

2007 External Quality Review Annual Report

**Washington State Healthy Options and State Children's
Health Insurance Program**

Washington Medicaid Integration Partnership

Medicare/Medicaid Integration Project

December 2007

Presented to Washington State Department of Social & Health Services,
Health and Recovery Services Administration

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Executive Summary

The federal Balanced Budget Act of 1997 (BBA) requires each state to implement a strategy for assessing and improving the quality of health care delivered to Medicaid enrollees by managed care organizations. The BBA also requires an annual, independent external quality review (EQR) of enrollees' access to services and of the quality and timeliness of those services. Aumentra Health produced this EQR annual report on behalf of the Washington State Department of Social & Health Services (DSHS), Health and Recovery Services Administration (HRSA). The report builds on the findings of previous EQR annual reports in 2005 and 2006.

Analytical approach

Federal regulations require the EQR annual report to describe how conclusions were drawn regarding the access, timeliness, and quality of care furnished by the health plans. To facilitate a systems approach to this analysis, Aumentra Health created composite measures of

- *access* to care—the process of obtaining needed health care
- *timeliness* of care—the time frame in which a person obtains needed care
- *quality* of care—the process and experience of receiving care

To evaluate these composite measures, Aumentra Health used data elements from individual reports produced for HRSA in 2007, covering the results of studies on

- health plan performance in key clinical areas
- Medicaid client families' satisfaction with services provided for adult enrollees, including those with chronic conditions
- health plans' compliance with BBA regulations and state contractual requirements

Separately, this report presents quality measurements for the Washington Medicaid Integration Partnership, a pilot project aimed at improving health care for elderly and disabled residents who are eligible for both Medicaid and Medicare coverage and who have complex healthcare needs. The 2006 annual report reported baseline data for some of these measurements.

The current report also discusses the Medicare/Medicaid Integration Project (MMIP), a state demonstration project for Medicare- and Medicaid-eligible clients age 65 and older in King and Pierce counties.

State-level highlights

Aumentra Health identified these high-level strengths of the Medicaid managed care program:

- State law enacted in March 2007 expands children's access to health care, increases primary care payments, and calls for system changes to ensure that all children get regular care from a medical home that provides preventive and well-child care (WCC) services and referral to needed specialty services. The law requires state agencies to identify health improvement goals for children and to adopt innovative purchasing strategies to achieve those goals. DSHS has developed an outline for a five-year program aimed at ensuring the delivery of care for children within a medical home.
- Value-based purchasing (pay for performance) incentives in HRSA's contract with managed care plans have spurred improvement in childhood immunizations and WCC

visit rates. Beginning in 2009, DSHS plans to link provider rate increases to quality improvement (QI) measures related to provision of a medical home, and to develop contract incentives for providers and health plans that achieve sustained improvement in those measures through use of evidence-based practices.

- The Healthy Options plans continue to perform at or above the national Medicaid average in several clinical measures, including access to primary care for children and adolescents, diabetes care, and timely prenatal and postpartum care. The percentage of children receiving all recommended immunizations has climbed steadily since 2002.
- HRSA has restructured, forming a new division that includes a quality monitoring section. This section will help ensure the integration of EQR results into the state's QI activities in accordance with the managed care quality strategy.

Recommendations

Building on the recommendations presented in previous EQR annual reports, Acumentra Health recommends that HRSA

- ***update its managed care quality strategy*** to reflect HRSA's new organizational structure—in particular, the planned integration of physical and mental health care and the creation of HRSA's new quality monitoring section
- ***continue to use value-based purchasing*** in its managed care contract with health plans and encourage the plans to develop strategies to implement pay for performance at the clinic or provider level
- ***continue work to improve the delivery of preventive care for children*** through focused studies, collaborating with health plans to provide performance feedback to providers, and continuing support for the Children's Health Improvement Collaborative
- ***continue to refine and standardize the TeaMonitor review process and scoring methods*** to define clear expectations for the health plans and to make year-to-year comparisons more meaningful and reliable
- advise or recommend that health plans ***study barriers to collecting adequate administrative data for HEDIS measures***
- require health plans to ***address the specific recommendations of the EQR report***

Introduction

Washington's Medicaid managed care program, administered by HRSA, provides healthcare benefits for more than 900,000 low-income residents, approximately half of whom are enrolled in the Healthy Options program. Approximately 2,900 residents are enrolled in the Washington Medicaid Integration Partnership (WMIP), a pilot program for elderly, blind, and disabled clients in Snohomish County. The healthcare needs of these enrollees are met through HRSA's contracts with managed care plans that, in turn, contract with healthcare providers. In addition, about 230 clients are enrolled in the Medicare/Medicaid Integration Project (MMIP), which combines medical and long-term care services for Medicare and Medicaid clients age 65 and older in King and Pierce counties.

BBA regulations require that every state Medicaid agency that holds contracts with managed care plans must evaluate and report on specific health plan activities. Aumentra Health, as the external quality review organization (EQRO) for HRSA, presents this annual report to fulfill the federal EQR requirements. As required, the report evaluates access to care for Medicaid managed care enrollees, the timeliness and quality of care delivered by health plans and their providers, and the extent to which each health plan addressed recommendations for quality improvement from the previous year's review.

The report includes information from the following activities, conducted in accordance with the protocols approved by the Centers for Medicare & Medicaid Services (CMS):

- validation of performance measures reported by health plans or calculated by the state
- validation of performance improvement projects (PIPs)
- a review of each health plan's compliance with standards established by the state for access to care, structure and operations, and quality measurement and improvement

EQR activities may encompass optional activities, such as administration or validation of consumer surveys and studies that focus on the quality of clinical or nonclinical services. This annual report presents the results of one such activity, the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) survey.

Aumentra Health gathered and synthesized the results from the above-mentioned activities to develop an overall picture of the quality of care received by Medicaid enrollees in Washington. Results at the state level and for each health plan are compared with national trends published by the National Committee for Quality Assurance (NCQA). The analysis assesses each health plan's strengths and opportunities for improvement and suggests ways that HRSA can help health plans improve the quality of the services they provide.

Washington's Medicaid managed care programs

Healthy Options

The Healthy Options program provides comprehensive medical benefits to low-income families, children younger than 19, and pregnant women who meet income requirements. Managed care programs also include Basic Health Plus, providing reduced-cost coverage to qualified residents, and the State Children's Health Insurance Program, covering families who earn too much money to qualify for Medicaid, yet cannot afford private insurance.

Medicaid eligibility is determined by federal poverty guidelines, issued annually by the U.S. Department of Health and Human Services. Historically, Washington has chosen to fund its Medicaid program above the federal minimum standard to cover additional low-income residents. Recent state legislation enacted the following changes in Medicaid eligibility and benefits:

- expanded Medicaid coverage to all children in families up to 250 percent of the Federal Poverty Level (FPL), or \$51,635 for a family of four, as of July 22, 2007, and required premiums for families with incomes above 200 percent of the FPL, or \$41,300 for a family of four
- expanded coverage to 300 percent of FPL (\$61,950 for a family of four) by January 2009; families with higher incomes may buy coverage
- appropriated \$63 million to cover 38,500 new children, including allocation for outreach and health education
- required DSHS to develop performance measures by December 2007 that link targeted provider rate increases to QI measures in January 2009

Currently, Washington serves an average of about 500,000 Medicaid enrollees in managed care at an annual cost of \$1 billion, and a roughly equal number of clients in fee-for-service programs, at a cost of \$2.5 billion. More than 80 percent of Healthy Options enrollees are younger than 19 years old.

In 2006, seven health plans served Medicaid managed care enrollees. Table 1 shows the approximate number and percentage of enrollees assigned to each health plan as of December 2006. Molina Healthcare of Washington serves nearly half of all enrollees, and Community Health Plan serves more than one-quarter. Figure 1 shows the counties served by each health plan.

Table 1. Healthy Options health plans, acronyms, and enrollees served, December 2006.

Health plan	Acronym	Number of enrollees	% of all enrollees
Asuris Northwest Health	ANH	1,306	<1
Community Health Plan	CHP	139,045	28
Columbia United Providers	CUP	30,534	6
Group Health Cooperative	GHC	16,734	4
Kaiser Permanente Northwest	KPNW	1,062	<1
Molina Healthcare of Washington	MHW	245,011	49
Regence BlueShield	RBS	34,768	7

HO/SCHIP Service Areas 2006

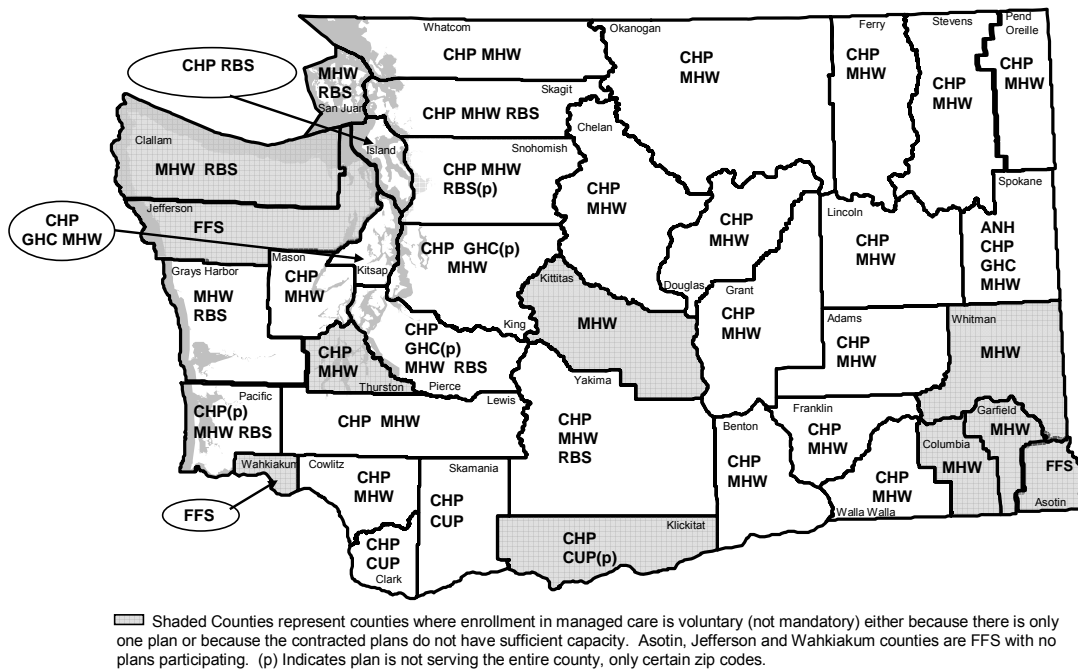


Figure 1. Distribution of Healthy Options health plans in Washington counties.

During 2006, at least one Healthy Options plan was active in 37 of the state's 39 counties. Enrollment is voluntary in some counties, either because only one health plan serves the county or because the contracted plans lack the provider network to accept new enrollees. Two rural counties, Asotin and Wahkiakum, have no Medicaid managed care providers, so Medicaid clients living in those counties may obtain their health care from fee-for-service providers.

Washington Medicaid Integration Partnership (WMIP)

This Medicaid pilot project, aimed at improving care for elderly, blind, and disabled residents of Snohomish County who have complex healthcare needs, began in January 2005. The project seeks to coordinate Medicaid-funded medical, mental health, substance abuse, and long-term care within a patient-centered framework. Molina, the managed care vendor, coordinates these services for WMIP clients. As of April 2007, about 2,700 clients were enrolled in WMIP.

