have a formal process in place to coordinate their oversight and management roles, although there are indications that additional meetings will be established with the Medical Director to focus specifically on the BHP.

The lack of a BHP strategic plan and strong integration of the clinical and operational components of the program make it difficult to determine whether the specific health needs of the BHP population are being met.

Some Expectations Are Unclear and Guidelines Are Limited

Both statutory and contract provisions address the promotion of appropriate, high-quality, cost-effective care, but do not include specific definitions for these terms. The contract does provide specific guidance related to preventive services and a cardiovascular disease quality initiative. The contract requires health plans to report on their top-five chronic conditions, but does not provide sufficient direction to ensure that health plans use a common methodology and categories in determining the top-five chronic conditions.

The Quality Improvement Standards incorporated into the contract address these basic issues of appropriate, high-quality, cost-effective care, but do not include specific definitions for these terms. Generally, the Quality Improvement Standards establish a base level of processes and plans that should be in place to ensure quality health care. The standards do not provide a tool for evaluating the actual quality of the services provided. For example, one of the standards is that the health plans have two disease management programs. By using the Quality Improvement Standards TEAMonitor can verify that two disease management programs are in place, but they could not evaluate or measure the actual quality of care or the outcomes of the programs.

The HCA's contract with health plans requires plans to report on performance measures. However, the focus of these measures is on customer service and administrative functions, not on health outcomes. Without health outcome measures, the HCA cannot evaluate the extent to which enrollees are receiving the care that they need to improve their overall health.

Without clear guidance and direction from the HCA concerning performance expectations, it is difficult to hold health plans accountable for their performance serving BHP enrollees.

Insufficient Monitoring of Health Plans to Ensure Quality Health Care Provision

The HCA's contract with health plans includes Quality Improvement Standards. During its annual two-day site visits to health plans, TEAMonitor, the interagency contract review team, reviews health plans based on these detailed standards relating to the processes and plans in place to ensure quality. But, as discussed above, these standards generally are not a tool that TEAMonitor can use to monitor the actual quality of the health care provided.

Additionally, TEAMonitor reviews HEDIS® data, a performance measurement tool used by the managed care community, to monitor health plans. However, the health plans are not required to separate BHP-specific HEDIS® information from their information on non-BHP commercial enrollees since some of the plans do not serve many BHP enrollees. But if health plans do not submit BHP-specific HEDIS® information, then this data is less effective in evaluating the performance of health plans in providing health care services to BHP enrollees.

In the course of our review, we found that the HCA's use of service utilization data is limited. The HCA's actuary uses that data to set rates and TEAMonitor reviews each health plan's utilization data during their annual site visits. This limited use of utilization data does not allow for detailed analysis of service utilization by BHP enrollees, which makes it difficult to determine the quality and specific nature of the care that health plans are providing to enrollees.

RECOMMENDATIONS

Throughout our interviews, there were indications that the new Health Care Authority administration is in the process of reviewing BHP contractual provisions, and reorganizing the administration of the program to better align the BHP with statutory program goals and objectives. In light of our findings and potential future changes to the program, JLARC's recommendations are designed to support the HCA's improvement initiative.

Recommendation 1

The HCA should develop goals and objectives for the BHP, focused on the statutory requirements to (1) assure quality; (2) use evidence-based treatment; and (3) explore chronic disease management.

Legislation Required:	None
Fiscal Impact:	JLARC assumes this can be provided within existing resources.
Completion Date:	September 2006

An implementation plan for the goals and objectives should be developed with input from the Legislature, legislative staff, and the health plans that contract with the BHP.

Recommendation 2

The HCA should develop more specific guidelines and performance requirements for future contracts, including defining key terms and developing clinical health-related performance measures for the health plans. At a minimum, this should include:

- **Specific care guidelines and reporting requirements for chronic conditions;**
- **Definitions of evidence-based care; and**
- **Uniform performance outcome measures that are aligned with the statutory requirement to provide quality health care.**

Legislation Required:	None
Fiscal Impact:	JLARC assumes this can be provided within existing resources.
Completion Date:	December 2006

The Basic Health Plan should work with the HCA Medical Director to determine appropriate care guidelines and clinical health-related performance measures.

