BASIC HEALTH PLAN STUDY: PART 1

PROPOSED FINAL REPORT

REPORT DIGEST

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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.