Medicare/Medicaid Integration Project (MMIP)

In June 2005, the state launched this demonstration project for Medicare- and Medicaid-eligible clients age 65 and older in King and Pierce counties. The MMIP focuses on preventive care and coordination to improve health outcomes and reduce expenditures for dual-eligible clients who are at home and who are frail. Evercare Premier coordinates medical and long-term care services for these clients. Enrollment is voluntary; as of October 2007, the MMIP had 230 enrollees.

State quality improvement activities

HRSA conducts and oversees a combination of mandatory and optional QI activities related to Medicaid managed care, as described below.

Managed Care Quality Strategy

HRSA's *Managed Care Quality Strategy* incorporates elements of the managed care contract, state and federal regulations, and CMS protocols related to assessing and improving the quality of services for Medicaid enrollees. Acumentra Health evaluated the quality strategy in August 2005 and found that it complies with the majority of federal standards regarding enrollee access, managed care structure and operations, and measurement and improvement.

Performance improvement projects

HRSA's managed care contract requires each health plan to conduct at least five PIPs, three clinical and two nonclinical. The PIPs must be designed to achieve and sustain significant improvement in areas expected to have a favorable effect on health outcomes and enrollee satisfaction. HRSA validates the PIPs' compliance with CMS standards through the TeaMonitor reviews. The scoring methodology for the PIPs is rigorous; a health plan must demonstrate compliance in 12 areas to receive a "Met" score. The Healthy Options contract requires a health plan to conduct a PIP to improve immunization and/or WCC rates if the plan's reported rates fall below established benchmarks.

Performance measurement

HRSA takes steps to ensure that the Medicaid managed care plans meet national benchmarks for performance. The managed care contract incorporates language based on NCQA accreditation standards related to quality management and improvement, utilization management, and enrollee rights and responsibilities. The contract contains specific provisions regarding the performance measures described below.

HEDIS®

Since 1998, HRSA has used the results of health plan performance in clinical measures from the Health Plan Employer Data & Information Set (HEDIS®)* for quality measurement. Valid and reliable, the HEDIS measures allow comparison of Washington health plans' performance with national aggregated averages for the Medicaid population.

In 2007, HRSA required each health plan (except for Asuris) to report HEDIS rates for

- childhood immunization status
- chlamydia screening in women
- comprehensive diabetes care
- use of appropriate medications for clients with asthma
- access to primary care practitioners (PCPs) for children and adolescents
- prenatal and postpartum care
- well-child care (WCC) visits for infants, children, and adolescents
- utilization of inpatient, ambulatory, and newborn care

* HEDIS is a registered trademark of the National Committee for Quality Assurance.

For the WMIP, Molina reported HEDIS rates for comprehensive diabetes care, utilization of inpatient and ambulatory care, and inpatient nonacute care utilization, as well as data on several non-HEDIS measures. For the MMIP, Evercare reported HEDIS rates for utilization of inpatient and ambulatory care, plus data on several non-HEDIS measures.

To ensure data integrity, NCQA requires certification of each health plan's data collection process by a certified HEDIS auditor. HRSA funded the 2007 HEDIS audit for Washington health plans to fulfill the BBA requirement for validation of performance measures. Molina (for the WMIP) and Evercare (for the MMIP) underwent a certified HEDIS audit that incorporated HEDIS validation of performance measures and CMS's Information Systems Capabilities Assessment tool.

CAHPS®

CAHPS surveys, developed and managed by the Agency for Healthcare Research and Quality (AHRQ), are designed to measure patients' experiences with the healthcare system. The survey includes questions for adults and for parents and guardians of children age 17 and younger. The results characterize patients' experiences in five domains: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making. HRSA and the Healthy Options plans use CAHPS results to evaluate their performance and to set goals for improvement. If a health plan's CAHPS scores fall below national benchmarks in areas designated by HRSA, the plan is required by contract to conduct a PIP aimed at improving performance in those areas.

Although the CAHPS survey is optional under CMS protocols, HRSA elects to incorporate the annual CAHPS data into state QI activities to reflect the voice of the consumer in the evaluation of access, quality, and timeliness of care. HRSA has taken steps to reduce the health plans' cost burden for conducting an annual survey. The current contract requires each plan to fund the adult CAHPS survey every other year; in alternating years, HRSA funds the child survey. The 2007 CAHPS survey sought responses from adults.

NOTE: As part of its Ambulatory CAHPS initiative, AHRQ replaced the CAHPS 3.0 Adult Survey with the CAHPS 4.0H, Adult Version. Because of revisions and changes in composites, the 2007 adult survey results cannot be compared with those from previous years.

TeaMonitor

HRSA participates with the state Health Care Authority (HCA) and the Department of Health (DOH) in TeaMonitor, an interagency, multidisciplinary team that oversees the state's managed care contracts. This approach is designed to achieve administrative efficiencies and to reduce the burden on contractors through a single annual on-site review of each health plan's compliance with federal and state regulations and contract provisions. After reviewing each health plan's compliance, auditors provide feedback to the plan. A plan that does not meet standards must submit a corrective action plan.

The TeaMonitor review requires detailed evidence and documentation of a plan's compliance with federal regulations and contract provisions. In 2007, the review rated health plans on more than 60 required elements of access, timeliness, and quality of care.

Value-based purchasing

Pay for performance is a leading strategy in state Medicaid agencies' efforts to improve the efficiency, timeliness, and quality of managed care.¹ Washington was one of the first states to incorporate value-based purchasing in its managed care contract. Since 2004, HRSA has provided incentive payments for improvement in WCC and childhood immunization rates, setting aside \$1 million per year for each measure. The incentive system rewards health plans on the basis of their performance on HEDIS rates relative to other health plans and on each plan's year-to-year improvement in its HEDIS rates relative to other plans. The plans receive pro-rated payments according to their rank in the performance scale.

The first payments to five health plans occurred in 2005; the top two plans, Molina and CHP, received approximately \$1.2 million and \$461,000, respectively. Beginning in 2006, the payment calculation formula was weighted more heavily for improvement over the prior year. The state paid \$781,528 to Molina, \$608,945 to CHP, and smaller amounts to other plans in March 2007. Incentive payments based on 2007 performance are expected in March 2008.

CHILD Profile

Clinics throughout Washington use DOH's CHILD Profile immunization registry, available online since 2004. Currently, about 75 percent of all Washington providers have data-sharing agreements with CHILD Profile (658 private and 202 public providers). As of June 2007, the registry contained about 5 million immunization records. The state uses the registry to increase monitoring of children's immunization status at the health plan and clinic levels. CHILD Profile has data-sharing agreements with similar registries in Oregon, Idaho, and Arizona.

CMS audit

During 2004, CMS audited HRSA to gauge the managed care program's compliance with BBA regulations. HRSA received the audit report in mid-2006. The report cited improvement opportunities in the areas of policies and procedures, program oversight, reporting, monitoring, technical assistance, corrective actions and enforcement, training, and finance.

The 2004 audit occurred before HRSA fully implemented the BBA standards in the TeaMonitor review; therefore, when CMS issued the audit report, HRSA already had responded to many of the findings. CMS conducted a follow-up site visit with HRSA in August 2007. A report of CMS's findings is pending.

Quality oversight

In response to the initial CMS audit, HRSA formed a quality oversight committee to review TeaMonitor results, recommend actions, and follow up on issues within the state's quality program. This committee held its first meeting in November 2006. More recently, HRSA has created a new Office of Quality and Care Management within the Division of Healthcare Services. The three sections of the new office focus on quality monitoring, managed care, and care management. The Quality Monitoring Section plans to examine EQR results across the Medicaid system as a whole. Planned activities for 2008 include joint educational meetings with the Healthy Options plans and the mental health regional support networks.

EQR activities

Table 2 summarizes the mandatory and optional EQR activities that HRSA has pursued and indicates which tasks and/or reports addressed those activities.

Table 2. Required and optional Medicaid managed care EQR activities.

Activity	How addressed
<i>Required</i>	
Validation of PIPs	TeaMonitor audits
Validation of performance measures	HEDIS audit by EQRO
Health plan compliance with regulatory and contractual standards	TeaMonitor audits
<i>Optional</i>	
Administration or validation of consumer or provider surveys of quality of care	CAHPS survey report by EQRO

Methods

BBA regulations provide a method for uniform oversight of Medicaid programs, based on each state's managed care quality strategy. This annual report combines results from HRSA's individual oversight activities to present a composite picture of care delivered to Washington Medicaid enrollees.

In aggregating and analyzing the data for this report, Acumentra Health used elements from the following reports produced for HRSA under the EQRO contract:

- 2007 HEDIS report of health plan performance in key clinical areas²
- 2007 CAHPS satisfaction survey of Medicaid adult clients³
- 2007 TeaMonitor reports on health plans' compliance with BBA regulations and state contractual requirements⁴

Each source report discusses the methodology for collecting and analyzing the specific data that appear in that report.

In addition, Acumentra Health developed a methodology for assigning statewide composite scores for access, timeliness, and quality, based on aggregations of the ratings for individual measures. The composite scoring procedure is described below.

Composite scoring

No standard method exists for measuring the quality of health care. HRSA and Acumentra Health used contract language, definitions of reliable and valid quality measures, and research literature to guide the approach to quality assessment.

Federal regulations require the EQRO to describe how conclusions were drawn regarding the access, timeliness, and quality of care furnished by the health plans. To address this requirement, Acumentra Health created composite measures of these three components of care. The definitions of these composites, derived from established theory and previous research, determined which HEDIS and CAHPS items fell into each composite.⁵

Quality of care is the most overarching composite, encompassing Access and Timeliness as well as the *process* of receiving care (e.g., the provision of treatment using evidence-based medicine) and the *experience* of receiving care, measured by the patient's perceptions. Although patient outcomes also are considered a component of quality of care, outcomes depend on numerous variables that may fall outside the provider's control, such as patients' adherence to treatment. Therefore, this assessment excluded measures of patient outcomes.

Access to care is the process of obtaining needed health care. Access encompasses measures that address a patient's experience *before* care is delivered. Access to care has an impact on patient experience as well as on patient outcomes.

Timeliness, a subset of Access, refers to the time frame in which a person obtains needed care. Timeliness of care is influenced by access to services, which can affect utilization of care, including appropriate care and over- or under-utilization of healthcare services.

Figure 2 illustrates the relationship of these components for quality assessment purposes.

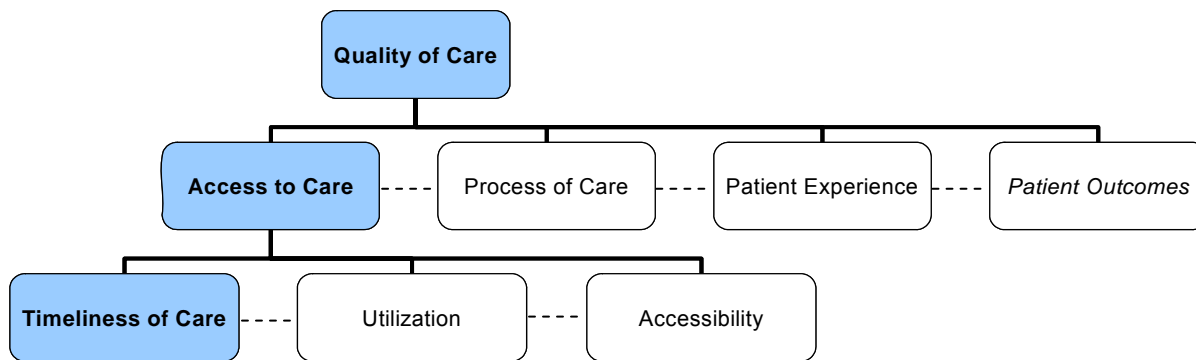


Figure 2. Components in measuring the quality of health care.