Recommendation 3

The HCA should improve its system of monitoring health plans. This should include:

- **The application of quality assessment tools to monitor the level and type of health care provided by the health plans specifically to BHP enrollees;**
- **Analysis and use of service utilization data to evaluate the quality and type of care provided specifically to BHP enrollees and to minimize costs; and**
- **A process for analyzing clinical health-related performance measures collected in new contracts and reporting this information to the Legislature.**

Legislation Required:	None
Fiscal Impact:	Will vary based on the specifics of the tools and processes that the HCA develops.
Completion Date:	January 2008

AGENCY RESPONSES

We shared the report with the Washington State Health Care Authority (HCA) and the Office of Financial Management (OFM) and provided them an opportunity to submit written comments. Their written responses are included as Appendix 2. JLARC's comments on these agency responses follow as Appendix 2A.

ACKNOWLEDGEMENTS

We appreciate the assistance provided by the Health Care Authority staff.

Ruta Fanning
Legislative Auditor

On January 4, 2006, this report was approved for distribution by the Joint Legislative Audit and Review Committee.

Representative Ross Hunter
Chair

APPENDIX 1: SCOPE AND OBJECTIVES

Basic Health Plan Study: Part 1

SCOPE AND OBJECTIVES

SEPTEMBER 2005

STATE OF WASHINGTON
JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE

STUDY TEAM

ISABEL MUÑOZ-COLÓN
CYNTHIA L. FORLAND

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RUTA FANNING

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MANDATE

The 2005-07 Operating Budget directs JLARC to conduct a performance audit of the Health Care Authority's (HCA) Basic Health Plan (BHP). The BHP provides health insurance coverage to low-income residents of Washington State. This JLARC study will be the first part of a two-part review of the BHP. **Part 1** of the BHP review, which is to be completed by December 2005, will examine the extent to which the BHP's policies and procedures promote or discourage the provision of appropriate, high-quality, cost-effective care for enrollees of the plan. **Part 2**, which is to be completed by July 2006, will have a separate scope and objectives document and will address questions related to the characteristics of BHP enrollees.

BACKGROUND

In 1987, the Legislature established the Basic Health Plan with the intent of providing or making more readily available basic health care services for low-income Washington residents. To qualify for the BHP enrollees must (1) not be eligible for Medicare and (2) have a gross family income at or below 200 percent of the federal poverty level.

The Basic Health Plan was created originally as an independent state agency with its own administrator and staff. In 1993, the BHP merged into the Health Care Authority. Currently, the Basic Health Plan provides state-subsidized coverage to approximately **101,000 people**. For fiscal year 2005, the BHP has budgeted approximately **$222 million** toward health plan benefits and $7 million for program administrative costs.

As directed in statute—and within budget constraints—BHP benefits are determined by the HCA Administrator. The Health Care Authority pays premiums directly to the managed health care systems, based on age and negotiated rates by county, with BHP enrollees paying a portion of the premium. The amount enrollees pay is determined on a sliding scale based on their age, family size, gross family income, county of residence, and health plan chosen by enrollee.

SCOPE

In this study, JLARC will focus on the Health Care Authority's management of the state-funded Basic Health Plan. This audit

will not include a review of the Maternity Benefits Program or the Basic Health Plus Program for low-income children because Medicaid funds these two programs and program eligibility is determined by the Health Recovery Services Administration (HRSA) located in Department of Social and Health Services.

OBJECTIVES

The objective for this study is to determine the extent to which HCA is ensuring that their contracted managed health care systems are providing appropriate, high-quality, cost-effective care. As directed by proviso language in the 2005-07 Operating Budget, JLARC will address the following questions in this review:

1. How and to what extent are enrollees encouraged to engage in wellness activities and receive preventative services?
2. How does the Health Care Authority identify and promote evidence-based treatment strategies in the BHP?
3. Are enrollees in the BHP encouraged to use high-quality providers? What criteria does the HCA use to determine the quality of providers?
4. How does the HCA identify BHP enrollees with chronic and other high-cost conditions? Also, how does the HCA ensure that appropriate interventions are provided for those enrollees?
5. How does the HCA encourage innovative health care service delivery methods?