Acumentra Health delineated three categories for each composite—Prevention, Treatment, and Member Satisfaction—based on NCQA reporting categories and measures. The organization’s quality experts reviewed each HEDIS and CAHPS data element and assigned it to one of the three composite measures if it pertained directly to the composite definition. The quality experts compared analysis results and resolved discrepancies during a consensus meeting.

In the Statewide Results section, Acumentra Health’s analyses of access, timeliness, and quality are presented in table format with star ratings. The star ratings show the results of comparing Washington’s statewide score with the NCQA Medicaid national average for each element. State averages were calculated by adding individual plan numerators and denominators, dividing the aggregate numerator by the aggregate denominator, and multiplying the resulting proportion by 100. For the national comparison, Acumentra Health used the 2007 Medicaid averages from the NCQA *Quality Compass*.[®] These national averages, calculated with data from more than 250 health plans, represent national trends for plan performance.⁶

In Acumentra Health’s rating system, one star means that Washington scored within the 10th percentile of national scores; two stars, between the 10th and 25th percentile (below average); three stars, between the 25th and 50th percentile (average); four stars, between the 50th and 75th percentile, and five stars, above the 90th percentile (above average). Figure 3 shows the stars and the percentile ranges.

90th percentile	☆☆☆☆☆
75th percentile	☆☆☆☆
50th percentile	☆☆☆
25th percentile	☆☆
10th percentile	☆

Figure 3. Percentiles and star ratings used for this report.

Statewide Results

Access to health care

HRSA has multiple mechanisms in place to monitor health plans' success in providing access to care for Healthy Options enrollees. For example, the managed care contract requires each plan to demonstrate that its provider network has sufficient capacity to serve all eligible enrollees, in terms of the number and types of providers required, the geographic location of providers and enrollees, and enrollees' cultural, ethnic, and language needs. Each health plan must ensure timely access to services and must have an integrated system that monitors network capacity in relation to enrollee utilization patterns. Therefore, the results of the standardized performance measures discussed in this section offer only a partial evaluation of how well the plans are meeting access standards.

The basic definition of access is a person's ability to obtain health care at the time it is needed. However, no single concise measure of access exists; rather, the concept encompasses many factors, including time to next appointment, the patient's ability to see a specialist, the adequacy of the healthcare network, and the availability of transportation and translation services.^{7,8,9}

The Access to Care composite measure developed for this report comprises nine elements in the categories of Prevention and Member Satisfaction, as shown in Table 3.

Table 3. Elements, sources, and categories of the Access to Care measure.

Element	Source report	Category
Child/Adolescent Access to PCPs (for each of four age groups)	HEDIS	Prevention
Infant WCC Visits (6 or more)	HEDIS	Prevention
WCC Visit, 3 to 6 Years	HEDIS	Prevention
Adolescent WCC Visit	HEDIS	Prevention
Getting Needed Care	CAHPS	Member Satisfaction
Customer Service	CAHPS	Member Satisfaction

The HEDIS measure of access to PCPs for children and adolescents describes the percentage of enrollees in four separate age groups who had at least one visit with a health plan PCP. HRSA required Healthy Options plans to report this measure for the first time in 2006. The health plan reports percentages for

- children 12–24 months and 25 months–6 years of age who had a visit with a PCP during the measurement year
- children 7–11 and adolescents 12–19 years of age who had a visit with a PCP during the measurement year or the prior year

The WCC elements measure health plans' success in providing WCC visits. These HEDIS indicators capture the percentage of Medicaid children with the recommended number of WCC visits for their age group:

- Infants in the first 15 months of life should receive *six or more* WCC visits during this period.

- Children in the 3rd, 4th, 5th, and 6th years of life should receive *at least one* WCC visit each year.
- Adolescents ages 12–21 should receive *at least one* WCC visit each year.

For 2007, the CAHPS element of Getting Needed Care assesses the ease of getting appointments with specialists and getting the care, tests, or treatment that the client believed necessary. The Customer Service element assesses the extent to which written materials, the Internet, or the health plan's customer service provided information the enrollee needed; how often the health plan's customer service treated the enrollee with courtesy and respect; and whether the health plan gave the enrollee forms to fill out, or whether the forms were easy to fill out.

Access measure results

Table 4 provides a look at overall access to health care in Washington, based on the above elements.

Overall, *access to PCPs* continues to improve for children and adolescents served by Healthy Options plans, and exceeds the national Medicaid performance for all age groups. Washington's average 2007 performance fell within the 50th percentile of nationwide scores for all age groups except 12–24 months, which fell within the 75th percentile. Nearly all children ages 12–24 months and at least 86 percent of those in other groups had a visit with a PCP.

In contrast, the Healthy Options plans are not keeping pace with the national improvement in *WCC visits*, although Washington's average score increased from 2006 to 2007 for all age groups, significantly for 3-to-6-year-old and adolescent visits. Washington's adolescent WCC visit rate rose from the 10th percentile to the 25th percentile of nationwide scores. On average, about half of the infants, two-fifths of the children, and two-thirds of the adolescents in Healthy Options did *not* receive the recommended WCC visits during the measurement year.

Taken in combination, these results suggest that access to PCPs is *not* the primary barrier to increasing rates of preventive care for children in Healthy Options. Providers may be able to shift the focus of their efforts and resources from improving access to ensuring that preventive care is delivered once the child arrives for a visit. To capitalize on "sick" visits as an opportunity to perform or schedule needed preventive services, clinics must have

- systems in place to identify patients who are due or overdue for recommended preventive health screenings
- a method to alert schedulers to this need
- flexibility to convert a sick visit to a more comprehensive preventive exam

With regard to Member Satisfaction, Washington's average CAHPS score for Getting Needed Care is within the 50th percentile of nationwide scores. Overall, 75 percent of respondents said that access to needed care was "usually or always easy," compared with 74 percent of respondents across the nation.

Washington's average score for Customer Service was 74 percent. Because of changes in the CAHPS survey, NCQA considers Customer Service a first-year element and will not report the national average or percentile rankings in *Quality Compass* until 2008. The 2007 CAHPS scores cannot be compared with scores from the 2005 adult survey because of changes in the survey.

In 2006 and again in 2007, a priority analysis of the CAHPS data for Healthy Options plans identified these two measures as areas in which QI activities could be most beneficial in improving overall customer satisfaction.

Table 4. Washington scores and national averages for Access to Care elements.

Access to Health Care: A Statewide Look			
Element	National average	Washington score	Washington rating
Prevention			
Child/Adolescent Access to PCPs:			
Ages 12–24 months	94%	97%*	☆☆☆☆
Ages 25 months–6 years	85%	86%*	☆☆☆
Ages 7–11 years	86%	88%*	☆☆☆
Ages 12–19 years	83%	87%*	☆☆☆
Infant WCC Visits (6 or more)	56%	48%*	☆☆
WCC Visit, 3–6 years	67%	59%*	☆
Adolescent WCC Visit	44%	36%*	☆☆
Member Satisfaction			
Getting Needed Care	74%	75%	☆☆☆
Customer Service	—	74%	—

Stars represent Washington's performance compared with the 2007 NCQA percentile rankings for Medicaid HEDIS and CAHPS. One star (lowest) represents the 10th percentile, five stars (highest) represent the 90th percentile.

*State percentage is significantly different from the NCQA percentage.

Note: Differences between state and national percentages may be larger than apparent because of rounding.

— NCQA does not report averages for first-year composites.

Statistical significance testing was not performed comparing the state average with the NCQA average for CAHPS.

Timeliness of health care

Timely access to health care is important because it can improve the quality of people's lives.¹⁰ Also, the cost of care is lower for enrollees and health plans when diseases are prevented or identified early. Presumably, the earlier an enrollee sees a medical professional, the sooner he or she can receive necessary healthcare services. Postponing needed care may result in increases in hospitalization and emergency room utilization.¹¹

HRSA has implemented multiple mechanisms to monitor timely access to care. The Healthy Options contract incorporates the BBA standards for timely access—for example, with regard to enrollee grievances, the timing requirements for filing, resolution, and notification all affect timely access. The contract requirements make health plans responsible for monitoring their networks to ensure that enrollees obtain care in a timely manner.

The Timeliness of Care composite measure comprises three elements in the categories of Prevention and Member Satisfaction, as shown in Table 5.

Table 5. Elements, sources, and categories of the Timeliness of Care measure.

Element	Source report	Category
Prenatal Care	HEDIS	Prevention
Postpartum Care	HEDIS	Prevention
Getting Care Quickly	CAHPS	Member Satisfaction

The HEDIS measures assess the timely initiation of prenatal care and postpartum visits for female enrollees who delivered a live birth during the measurement year:

- prenatal care: percentage who received a prenatal care visit in the first trimester or within 42 days of enrollment
- postpartum care: percentage who had a postpartum visit on or between 21 days and 56 days following delivery

The CAHPS element, Getting Care Quickly, measures the extent to which the enrollee got care that was needed “right away” and whether the enrollee got an appointment with a doctor or clinic as soon as needed.

Timeliness measure results

Table 6 offers a look at the overall timeliness of care in Washington, based on the above elements.

Washington's 2007 scores on prenatal and postpartum care were significantly higher than the nationwide scores. The statewide score for *prenatal care* (84 percent) was below the 2006 average, but not significantly lower. The 2007 score for *postpartum care* also was essentially the same as in 2006, with nearly two-thirds of women receiving timely care. Statewide scores on these measures have remained relatively constant for several years, while the rest of the nation has “caught up” with Washington's performance.

Statewide, respondents for 81 percent of Healthy Options enrollees said that they “usually” or “always” received care quickly, compared with 79 percent of respondents nationwide.

Table 6. Washington scores and national averages for Timeliness of Care elements.

Timeliness of Health Care: A Statewide Look			
Element	National average	Washington score	Washington rating
Prevention			
Prenatal Care	81%	84%*	☆☆☆
Postpartum Care	59%	62%*	☆☆☆☆
Member Satisfaction			
Getting Care Quickly	79%	81%	☆☆☆

Stars represent Washington’s performance compared with the 2007 NCQA percentile rankings for Medicaid HEDIS and CAHPS. One star (lowest) represents the 10th percentile, five stars (highest) represent the 90th percentile.

*State percentage is significantly different from the NCQA percentage.

Note: Differences between state and national percentages may be larger than apparent because of rounding. Statistical significance testing was not performed comparing the state average with the NCQA average for CAHPS.

Quality of health care

The process of treating a patient, the patient's experience of that treatment, and whether the enrollee's health improves (patient outcome) are integral to determining the quality of health care. For this analysis, Acumentra Health assessed processes of care and the patient experience, but not patient outcomes, because those outcomes depend on numerous variables (such as the patient's adherence to treatment) that may fall outside the provider's control.

The Quality of Care composite measure comprises six elements representing a combination of Prevention, Treatment, and Member Satisfaction measures, as shown in Table 7.

Table 7. Elements, sources, and categories of the Quality of Care measure.