TIMEFRAME FOR THE STUDY

Preliminary report to JLARC in November of 2005 and the final report in January of 2006.

JLARC STAFF CONTACT FOR THE STUDY

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APPENDIX 2: AGENCY RESPONSES

- Washington State Health Care Authority

- Office of Financial Management

JLARC's Comments on agency responses follow as Appendix 2A

Washington State
Health Care Authority

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December 12, 2005

Ruta Fanning
Legislative Auditor
Joint Legislative Audit and Review Committee
506 16th Avenue SE
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Dear Ms. Fanning:

Thank you for the opportunity to review and comment on the Joint Legislative Audit and Review Committee (JLARC) preliminary report on the "Basic Health Plan (BHPP) Study: Part I." As you will see, we partially concur with the recommendations of your report and our response outlines steps we intend to take to meet your recommendations. Conversely, we provide comments in areas where your report overlooked or misinterpreted the efforts currently in place which promote or discourage the provision of appropriate, high-quality, cost effective care.

RECOMMENDATION	AGENCY POSITION	COMMENTS
Recommendation 1: HCA should develop goals and objectives for BHP focused on: assuring quality, using evidenced-based treatment, and exploring chronic disease management	Partially Concur	The HCA has adopted through contract, and oversees through TEAMonitor, standards for quality, developed by the National Committee for Quality Assurance (NCQA). The quality measurements of our program encompass more than 60 standards and 40 health parameters in auditing our health plans. The HCA, under the direction of Governor Gregoire and the leadership of Steve Hill, is currently involved in inter-agency and community-led efforts to incorporate higher quality, evidence-based treatment, and chronic disease management into its health care procurement activities.

Recommendation 2 HCA should develop specific guidelines and performance requirements for contracts with health plans	Partially Concur	Current HCA/BHP contracts require health plans to adopt NCQA standards which incorporate health outcomes and chronic disease management guidelines established by organizations such as the American Diabetes Association and the American Heart and Stroke Association. JLARC recommendations are in alignment with the current efforts of the Health Quality and Efficiency work group and coincide with the Governor's emphasis on accountability (i.e., Government Management, Accountability and Performance program - GMAP).
Recommendation 3 HCA should improve its system of monitoring health plans: application of quality assessment tools, analysis and use of service utilization data, analysis of health-related performance measures	Partially Concur	The HCA/BHP licenses rights to utilize the highly-regarded NCQA performance assessment tool. The use of this tool both supports administrative simplification in the monitoring of health plans and ensures a consistent and accurate assessment of quality performance. Work is underway at the HCA to incorporate service utilization data into its procurement efforts, recognizing the collection of this information will require additional resources and budget allocation to manage, monitor, and report data consistently and reliably.

Since last April, the HCA, under directives of the Governor, has been working with other state agencies to address the problem of increasing health care costs, inefficiency in the delivery of health care, and the lack of consistent and transparent information both at the patient and insurer level. The Health Quality and Efficiency work group established five key objectives which align with the findings of the JLARC study. They are:

1) Increased use of evidence-based health care,
2) Focus on wellness,
3) Better management of chronic care,
4) Transparency in health care information; and
5) Improved health information technology.

As we formed our responses to the Committees recommendations, we struggled with the scope of the directives specific to Basic Health. Our program's members are in the same predicament as all citizens of the state. Health plans do not have the authority to choose whether to pay when care is inconsistent with their quality standards. Evidence-based medicine is one way to take on this issue but it is much bigger than Basic Health and in order for it to be effective it must be incorporated into all standards of care, across all health plans, impacting all lines of business, and incorporating every person in the state of Washington who receives and delivers care. As Senator Thibaudeau noted during the JLARC meeting, is Basic Health being held to a higher standard than is a reality in the health care industry?

The challenge is much greater than Basic Health and requires far more than contractual changes to our procurements or special quality measuring tools. It requires leadership and legislative guidance.