Element	Source report	Category
Childhood Immunizations (Combo 2)	HEDIS	Prevention
Chlamydia Screening in Women (ages 16–25)	HEDIS	Prevention
Diabetes Care (HbA1c test)	HEDIS	Treatment
Asthma Care (ages 5–56)	HEDIS	Treatment
How Well Doctors Communicate	CAHPS	Member Satisfaction
Shared Decision Making	CAHPS	Member Satisfaction

The HEDIS childhood immunization measure, called Combination #2 (Combo 2), assesses the percentage of enrolled children who turned two years old during the measurement year and who received all of the following immunizations by their second birthday:

- four diphtheria, tetanus, and pertussis (DTaP)
- three polio (IPV)
- one measles, mumps, and rubella (MMR)
- three Haemophilus influenzae type b (HiB)
- three hepatitis B (Hep B)
- one varicella or chicken pox (VZV)

The chlamydia screening measure assesses the percentage of women 16–25 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. HRSA required health plans to report this measure for the first time in 2006, responding to high rates of chlamydia infections in Washington. In 2006, 17,819 cases of chlamydia were reported in the state. The number of cases and the calculated incidence rate (279.5 per 100,000 residents) fell slightly from the all-time highs reached in 2005.¹²

The diabetes care measure assesses the percentage of adult enrollees with diabetes (type 1 or type 2) who received an HbA1c (blood sugar) test during the measurement year. HRSA did not require the Healthy Options plans to report this measure in 2006, although the plans reported it in 2005 and previous years. Because children younger than 18 account for more than 80 percent of Washington's Medicaid population, health plans with low overall enrollment may have difficulty finding enough adult enrollees eligible for the diabetes measure components.

The asthma care measure assesses the percentage of enrollees ages 5–56 with persistent asthma who were prescribed medications during the measurement year or the previous year, consistent with the National Asthma Education and Prevention Program (NAEPP) *Guidelines for the Diagnosis and Management of Asthma*. HRSA has required Healthy Options plans to report this

measure since 2003 because of the prevalence of asthma in Washington, which the Centers for Disease Control and Prevention has identified as among the highest in the nation. Currently, about 1 in 10 women, 1 in 14 men, and between 7 and 10 percent of middle school and high school-aged children in Washington have asthma.¹³

The CAHPS element, How Well Doctors Communicate, assesses adults' perceptions of how carefully doctors listened to and explained things to them, and whether doctors spent enough time with patients and showed respect for them. Shared Decision Making, a new CAHPS measure for 2007, evaluates whether doctors explained treatment options to the enrollee, including the pros and cons of each option, and whether the doctor allowed the enrollee to choose an option he or she considered best. Scores presented in Table 8 reflect the "Usually" and "Always" categories.

Quality measure results

Table 8 looks at the overall quality of health care in Washington, based on the above elements.

Washington's average scores were significantly below the national averages for *childhood immunizations*, *chlamydia screening*, and *asthma care*, falling within the 25th percentile of nationwide scores. For *diabetes care*, the state's average score was significantly above the national average.

Washington's Combo 2 immunization results in 2007 (67 percent) were below the U.S. average but showed significant improvement from the state's 64 percent average in 2006. The federal benchmarking report, *Healthy People 2010*, sets 80 percent as the target for health plans to achieve by 2010 for five immunizations—DTaP, IPV, MMR, HiB, and HepB.¹⁴ On average, Healthy Options plans have exceeded this target rate for MMR, IPV, HiB, and HepB each year since 2003, and rates for DTaP and VZV have climbed to 79 percent. In July 2005, the state added VZV to the list of immunizations required for entry into schools and child-care facilities, effective July 1, 2006. This policy change may have contributed to the significantly higher statewide VZV immunization rates in 2007 (and thus to higher Combo 2 rates).

In 2007, the average rates for asthma care rose in Washington and across the nation. Washington's rates remained in the 50th percentile of nationwide results.

As to diabetes care, the Healthy Options plans as a group continue to outperform the national Medicaid average for HbA1c testing.

With regard to Member Satisfaction, the statewide scores for How Well Doctors Communicate and Shared Decision making were 87 percent and 91 percent, respectively. The scores for How Well Doctors Communicate fell within the 50th percentile of nationwide scores. NCQA will not report the national average or percentile rankings for Shared Decision Making until 2008.

The priority analysis of CAHPS responses performed in 2007 identified one of the questions relating to How Well Doctors Communicate as an area in which QI activities could be beneficial in improving overall customer satisfaction. That question probed whether the patient's personal doctor spent enough time with the patient.

Table 8. Washington scores and national averages for Quality of Care elements.

Quality of Health Care: A Statewide Look			
Measure	National average	Washington score	Washington rating
Prevention			
Childhood Immunizations (Combo 2)	73%	67%*	☆☆
Chlamydia Screening in Women, ages 16–25	52%	50%*	☆☆
Treatment			
Diabetes Care (HbA1c test)	78%	82%*	☆☆☆
Asthma Care, ages 5–56	87%	86%*	☆☆☆
Member Satisfaction			
How Well Doctors Communicate	86%	87%	☆☆☆
Shared Decision Making	—	91%	—

Stars represent Washington’s performance compared with the 2007 NCQA percentile rankings for Medicaid HEDIS and CAHPS. One star (lowest) represents the 10th percentile, five stars (highest) represent the 90th percentile.

*State percentage is significantly different from the NCQA percentage.

Note: Differences between state and national percentages may be larger than apparent because of rounding.

— NCQA does not report averages for first-year composites.

Statistical significance testing was not performed comparing the state average with the NCQA average for CAHPS.

Health Plan Results

After comparing statewide performance in access, timeliness, and quality with the nationwide performance levels, Acumentra Health compared the performance of individual health plans with the statewide scores.

Access to health care

The plans are providing *access to PCPs* for nearly all infant enrollees up to age 24 months, averaging 97 percent. More variation is evident in access to PCPs for older children. For those 2 to 19 years old, rates for MHW and RBS were significantly higher than the state averages. In contrast, the rates for CHP and CUP were significantly below the state averages, though CHP's percentages varied from the state aggregates by only 2 points. GHC's rates were mixed—significantly higher than the state aggregate for the adolescent age group, and significantly lower for 2-to-11-year-olds.

The percentages of *WCC visits* for enrollees in all three age groups varied substantially by health plan (see Table 9). Overall, MHW and RBS stood out for high performance; their rates significantly exceeded the state aggregate in all age groups.

Infants: More than half of the infants enrolled with MHW (60 percent) and with RBS (59 percent) received at least six WCC visits, significantly above the state average of 48 percent. In contrast, CUP's and GHC's proportions of infants with the recommended number of WCC visits (37 percent and 39 percent, respectively) were significantly below the state average.

Ages 3–6: RBS (70 percent) and MHW (68 percent) reported the highest proportions of WCC visits for children in this age group; both percentages were significantly higher than the state average and were above the national average. In contrast, CUP, GHC, and KPNW reported WCC visit rates that were significantly below the state average of 59 percent.

Adolescents: Rates of WCC visits for adolescents showed some variation. RBS, at 51 percent, stood out as a top performer in getting adolescents in for a WCC visit. MHW, at 42 percent, also significantly exceeded the state average of 36 percent. Rates for CHP, CUP, and GHC were significantly below the state average.

Among health plans, the 2007 rates for infants', children's, and adolescents' WCC visits are almost uniformly above the 2006 rates. Only MHW's rate was significantly higher than the previous year for infants, and only RBS's rates were significantly higher than the previous year for children and adolescents.

All Healthy Options plans have struggled to improve their rates of preventive care for children, reporting incremental variations from year to year. As a group, the plans have significantly improved the percentage of infant and children WCC visits since 2003. Conversely, even though the percentage of adolescent WCC visits rose significantly from 2006 to 2007, the five-year trend has not been positive.

Within the Member Satisfaction elements, scores varied among health plans. The scores for Getting Needed Care ranged from 68 percent (CHP and MHW) to 84 percent (GHC), bracketing the state average of 75 percent. Customer Service scores ranged from 73 percent (MHW) to 82 percent (CUP) around the state average of 74 percent. Scores shown in Table 9 reflect the "Usually" and "Always" response categories.

Table 9. Health plan and state scores for Access to Care measures.^a

Measure	CHP	CUP	GHC	KPNW	MHW	RBS	State
Prevention							
Access to PCPs:							
...12–24 months	97% ▼	96% ▼	98%	100%	98% ▲	98%	97%
...25 mos–6 yrs	84% ▼	81% ▼	82% ▼	82%	88% ▲	89% ▲	86%
...7–11 years	86% ▼	84% ▼	85% ▼	88%	90% ▲	92% ▲	88%
...12–19 years	85% ▼	80% ▼	88% ▲	88%	89% ▲	90% ▲	87%
Infant WCC Visits (6+ visits)	45%	37% ▼	39% ▼	—	60% ▲	59% ▲	48%
Child WCC Visit, 3 to 6 Years	61%	53% ▼	46% ▼	47% ▼	68% ▲	70% ▲	59%
Adolescent WCC Visit	30% ▼	27% ▼	31% ▼	35%	42% ▲	51% ▲	36%
Member Satisfaction							
Getting Needed Care	68%	80%	84%	—	68%	76%	75%
Customer Service	—	82%	79%	—	73%	76%	74%

▲ Health plan percentage is significantly higher than state average (p<0.05).

▼ Health plan percentage is significantly lower than state average (p<0.05).

— Sample size was less than the minimum required.

^aAsuris did not conduct HEDIS or CAHPS in 2007.

Note: Differences between plan and state percentages may be larger than apparent because of rounding.

Timeliness of health care

Health plan performance varied relatively widely in the elements of the Timeliness of Care composite (see Table 10).

Statewide, 84 percent of enrollees who delivered live births during the measurement year received timely *prenatal care* visits. All plans except GHC scored at or above the state average; GHC's 66 percent was significantly below average. CUP and RBS exceeded 90 percent, significantly higher than the state average.

For timeliness of *postpartum care*, KPNW's 85 percent was significantly higher than the state average of 62 percent. CUP (64 percent) and RBS (64 percent) also exceeded the state average, while GHC's 60 percent and CHP's 57 percent were below the state average.

The statewide average scores for prenatal and postpartum care declined from 2006 to 2007, although not significantly. Scores on the postpartum care measure improved from 2006 to 2007 for KPNW and GHC, while scores for prenatal care increased significantly for CUP and RBS.

Two plans scored above the state aggregate in Getting Care Quickly—CUP (87 percent) and MHW (83 percent)—while GHC (80 percent) and CHP (70 percent) scored below the aggregate. The scores shown in Table 10 reflect the “Usually” and “Always” response categories.

Table 10. Health plan and state scores for Timeliness of Care measures.^a

Measure	CHP	CUP	GHC	KPNW	MHW	RBS	State
Prevention							
Prenatal Care	85%	91% ▲	66% ▼	88%	87%	91% ▲	84%
Postpartum Care	57%	64%	60%	85% ▲	61%	64%	62%
Member Satisfaction							
Getting Care Quickly	70%	87%	80%	—	83%	81%	81%

▲ Health plan percentage is significantly higher than state average ($p < 0.05$).

▼ Health plan percentage is significantly lower than state average ($p < 0.05$).

— Sample size was less than the minimum required.

^aAsuris did not conduct HEDIS or CAHPS in 2007.

Note: Differences between plan and state percentages may be larger than apparent because of rounding.

Quality of health care

Overall, the Healthy Options plans performed well on asthma care, diabetes care, How Well Doctors Communicate, and Shared Decision Making, and not as well on childhood immunizations and chlamydia screening. (See Table 11.)

For *Combo 2 immunizations*, only one plan (CUP) scored significantly below the state average of 67 percent. Most plans scored higher in 2007 than in 2006; however, none significantly higher.

Collectively, the health plans provided *chlamydia screening* for 50 percent of women ages 16–25. The screening percentage was higher for women ages 21–25 (53 percent) than for those ages 16–20 (48 percent), reflecting the national pattern. Overall, KPNW and GHC reported the highest percentages at 55 percent, though only GHC’s percentage was significantly higher than the state average because of Kaiser’s sample constraints.

Plan performance on *diabetes care* (HbA1c testing) ranged from a low of 74 percent (RBS) to a high of 92 percent (GHC). Most health plans performed at or above the national average. Small sample sizes for this adult measure complicate the interpretation of significance test results.

Plan performance on *asthma care* did not vary significantly from the state average of 86 percent, except that GHC’s 77 percent was significantly below average.

Plan scores for the Member Satisfaction elements, How Well Doctors Communicate and Shared Decision Making, varied relatively little from the aggregate. Enrollees reported a high degree of satisfaction with how well their doctors communicated (87 percent) and allowed them to share in decisions regarding their treatment options (91 percent). The scores shown in Table 11 reflect the “Usually” and “Always” response categories.

Table 11. Health plan and state scores for Quality of Care measures.^a

Measure	CHP	CUP	GHC	KPNW	MHW	RBS	State
Prevention							
Child Immunizations (Combo 2)	69%	62% ▼	68%	73%	65%	69%	67%
Chlamydia Screening, ages 16–25	49%	50%	55% ▲	55%	50%	50%	50%
Diabetes Care (HbA1c test)	84%	77%	92% ▲	—	78% ▼	74% ▼	82%
Asthma Care, ages 5–56	84%	89%	77% ▼	—	86%	89%	86%
Member Satisfaction							
How Well Doctors Communicate	84%	87%	89%	—	85%	85%	87%
Shared Decision Making	93%	94%	86%	—	90%	90%	91%

▲ Health plan percentage is significantly higher than state average ($p < 0.05$).

▼ Health plan percentage is significantly lower than state average ($p < 0.05$).

— Sample size was less than the minimum required.

^aAsuris did not conduct HEDIS or CAHPS in 2007.

Note: Differences between plan and state percentages may be larger than apparent because of rounding.

Regulatory and Contractual Standards

During the first half of 2007, Washington's TeaMonitor reviewers scored health plans on their compliance with more than 60 required elements in 16 categories of standards, based on BBA rules and Healthy Options contract provisions. TeaMonitor auditors rated each plan as having "Met," "Partially Met," or "Not Met" the requirements for each standard listed below:

- Availability of Services
- Furnishing of Services (Timely Access)
- Timely Claims Payment
- Program Integrity
- Primary Care and Coordination
- Additional Services for Enrollees with Special Healthcare Needs
- Coverage and Authorization of Services
- Emergency and Post-Stabilization Services
- Enrollee Rights
- Enrollment and Disenrollment
- Grievance Systems
- Performance Improvement Projects (PIPs)
- Practice Guidelines
- Provider Selection (Credentialing)
- Quality Assessment and Performance Improvement (QAPI) Program
- Subcontractual Relationships and Delegation

For a more detailed description of these standards, including a list of relevant Healthy Options contract provisions and a list of elements within each BBA regulation, see Appendix B.

Compliance scoring methods

The comprehensive TeaMonitor audits produce a large amount of data. For purposes of analysis, Acumentra Health designed a scoring system that is intended to provide an easily understandable presentation of the data.

TeaMonitor assigned each of the required elements a score of Met, Partially Met, or Not Met, unless the element was not scored. Using scores from the TeaMonitor reports, Acumentra Health calculated compliance scores for each standard, expressed as a percentage of each standard's elements that were Met. These percentage scores appear in Table 12 and in the Health Plan Profiles in Appendix A. The scores were calculated as follows.

Denominator: the number of scored elements within a particular standard. Elements not scored were removed from the denominator.

Numerator: the number of scored elements that received a Met score. Compliance with a standard is defined as fully meeting the standard, since the Healthy Options contract requires a health plan to implement a corrective action plan to achieve full compliance with any standard that is below a Met score.

As an example, five elements comprise the standard for Availability of Services. If a plan scored Met on three elements, Partially Met on one element, and Not Met on one element, the plan's

score would be calculated using a denominator of 5 (total elements scored) and a numerator of 3 (elements Met). The percentage score for that plan on that standard would be 3/5, or 60 percent. However, if the plan scored Met on three elements and Partially Met on one element, and was not scored on the fifth element, the plan's score would be calculated using a denominator of 4 (element not scored is not included in the denominator) and a numerator of 3 (elements Met). The plan's score on that standard would be 3/4, or 75 percent.

Compliance results

Table 12 breaks out the 2007 compliance scores assigned by TeaMonitor for each of 15 standards (excluding PIPs) by health plan. (Note: TeaMonitor combines its review of Regence BlueShield and Asuris, since the two plans share administrative functions and resources.) Figure 4 shows the change in compliance scores on selected standards from 2006 to 2007.

The 2007 scores indicate a notable improvement in compliance across health plans. Statewide scores improved for Availability of Services, Primary Care and Coordination, Additional Services for Enrollees with Special Healthcare Needs (SHCN), Coverage and Authorization of Services, Enrollee Rights, Grievance Systems, Practice Guidelines, QAPI Program, and several other standards. As a group, the plans met at least 50 percent of all elements in these standards, except for the SHCN standard (46 percent). The only standards for which the statewide score fell in 2007 were Furnishing of Services and Provider Selection (Credentialing).

The plans demonstrated perfect compliance with the Practice Guidelines standard (promulgating and maintaining guidelines based on reliable and valid clinical evidence, and using the guidelines to guide clinical decision making), as well as with Primary Care and Coordination, Emergency and Post-Stabilization Services, and Enrollment and Disenrollment. Overall, the plans met 92 percent of the elements of Coverage and Authorization of Services.

No plan fully met the standard for Enrollee Rights (13 elements) or for Grievance Systems (19 elements). RBS/ANH, however, met 92 percent of the Enrollee Rights elements, while MHW met 83 percent. CUP, KPNW, and MHW met between 83 and 89 percent of the Grievance Systems elements.

Only CHP, KPNW, and RBS/ANH complied fully with the Program Integrity standard in 2007. This regulation requires managed care organizations to maintain administrative and management arrangements or procedures to guard against fraud and abuse. Several plans still failed to meet the Subcontractual Relationships and Delegation standard, reflecting insufficient subcontract language and/or oversight of the entities to which the plans delegated responsibility for providing care and services. TeaMonitor added an element to the Claims Payment standard for 2007, making it difficult to compare the 2006 and 2007 scores for that standard.

Many of the Partially Met or Not Met ratings relate to deficiencies in the health plans' written policies and procedures or in other documentation to support compliance. HRSA required the plans to address all of these standards through corrective action plans following the TeaMonitor review. Therefore, the scores shown in Table 12 may not reflect the status of plan performance as of December 2007.

Table 12. Compliance scores for regulatory and contractual standards by health plan.^a

Compliance with Managed Care Standards: Health Plan Comparison (Percentage of elements Met, Partially Met, and Not Met)																						
Standard (# of elements)	CHP			CUP			GHC			KPNW			MHW			RBS/ANH			State			
	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	M	PM	NM	
Availability of Services (5)	80	0	20	100	0	0	40	40	20	0	40	60	100	0	0	80	0	20	67	13	20	
Furnishing of Services (2)	0	50	50	100	0	0	50	50	0	0	100	0	100	0	0	50	0	50	50	33	17	
Program Integrity (1)	100	0	0	0	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	50	50	0
Claims Payment (2)	100	0	0	100	0	0	50	0	50	50	0	50	0	100	0	50	50	0	58	25	17	
Primary Care and Coordination (1)	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	
Additional Services for Enrollees with Special Healthcare Needs (4)	0	100	0	75	0	25	50	25	25	25	0	75	75	25	0	50	0	50	46	25	29	
Coverage and Authorization of Services (4)	75	25	0	75	25	0	100	0	0	100	0	0	100	0	0	100	0	0	92	8	0	
Emergency and Post-stabilization Services (1)	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	
Enrollee Rights (13)*	77	23	0	75	25	0	67	25	8	54	31	15	83	17	0	92	8	0	75	21	4	
Enrollment/Disenrollment (1)	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	
Grievance Systems (19)**	63	37	0	89	11	0	42	16	42	83	17	0	84	16	0	68	21	11	72	19	9	
Practice Guidelines (3)	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	100	0	0	
Provider Selection (Credentialing) (3)***	100	0	0	50	50	0	33	67	0	100	0	0	100	0	0	67	33	0	76	24	0	
QAPI Program (5)	0	100	0	80	20	0	80	20	0	40	20	40	100	0	0	80	0	20	63	27	10	
Subcontractual Relationships and Delegation (1)	0	0	100	100	0	0	0	0	100	100	0	0	100	0	0	0	0	100	50	0	50	

M=Met; PM=Partially Met; NM=Not Met

Note: Not all health plans were scored on all elements of each standard. Percentages may not add to 100 because of rounding.

*CUP and MHW were scored on 12 elements. **KPNW was scored on 18 elements. ***CUP was scored on 2 elements.

^a These standards were scored during the first half of 2007. Some "Partially Met" and "Not Met" scores were due to insufficient documentation to support compliance. Since then, health plans with a score of "Partially Met" or "Not Met" for any standard have submitted corrective actions plans; therefore, the above scores may not reflect the status of plan performance as of December 2007.