Recommendation 1: NCQA accredits and certifies, through a rigorous and comprehensive review, a wide range of health care organizations including managed care organizations and disease management programs. The NCQA has been the central national figure for driving health care quality and its seal is widely recognized and sought. These attributes are precisely why the HCA selected the NCQA assessment tool to conduct our audits of participating health care plans in Basic Health (BHP) and Public Employees Benefit Board (PEBB). The five state contracted health plans are monitored by an intra-agency audit team, TEAMonitor, which has been in existence for ten years. TEAMonitor is led by the HCA Medical Director and is staffed by HCA, DSHS (Medicaid), and Department of Health (DOH). TEAMonitor audits for such things as under-over utilization, appeals and grievances, denials of care, chronic disease management, and provider credentialing. As a point of clarification in the JLARC presentation: patient data and claims *are* reviewed during a health plan's audit. The JLARC auditors reported during their presentation to the committee that TEAMonitor audited a process rather than actual member records. TEAMonitor is more than an auditing process; it researches for results at the patient level and at the point of treatment, with the provider.

Can the HCA do more? Absolutely. Our objective is to lead the state by procuring innovative, cost-effective, and efficacious health care delivery. Governor Gregoire's strategic plan seeks to accomplish this for Basic Health and all state agencies that purchase health care.

Recommendation 2: Evidence based guidelines are clinical practice standards known to be effective in improving health outcomes. If a health plan has not adopted guidelines from an evidenced-based source, then an appropriate board-certified specialist(s) from the specific specialty provides guidance. Because of this, many evidenced-based guidelines are similar, but not exact. The HCA is working in collaboration with the Foundation for Health Care Quality, Washington Healthcare Forum, National Quality Forum, and the Puget Sound Health Alliance to use the same evidenced based guidelines

throughout Washington. This brings consistency to care management and its subsequent evaluation while improving quality and outcomes.

The HCA will clarify in our contracts, specific quality improvement measurements around acute, chronic and preventive measures through the use of national standards or benchmarks. The universal guidelines must align with both state and community efforts in chronic disease and prevention initiatives in order for the collection of data to be statistically relevant. In separating HEDIS data to the BHP level, we run the risk of reaching statistically irrelevant conclusions – this is why we do not ask for our HEDIS data to be separated today.

The procurement strategies we are developing today will emphasize evidence-based treatment, utilization of health care data, and quality improvement standards and will reflect the Governor's intention to report measures that are predictors of good health outcomes. Agencies and programs, like HCA and BHP, will be directed to include a comprehensive set of performance measures based on regulatory requirements, demographic characteristics and potentially actual disease burden in the populations being served. This requirement will apply to Basic Health contracts as well as contracts for state employee health benefits (PEBB) and the Department of Social and Health Service's Healthy Options program.

As we mentioned earlier, contracting for this data is only the first step - collecting, managing and reporting it will require resources. We are optimistic JLARC's focus on these areas will be followed by legislative support in securing the necessary resources for our agency to ensure the delivery of the committee's recommendations.

Recommendation 3: Efforts to improve our system for monitoring health plans has been underway for some time, in addition to legislative direction to focus our efforts on cost-reductions and ensuring the financial eligibility of enrollees. The JLARC study indicates Basic Health's focus on administrative performance measures, such as average speed of answer and turnaround time for ID card issuance, has occurred at the expense of quality health care. This simply is not correct.

HCA's efforts to monitor and analyze clinical-related performance measures occur today, under our current contracts. TEAMonitor ensures corrective action plans are issued when health plans are not in compliance with our contract. At a minimum, contracted health plans must have quality improvement for cardiovascular disease, the 4th DTaP in the immunization cycle, and improved Chlamydia screening.

Under TEAMonitor, any health plan's HEDIS (Health Employer Data Information Set) measure that is below national benchmarks (Healthy People 2010) is reviewed. If a carrier has not met these metrics, TEAMonitor members require a plan of action for improvement or analysis of the barriers to reach this performance level.