Access Standards

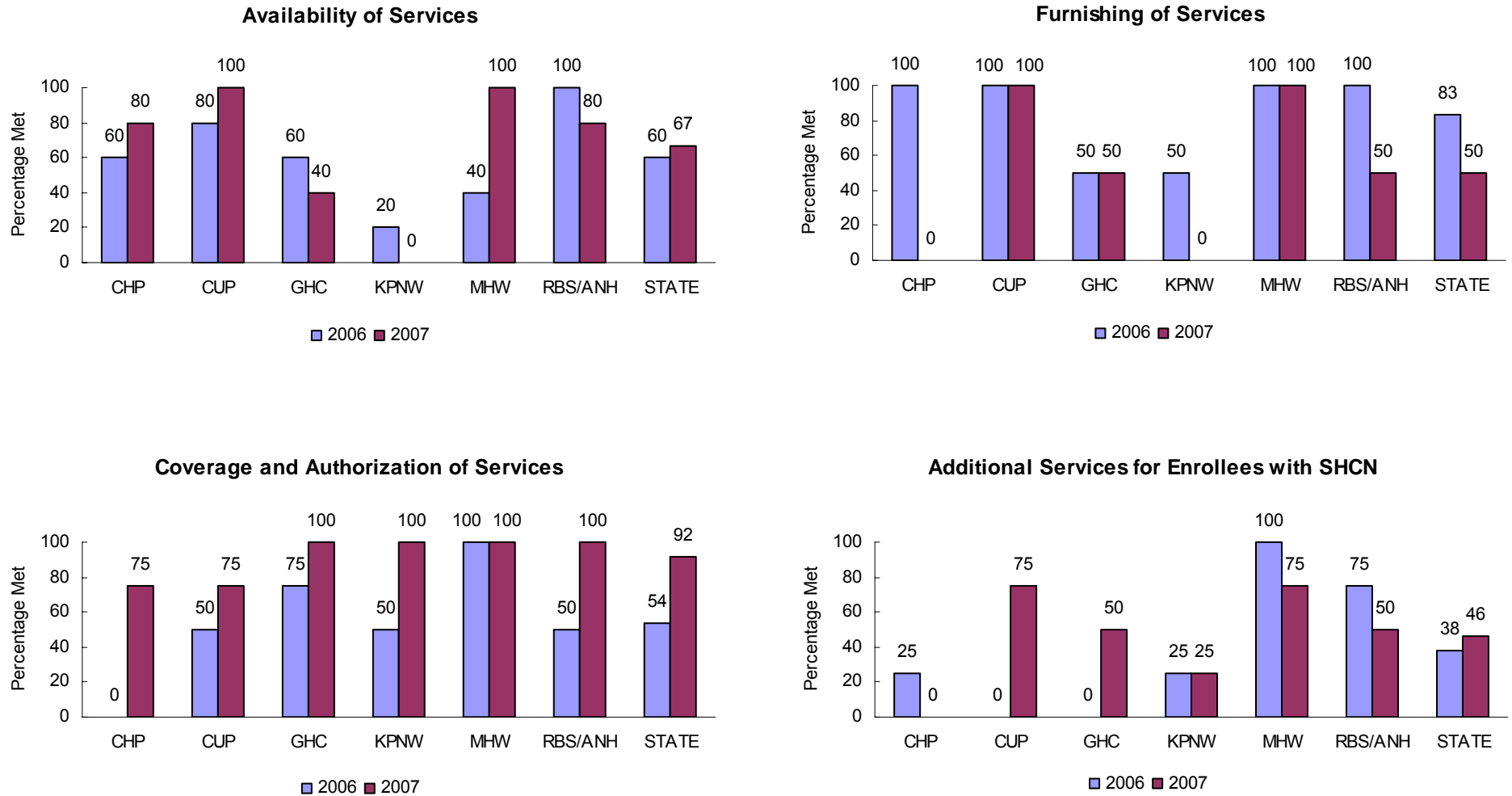


Figure 4. Changes in compliance scores for selected regulatory standards by health plan, 2006–2007.

Timeliness and Quality Standards

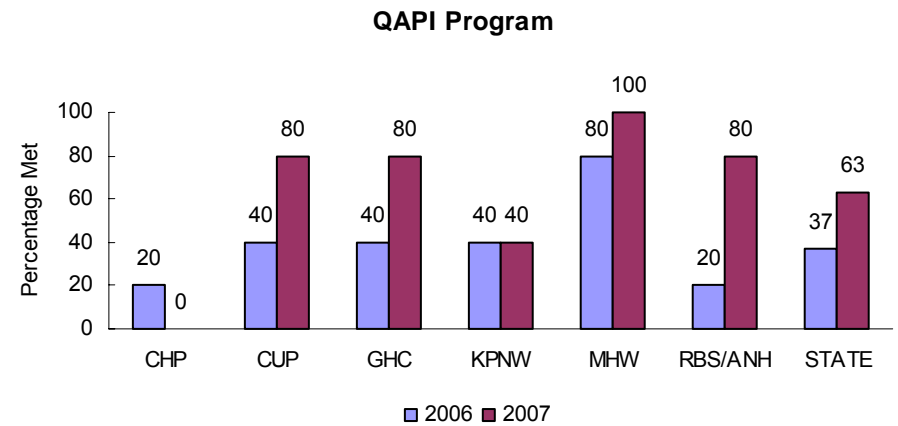
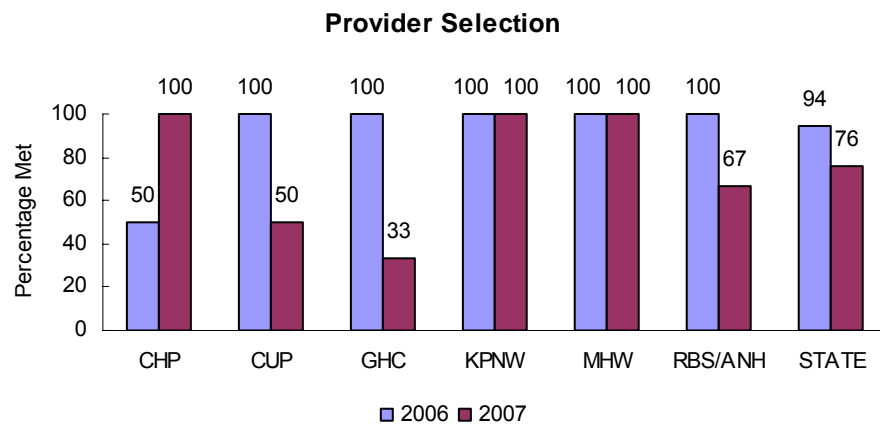
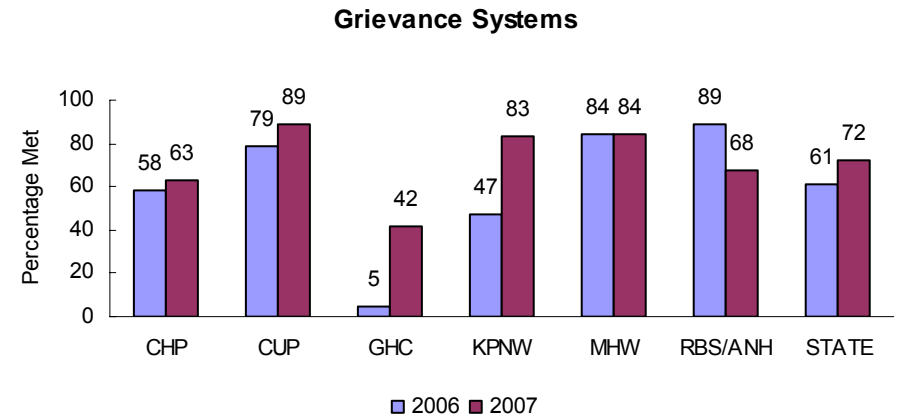
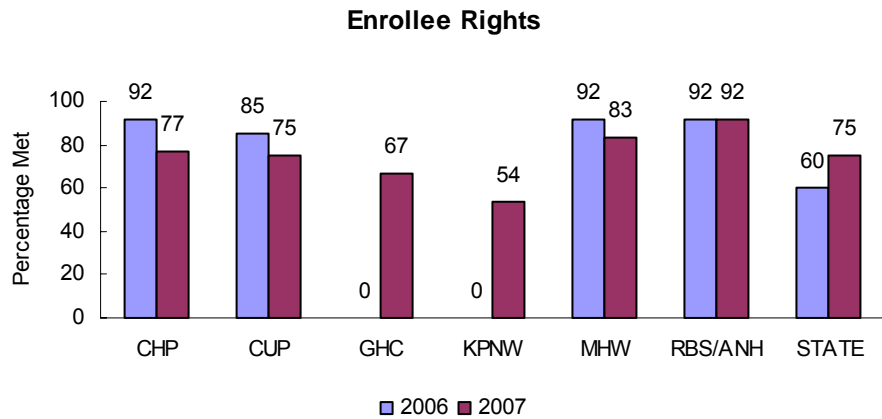


Figure 4. Changes in compliance scores for selected regulatory standards by health plan, 2006–2007 (cont.).

Corrective action plans

In 2007, TeaMonitor reviewed health plans' 2006 corrective action plans (CAPs), documenting resolution of corrective action as part of the TeaMonitor review process. If, as part of the 2007 TeaMonitor review, old or new findings were observed, TeaMonitor documented those findings and required corrective action. The state required a 2007 CAP from plans that scored Partially Met or Not Met on any element reviewed by TeaMonitor or on any element left unresolved or incomplete as a result of the 2006 CAP. Plans had to submit their CAPs within 45 days of the final TeaMonitor report. TeaMonitor staff reviewed the corrective action once. If TeaMonitor staff did not accept any part of a health plan's CAP, follow-up was delegated to the assigned state contract manager.

Table 13 shows the disposition of CAPs required in 2007. (Note: Because TeaMonitor was still reviewing some CAPs at the time of this analysis, this table may not reflect the status of CAPs as of December 2007.)

Table 13. Disposition of health plans' corrective action plans, 2007.

Health plan	CAPs required	CAPs accepted	CAPs not accepted	CAP status not resolved
CHP	22	17	0	5
CUP	9	9	0	0
GHC	25	8	10	7
KPNW	21	15	5	0
MHW	7	6	0	0
RBS/ANH	15	15	0	0

Overall, TeaMonitor required fewer CAPs in 2007 than in 2006. The majority of CAPs involved submitting revised documentation to support compliance with specific regulations. TeaMonitor accepted most of the CAPs, though sometimes with conditions or requirements for additional documentation. The CAPs not accepted by TeaMonitor were related to

- availability of services: description of strategic plans, standards and quality indicators, analysis of network limitations, monitoring of providers, direct access to women's healthcare services, out-of-network services, second opinions
- evidence of case management and treatment plans for enrollees with special healthcare needs
- grievance systems: content and format of notices of action, monitoring and analysis of appeals
- enrollee rights: formats of member information material, samples of action and denials
- claims payment standards

Corrective action in response to TeaMonitor findings is an ongoing activity for health plans. HRSA expects that plans will complete most of the required actions by the time of the next TeaMonitor review.

PIP validation

This analysis discusses the health plans' PIPs separately from other compliance requirements, as the PIPs are a stand-alone activity required by the Healthy Options contract as well as by federal regulations. The contract requires each plan to conduct at least five PIPs—three clinical and two nonclinical. If the plan is obligated to conduct a PIP for WCC or childhood immunizations because of substandard performance on HEDIS measures, the plan may count the required project toward meeting the requirement for three clinical PIPs.

PIP validation by TeaMonitor follows the rigorous standards set by CMS. A health plan must conduct its PIPs as formal studies, including descriptions of the study question, numerator and denominator, confidence interval, and tests for statistical significance. In addition, all Medicaid enrollees must have access to the interventions described in the PIP.

For the 2007 TeaMonitor reviews, two different HRSA staff members reviewed the PIPs—one reviewer assessed five, and the other reviewer assessed one plan's submissions. Both reviewers received a scoring guide and training session on how to use the tool. Completed PIP reviews were examined by the project lead. Findings were edited and, in some cases, scores were modified following discussion and agreement between reviewers.

None of the health plans fully met the overall compliance standard for PIPs. All six plans received "Partially Met" scores.

Table 14 shows the topics of the PIPs conducted by each health plan and the scores assigned by TeaMonitor. Among the clinical PIPs, all six health plans addressed WCC visits and child and/or adolescent immunizations, and four addressed asthma care or management. Many of these PIPs were required by contract. The nonclinical PIPs ranged more widely, covering topics such as enrollee access, satisfaction with customer service, member communications, timeliness of postpartum care, reducing inappropriate use of the emergency department, and quality of the health plan's specialty network.

A discussion of the PIP scores for each health plan follows Table 14. The comments with regard to strengths, opportunities for improvement, and other aspects of the PIPs are derived from the final TeaMonitor report for each plan. Appendix C itemizes the steps that TeaMonitor used in assessing the health plans' PIPs.

Table 14. PIP topics and scores by health plan, 2007.