Health plan disease management programs are evaluated in accordance to NCQA standards. The programs include cardiovascular disease, diabetes, asthma, back pain,

high risk pregnancy, depression and others depending on the population. The JLARC recommendation to report to the Legislature in January 2008, will add public accountability and transparency to the process.

JLARC staff referenced other states whose health care programs better ensure quality health care (Massachusetts, Wisconsin, and Oregon). We are confident JLARC recognizes that simply reporting data and information is not an indicator of quality health care service. In the case of Oregon, encounter data was provided as a requirement of the state's contract with health plans. As Barney Speight, Deputy Administrator for the Health Care Authority, reported, managing and using this data effectively to guide health care purchasing decisions is not without challenges; however, with legislative support and executive guidance, we are prepared to undertake this initiative.

Additionally, the Governor has launched the Government Management, Accountability and Performance (GMAP) Program. In those forums, agency directors report to the Governor on key management and policy challenges. I have had the privilege in the past to report on the following health care performance and quality measures:

- Tracking annual increases in the cost of Basic Health
- Using health plan and provider information to evaluate and improve quality, including:
  - Promoting the transparency/clarity of health plan and provider information and performance
  - Working with Puget Sound Health Alliance (PSHA) to develop data warehouse/decision-support system capabilities as tools to evaluate provider quality and cost
  - Developing a plan to support and encourage the success of PSHA and other collaborative efforts.
- Using medical evidence to guide coverage decisions, including:
  - Implementing evidenced-based assessment of new technologies and coverage decisions across agencies
  - Using evidence-based assessments to inform state reimbursement priorities.

In addition to the above areas of measurement reported to the Governor by way of GMAP, the Health Care Authority and Basic Health remain committed to ensuring exceptional administrative performance, not only from our health plan partners but internally. We recognize the urgent need for access to health care. That is why we must respond to calls in a timely manner, must process applications and appeals accurately, we must ensure ID cards are issued *before* a BHP member goes to the pharmacy, and that every person utilizing Basic Health is rightfully entitled to this benefit. Failing to hold ourselves and our plan partners accountable in these areas, in equal measure, would be irresponsible and would be a disservice to Basic Health members, many of whom struggle with just going to the doctor, as well as to the state's taxpayers. So we will continue to monitor and report on these performance metrics along with clinical quality outcomes.

I appreciate the opportunity to respond to JLARC's audit. The HCA recognizes we have room for improvement and stands ready to address any and all shortcomings in our program. We have confidence in the leadership of our Governor on these matters and will incorporate the recommendations of this audit as we pursue these changes in collaboration with purchaser, provider, and health plan colleagues through the Puget Sound Health Alliance. We appreciate the Legislature's long support of Basic Health and look forward to continued operational efficiency under its guidance.

Sincerely,

Steve Hill BS

Steve Hill
Administrator

cc: Victor Moore (OFM)
Barney Speight (HCA)
Beth Dupre (BHP)

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December 13, 2005

Ms. Ruta Fanning
Legislative Auditor
Joint Legislative Audit and Review Committee
506 - 16th Avenue SE
Olympia, WA 98501-2323

Dear ~~Ms. Fanning~~ Ruta:

Thank you for inviting the Office of Financial Management to review and comment on the Joint Legislative Audit and Review Committee's (JLARC) preliminary report on the "Basic Health Plan Study: Part I." I am writing to offer the following responses to your specific recommendations and to highlight the direction Governor Gregoire is taking on health care quality and accountability.

RECOMMENDATION	AGENCY POSITION	COMMENTS
Recommendation 1	Concur	As outlined below, the Health Care Authority, under the direction of Governor Gregoire, is a key participant in the five-point Health Quality and Efficiency Project involving all state health-purchasing agencies. This recommendation is consistent with this direction.
Recommendation 2	Concur	This recommendation, again, is in line with the health quality and efficiency work under way, as well as the Governor's emphasis on measuring accountability through the Government Management, Accountability and Performance (GMAP) program.
Recommendation 3	Partially concur	This recommendation aligns with the Governor's goal to better utilize data to improve health quality. It will be incumbent upon OFM and the Legislature to assess staff resources available to accomplish this goal, and to balance efforts for increased data against recent work undertaken to reduce the administrative burden of providers.