Plan	PIP topic	Score
CHP	Clinical: Childhood Immunizations: Improving HEDIS Measurement Rates	Partially Met
	Clinical: Improving Clinical Outcomes for Members with a Diagnosis of Asthma	Met
	Clinical: Well-Child Exams: Improving HEDIS Measurement Rates	Partially Met
	Nonclinical: Improving Access to Appointments	Partially Met
	Nonclinical: Improving Customer Service	Partially Met
CUP	Clinical: Improving Well-Child Visits	Partially Met
	Clinical: Improving Early Childhood Immunization Rates	Met
	Clinical: Improving Management of Asthma as a Chronic Disease	Partially Met
	Nonclinical: Decreasing Inappropriate Emergency Department Utilization	Partially Met
	Nonclinical: Improving Member Understanding of Plan Benefits and Services	Partially Met
GHC	Clinical: Improving Well-Child and Well-Adolescent Visit Rates	Partially Met
	Clinical: Improving Childhood and Adolescent Immunization Rates	Partially Met
	Clinical: Improving Antidepressant Medication Management during the Acute Phase of Treatment	Partially Met
	Nonclinical: Improving Primary Care Access	Partially Met
	Nonclinical: Member Utilization of Online Services to Enhance Health Information and Patient Self-Care	Met
KPNW	Clinical: Adolescent Immunizations	Partially Met
	Clinical: Pediatric Obesity	Partially Met
	Clinical: Well-Child Visits	Met
	Nonclinical: Postpartum Follow-up	Partially Met
	Nonclinical: Telephone Access to Membership Services	Met
MHW	Clinical: Improvement of HEDIS Well-Child Rates	Partially Met
	Clinical: Asthma Medication Prescribing Practices Among Prescribing Physicians	Partially Met
	Clinical: Improving Childhood Immunization Rates	Met
	Nonclinical: Improving Satisfaction with Customer Service	Partially Met
	Nonclinical: Improving the Quality of the Specialty Network	Partially Met
RBS/ ANH	Clinical: Improve Appropriate Medication Use for Medicaid Members with Asthma	Met
	Clinical: Medicaid Well-Child Visits With a Disparity Aspect Involving the Hispanic Population	Met
	Clinical: Improving the Rate of Child Immunizations in the Medicaid Population	Met
	Nonclinical: Improve Response Time of Pharmacy Prior Authorization Denials	Partially Met
	Nonclinical: Getting Help from Customer Service for Medicaid and PEBB Enrollees	Partially Met

Community Health Plan

Table 15 displays the topics and scores of CHP's PIPs in the past three years. CHP carried over a clinical project from 2005 through 2007, aimed at improving asthma care outcomes. In 2007, CHP continued one clinical and one nonclinical PIP from 2006, and began a new nonclinical PIP aimed at improving access to appointments. CHP conducted contractually required PIPs related to well-child care, immunizations, and customer service.

Table 15. Community Health Plan PIP topics and scores, 2005–2007.

Topic	2005	2006	2007
Clinical: Improve Clinical Outcomes for Members With Diagnosis of Asthma	Met	Met	Met
Clinical: Well-Child Exams: Improving HEDIS Measurement Rates	Not conducted	Partially Met	Partially Met
Clinical: Improve Rates of Prenatal Care Initiation and Postpartum Care	Not conducted	Not Met	Not conducted
Clinical: Childhood Immunizations: Improving HEDIS Measurement Rates	Met	Not conducted	Partially Met
Clinical: Diabetes: Improving Clinical Outcomes for People With Diabetes	Met	Not conducted	Not conducted
Nonclinical: Improving Customer Service – Access	Not conducted	Partially Met	Not conducted
Nonclinical: Improving Customer Service	Not conducted	Partially Met	Partially Met
Nonclinical: Creating a System That is Easy for Customers to Use	Not Met	Not conducted	Not conducted
Nonclinical: Improving Access to Appointments	Not conducted	Not conducted	Partially Met

Strengths

- The PIP addressing asthma care fully met standards from 2005 through 2007 and is considered a best-practice project.
- In the two nonclinical PIPs, Improving Access to Appointments and Improving Customer Service, CHP was commended for its robust survey methods, which TeaMonitor called a “best practice across all health plans.”
- Data displays were strong across several PIPs; TeaMonitor cited as a best practice CHP's use of Performance Evaluation Tool graphs to provide clinic-specific feedback.

Opportunities for improvement

- CHP failed to improve its score on two PIPs carried over from 2006: Well-Child Exams and Improving Customer Service. In both cases, it is possible that not enough time had elapsed since the start of new interventions to demonstrate improvement.
- In some cases, CHP provided insufficient documentation of HEDIS measures, resulting in a “low confidence” rating.
- In its two nonclinical projects, CHP did not differentiate or call out underperforming clinics to identify where improvements were most needed.

Columbia United Providers

Table 16 displays the topics and scores of CUP's PIPs in the past three years. As shown, CUP carried over its three clinical PIPs from 2005 through 2007. CUP began two new nonclinical PIPs in 2007. The plan conducted contractually required PIPs related to immunizations, well-child care, and customer service.

Table 16. Columbia United Providers PIP topics and scores, 2005–2007.

Topic	2005	2006	2007
Clinical: Improving Early Childhood Immunization Rates	Met	Met	Met
Clinical: Improving Management of Asthma as a Chronic Disease	Met	Partially Met	Partially Met
Clinical: Improving Well-Child (EPSDT) Rates	Partially Met	Partially Met	Partially Met
Nonclinical: Improving Timely Access to Obstetrical Care	Not Met	Met	Not conducted
Nonclinical: Improving Communication With Members	Not conducted	Partially Met	Not conducted
Nonclinical: Improving Access to GI Services in Clark County	Not Met	Not conducted	Not conducted
Nonclinical: Decreasing Inappropriate Emergency Department Utilization	Not conducted	Not conducted	Partially Met
Nonclinical: Improving Member Understanding of Plan Benefits and Services	Not conducted	Not conducted	Partially Met

Strengths

- TeaMonitor reported high confidence in the validity of all five PIPs.
- PIP documentation was consistently thorough, including excellent data displays.
- The PIPs featured novel interventions that engaged enrollees, schools districts, providers, and the plan's medical director—e.g., outreach phone calls to new members to provide education about plan benefits proactively, partnering with school districts to improve the care of children with asthma, and dialogue between the medical director and the hospital community about ER utilization.

Opportunities for improvement

- CUP's nonclinical project, Improving Member Understanding of Plan Benefits and Services, contained incomplete and incorrect documentation.
- The PIP targeting well-child visits achieved improvement only for the infant population; rates for children and adolescents remained stagnant.
- Most of CUP's "Partially Met" scores were due to lack of statistical improvement.

Group Health Cooperative

Table 17 displays the topics and scores of GHC’s PIPs in the past three years. GHC carried over two clinical PIPs and one nonclinical PIP from 2006 to 2007, and began two new PIPs in 2007, aimed at improving antidepressant medication management and access to primary care.

Table 17. Group Health Cooperative PIP topics and scores, 2005–2007.

Topic	2005	2006	2007
Clinical: Improving Well-Child and Well-Adolescent Visit Rates	Not conducted	Partially Met	Partially Met
Clinical: Improving Childhood and Adolescent Immunization Rates	Not Met	Met	Partially Met
Clinical: Improving Identification and Referral to Needed Services of Children with Special Healthcare Needs	Not conducted	Partially Met	Not conducted
Clinical: Coordinating Services for Children with Special Healthcare Needs	Not Met	Not conducted	Not conducted
Clinical: Physician Linkage Project: Increasing the Use of Appropriate Primary Care Services in the Medicaid Population	Not Met	Not conducted	Not conducted
Clinical: Improving Antidepressant Medication Management During the Acute Phase of Treatment	Not conducted	Not conducted	Partially Met
Nonclinical: Improving Member Utilization of Online Services	Not conducted	Met	Met
Nonclinical: Improving Member Satisfaction with Lab Service	Not conducted	Partially Met	Not conducted
Nonclinical: Improving Cultural Competency Across Group Health Systems and Services	Not Met	Not conducted	Not conducted
Nonclinical: Maintaining Improvements Made in Primary Care Access	Not Met	Not conducted	Not conducted
Nonclinical Project: Improving Primary Care Access	Not conducted	Not conducted	Partially Met

Strengths

- GHC’s PIP documentation was consistently thorough.
- Use of electronic datasets—some specially tailored—for measurement collection and reporting helped ensure reliability and validity of measures.
- TeaMonitor cited excellent description of methods and display of measurement data, including trend data.
- GHC has implemented a wide range of interventions in all five projects.
- The performance feedback used in the Improving Well-Child and Well-Adolescent Visit Rates PIP was identified as a “best practice” intervention by TeaMonitor.

Opportunities for improvement

- The Improving Childhood and Adolescent Immunization Rates PIP earned a “Partially Met” score in 2007 after earning a “Fully Met” score in 2006.
- Not enough time has elapsed to assess the effectiveness of interventions for all three clinical PIPs and for the nonclinical PIP on Improving Primary Care Access.

Kaiser Permanente Northwest

Table 18 displays the topics and scores of KPNW's PIPs in the past three years. KPNW carried over two clinical PIPs from 2006 to 2007: a project targeting pediatric obesity (also conducted in 2005) and a project addressing adolescent immunizations.

Table 18. Kaiser Permanente Northwest PIP topics and scores, 2005–2007.

Topic	2005	2006	2007
Clinical: Adolescent Immunizations	Not conducted	Partially Met	Partially Met
Clinical: Pediatric Obesity	Not Met	Not Met	Partially Met
Clinical: Well-Child Visits	Not conducted	Not Met	Partially Met
Clinical: Asthma Medication Management	Not Met	Not conducted	Not conducted
Clinical: Improving Childhood Immunization Rates	Not Met	Not conducted	Not conducted
Nonclinical: Postpartum Follow-up	Not Met	Met	Met
Nonclinical: Non-English Speaking Project	Not conducted	Not Met	Not conducted
Nonclinical: Pre-Term Birth Prevention	Not Met	Not conducted	Not conducted
Nonclinical: Telephone Access to Membership Services	Not conducted	Not conducted	Met

Strengths

- The nonclinical project, Telephone Access to Membership Services, achieved a score of “Met” in its first year. This score is commendable for a first-year project.
- The scores earned by the clinical PIPs on pediatric obesity and well-child visits improved from “Not Met” in 2006 to “Partially Met” in 2007.
- Use of robust data from Kaiser’s electronic medical record enables reliable and valid data reporting.
- TeaMonitor cited thorough documentation for three of KPNW’s PIPs.

Opportunities for improvement

- TeaMonitor found that KPNW failed to use the proper HEDIS measures to conduct the PIP on adolescent immunizations. As a result, the study lacked face validity; TeaMonitor expressed low confidence in the study findings.
- Not enough time has elapsed to assess improvement in adolescent immunizations.
- Statistically significant improvement in the postpartum PIP was not reported and did not appear likely from 2005 to 2006.
- Improvements in WCC visits were documented for children (primarily 3–6 year-olds) but not for infants or adolescents. Overall, reported improvements were not well documented. The only intervention employed was a reminder letter.

Molina Healthcare of Washington

Table 19 displays the topics and scores of MHW's PIPs in the past two years. As shown, MHW carried over all five PIPs from 2006 to 2007; four of these also were conducted in 2005. MHW conducted contractually required PIPs for immunizations, WCC, and customer service.

Table 19. Molina Healthcare of Washington PIP topics and scores, 2005–2007.

Topic	2005	2006	2007
Clinical: Improving Childhood Immunization Rates	Met	Met	Met
Clinical: Improving HEDIS Well-Child Rates	Partially Met	Met	Partially Met
Clinical: Asthma Medication Prescribing Practices	Met	Met	Partially Met
Nonclinical: Improving the Quality of the Specialty Network	Partially Met	Partially Met	Partially Met
Nonclinical: Improving Satisfaction With Customer Service	Not conducted	Partially Met	Partially Met
Nonclinical: Access to Member Services	Met	Not conducted	Not conducted

Strengths

- TeaMonitor cited MHW's PIP documentation as a best practice.
- Use of HEDIS and CAHPS ensures valid and reliable measures.
- TeaMonitor cited as best practices the activity table, documentation of key aspects of care, and outcome tables in the nonclinical PIP on Improving the Quality of the Specialty Network.
- MHW's PIPs featured excellent use and display of statistical analyses to document outcomes.
- The PIPs demonstrated consistent dedication to improving asthma care, using different interventions aimed at both providers and enrollees and revising the strategies yearly. TeaMonitor cited this approach as a best practice.