By way of background, when Governor Gregoire appointed Steve Hill as administrator of the Health Care Authority last April, she asked him to tackle the problem of ongoing double-digit health cost growth that takes an ever-larger bite out of the state budget. In response, Mr. Hill and a group of state agency directors and staff developed a long-term, five-point strategic plan that the Governor will kick off in her 2006 supplemental budget and legislative proposal. The goal of the plan is to

ensure state health dollars are spent on services that improve health outcomes and not spent on services that are unnecessary, ineffective, duplicative, or unsafe.

The five strategies for accomplishing this goal are to:

1) Emphasize evidence-based health care
2) Promote prevention, healthy lifestyles, and healthy choices
3) Better manage chronic care
4) Create more transparency in the health system, and
5) Make better use of information technology.

JLARC's first recommendation to focus on (1) ensuring quality; (2) using evidence-based treatments, and (3) exploring chronic disease management is in accordance with the Governor's strategic plan for all state health care purchases, including for the Basic Health program.

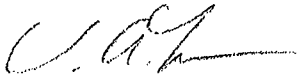
Recommendation 2 speaks directly to the Governor's intention to direct state agencies that purchase health care through managed care contracts to include requirements in their upcoming contracts to report on measures that are predictors of good health outcomes. These requirements will apply to Basic Health contracts as well as those for state employee health benefits and the Department of Social and Health Services' Healthy Options program.

The third recommendation is consistent with the five-point strategy outlined above, especially in its emphasis on increased transparency in the health system. Lack of robust information about health quality and costs, and the resulting challenge for both consumers and purchasers to make use of such information in making decisions, is characteristic of the health care system throughout the country and is not specific to our state's Basic Health program.

Finally, the focus on measurement and accountability can be seen in the newly-launched Government Management, Accountability and Performance (GMAP) program where the Governor personally presides over performance review sessions. In those forums, agency directors report regular to the Governor on the most important management and policy challenges. Steve Hill will report on relevant items during GMAP sessions including: using health plan and provider information to evaluate and improve quality; promoting the transparency/clarity of health plan and provider information and performance; working with Puget Sound Health Alliance (PSHA) to develop data warehouse/decision-support system capabilities as utilization review tools to evaluate provider quality and cost; and using medical evidence to guide coverage decisions

We are pleased your recommendations are consistent with work that has been initiated, and we are eager to work with you and other legislative partners to advance the Governor's health priorities.

Sincerely,



Victor A. Moore
Director

APPENDIX 2A – JLARC'S COMMENTS ON AGENCY RESPONSES

We are pleased that the Health Care Authority's (HCA) response to the JLARC report recognizes room for improvement in the Basic Health Plan (BHP) and that the HCA plans to incorporate JLARC's recommendations as they pursue changes in their management of the BHP. We also recognize that additional resources may become necessary to fully implement JLARC's recommendations.

We would like to clarify some of the issues that the Health Care Authority mentioned in their response. The Health Care Authority raises the question of whether the Basic Health Plan is being held to an unrealistic standard given the current state of the health care industry. Our report did not set new standards for the BHP, but explored the issues identified in the study mandate included in the 2005-07 Operating Budget. Further, for each of the issues identified by the Legislature, we reviewed relevant statutory provisions, which in some cases apply not only to the BHP but also to a broader range of state health care programs. As we developed our recommendations for the BHP, we considered practices in other states that demonstrate the possibility of additional progress in the provision of state-funded health care.

As discussed in the report, TEAMonitor does review each health plan's health care service utilization data on site with health plans during its annual two-day site visits. However, the Health Care Authority does not regularly collect or maintain this data, which limits its ability to perform analysis of service utilization.

Finally, we agree that the administrative and customer service performance measures that the Health Care Authority monitors are important. Our report specifically states that these measures are useful performance indicators. Our concern is that the HCA does not have additional measures related to the health outcomes of Basic Health Plan enrollees. Without health outcome measures, the HCA cannot evaluate the extent to which enrollees are receiving the care that they need to improve their overall health.