Opportunities for improvement

- Given the lack of sustained improvement shown by its PIPs, especially for immunizations and well-child care, TeaMonitor suggested that MHW revise its interventions.
- Most of MHW's "Partially Met" scores were due to lack of statistically significant improvement.

Regence BlueShield/Asuris Northwest Health

Table 20 displays the topics and scores of RBS/ANH's PIPs in the past three years. RBS/ANH carried over two projects from 2005 through 2007; one of these, aimed at improving asthma treatments, received a score of "Met" in 2007. The plan also continued a PIP initiated in 2006, addressing well-child visits among the Hispanic population. RBS/ANH conducted contractually required PIPs for immunizations, well-child care, and customer service.

Table 20. Regence BlueShield/Asuris Northwest Health PIP topics and scores, 2005–2007.

Topic	2005	2006	2007
Clinical: Improve Appropriate Medication Use for Members With Asthma	Partially Met	Partially Met	Met
Clinical: Well-Child Visits With a Disparity Aspect Involving the Hispanic Population	Not conducted	Partially Met	Met
Clinical: Improve Rate of Child Immunizations	Not conducted	Met	Met
Clinical: Identification/Treatment of Depression in Members With Diabetes	Met	Not conducted	Not conducted
Clinical: Increase Maternal Awareness, Decrease Preterm Births	Met	Not conducted	Not conducted
Nonclinical: Improve Response Time of Pharmacy Prior-Authorization Denials	Not Met	Partially Met	Partially Met
Nonclinical: Improve Getting Help From Customer Service	Not conducted	Partially Met	Partially Met
Nonclinical: Reduce Complications and Problems in Referral Process	Not Met	Not conducted	Not conducted

Strengths

- RBS/ANH achieved "Met" scores for three of its five PIPs, with the other two earning "Partially Met" scores. This was the best overall performance among all plans.
- The scores of the PIPs addressing asthma medications and well-child visits improved from "Partially Met" in 2006 to "Met" in 2007.
- TeaMonitor cited as a best practice the PIP related to well-child visits among the Hispanic population, which addresses health disparities.
- Other best practices cited by TeaMonitor included use of control charts to display data and use of HEDIS and non-HEDIS measures for patients with asthma.

Opportunities for improvement

- TeaMonitor found that RBS/ANH will need to implement additional interventions to sustain improvement in immunization rates.
- RBS/ANH provided no tests of statistical significance for the PIP related to timeliness of prior authorization for pharmacy prescriptions. This PIP showed no evidence of sustained improvement; TeaMonitor reported low confidence in the validity of the results.

Washington Medicaid Integration Partnership (WMIP) Evaluation

The Washington Medicaid Integration Partnership (WMIP) seeks to integrate medical, mental health, substance abuse, and long-term care services that the state traditionally has provided separately for categorically needy aged, blind, and disabled Medicaid beneficiaries. These beneficiaries, who tend to have complex health profiles, are the fastest growing and most expensive segment of DSHS's client base. Intermediate goals of the WMIP include improving the use of mental health and substance abuse services, which account for a considerable portion of total healthcare costs. Longer-term objectives are to improve the patients' quality of life and independence, reduce outpatient admissions and ER visits, and reduce medical costs.

The state contracts with MHW to conduct this pilot project in Snohomish County, with expansion planned as the pilot project matures. MHW is expected to

- provide intensive care coordination to help clients navigate the healthcare system
- involve clients in care planning
- assign each client to a care coordination team and have consulting nurses available on the phone 24 hours per day
- use the Chronic Care Model to link medical, pharmacy, and community services
- use standards for preventive health and evidence-based treatment to guide care plan development and improve health outcomes

The WMIP target population is Medicaid enrollees age 21 or older who are aged, blind, or disabled, including Medicaid-only enrollees and those dually eligible for Medicare and Medicaid. WMIP excludes children under 21, Healthy Options enrollees, and recipients of Temporary Assistance for Needy Families. As of November 2007, WMIP enrollment totaled about 2,900, a gain of about 300 clients since 2006.

Because the WMIP population differs categorically from the traditional Medicaid population, it is not possible to compare the WMIP data meaningfully with the data reported by Healthy Options plans or with national data for health plans serving traditional Medicaid recipients.

In 2006, Molina reported three HEDIS measures for the WMIP population: comprehensive diabetes care, inpatient care utilization—general hospital/acute care, and ambulatory care utilization. For 2007, HRSA required one additional measure: inpatient care utilization, nonacute care. Molina also conducted the CAHPS survey of adult members' satisfaction with services provided by WMIP, plus two HEDIS-like measures of screening, access, and treatment for chemical dependency and drugs to be avoided in the elderly, both validated by means of CMS's Information Systems Capabilities Assessment tool. Tables 21–27 report the results.

Table 21. WMIP scores on comprehensive diabetes care measures (n=193).

	%
HbA1c tests (percentage tested)	82.90
Enrollees with HbA1c levels poorly controlled (percentage with HbA1c>9.0%)	42.49
Enrollees with HbA1c levels with good control (percentage with HbA1c<7.0%)	36.79
Dilated retinal exams (percentage examined)	54.40
Lipid profile (LDL-C) performed (percentage profiled)	76.17
Lipids controlled (percentage with <100mg/dL)	31.09
Nephropathy monitored annually (percentage monitored)	77.72
Blood pressure control (percentage with <130/80 mm Hg)	31.61
Blood pressure control (percentage with <140/90 mm Hg)	56.48

Table 22. WMIP scores on inpatient utilization measures for general hospital/acute care.

	Discharges/ 1000MM ^a	Days/ 1000MM ^a	ALOS ^b
Total inpatient discharges and days	14.76	72.66	4.92
Medical discharges and days	7.16	26.15	3.65
Surgical discharges and days	7.43	34.19	6.53

^a1000MM = 1000 member months.^bALOS = average length of stay in days.**Table 23. WMIP scores on inpatient utilization, nonacute care.**

	Discharges/ 1000MM ^a	Days/ 1000MM ^a	ALOS ^b
Inpatient discharges and days	1.21	6.65	5.52

^a1000MM = 1000 member months.^bALOS = average length of stay.**Table 24. WMIP scores on ambulatory care measures.**

	Visits/1000MM ^a
Outpatient visits	470.32
Emergency room visits	104.28
Surgery or procedures performed	10.70
	Stays/1000MM ^a
Observation room stays resulting in discharge	0.95

^a1000MM = 1000 member months.**Table 25. WMIP scores on screening, access, and treatment for chemical dependency.**

	%
New member screened	15.50
Needed assessment	8.30
Referred for assessment	21.20
Needed treatment	60.00
Completed treatment	100.00

Table 26. WMIP scores on drugs to be avoided in the elderly.

	%
At least one drug	19.08
At least two drugs	4.62

Table 27. WMIP scores on CAHPS measures.

	%
Access to Health Care^a	
Getting Needed Care	71
Customer Service	72
Timeliness of Health Care^a	
Getting Care Quickly	79
Quality of Health Care^a	
How Well Doctors Communicate	85
Shared Decision Making	87

^a Scores reflect “Always” and “Usually” response categories.

The WMIP pilot program began performance evaluation at its onset, with its first measures conducted in 2005. As this program continues to grow and develop, performance measures have changed, as with the addition of measures in 2007. Even though comparative data are unavailable for some measures, it is possible to evaluate changes from the 2006 baseline measurements for some diabetes and utilization indicators. Evaluation criteria will become more stable as the program matures, allowing more sophisticated analysis and comparisons.

Utilization rates for general hospital/acute care declined from 2006 to 2007—a positive trend for this population with complex healthcare needs—although the declines were not statistically significant. At the same time, the rates of outpatient and ER visits for the WMIP population increased significantly. Considering comprehensive diabetes care, fewer enrollees were screened for HbA1c (blood sugar) levels and more enrollees were identified as in poor control, while more enrollees had a dilated retinal exam; however, none of these changes were significant. Member satisfaction scores ranged from a low of 71 percent to a high of 87 percent. Enrollees reported a high degree of satisfaction with how well their doctors communicated (85 percent) and allowed them to share in decisions regarding their treatment options (87 percent).

At this time, no normative data exist with which to compare the WMIP performance measure results. As the program continues, year-to-year changes may be evaluated and opportunities for improvement may be identified. As data become available from other states with similar programs, HRSA may be able to define more specific improvement goals.

As part of the Medicaid Value Program (MVP) sponsored by the Center for Health Care Strategies (CHCS), analysts evaluated the WMIP intervention program with outcome measures reported to CHCS in 2007. According to the CHCS report, the WMIP intervention was one of the more developed programs in the MVP, and its project team was well prepared to provide quantitative measures of the program’s progress. The reported outcomes suggest that WMIP has shown success in slowing the rate of growth in hospital admissions and the number of hospital

mental health days, and that many enrollees believe their care is better coordinated under MHW than under the traditional fee-for-service arrangement.¹⁵

Findings from the WMIP and other similar initiatives suggest that effective integration efforts can result in significant cost savings and improvement in the quality of care. The Colorado Access Integration Model, cited in the above report, demonstrated a significant reduction in ER and inpatient hospitalization visits and an increase in outpatient provider office visits, leading to direct cost savings. Evidence suggests that improvement in the chronic disease conditions that often accompany this population can save costs. Each 1 percent reduction in HbA1c level for people with diabetes reduces the risk of developing eye disease, nerve disease, and kidney disease by 40 percent.¹⁶ In 2002, medical expenditures incurred by people with diabetes averaged \$13,243 per person, compared with \$2,560 per person without diabetes.¹⁷

The Washington legislature has approved a 2008 expansion of WMIP, with funding for up to 13,000 total patients.

Washington Medicare/Medicaid Integration Project (MMIP) Evaluation

In June 2005, Washington launched the Medicare/Medicaid Integration Project (MMIP), a new resource for Medicare- and Medicaid-eligible clients age 65 and older in King and Pierce counties. The MMIP focuses on preventive care and healthcare coordination to improve health outcomes and reduce expenditures for dual-eligible clients who are frail and have complex healthcare needs. The state contracts with Evercare Premier to conduct this project that combines medical and long-term care services in one package. Evercare is expected to

- provide network doctors and providers to serve this population
- provide consulting nurses available on the phone 24 hours per day
- assign each client to a care manager to help coordinate medical and long-term care services
- provide value-added services and additional benefits, such as enhanced hearing and vision benefits and medical transportation

The MMIP target population is dual-eligible enrollees age 65 or older. Enrollment is voluntary and is coordinated through Evercare representatives. Enrollees may disenroll at any time. As of October 2007, 230 members were enrolled.

In 2007, Evercare reported two HEDIS measures for the MMIP population: inpatient care utilization—general hospital/acute care, and ambulatory care utilization. Evercare also conducted two HEDIS-like measures: diabetes care and coronary artery disease. Evercare underwent a certified HEDIS audit that incorporated HEDIS validation of performance measures and CMS's Information Systems Capabilities Assessment tool. MMIP fully complied with the performance measure validation requirements.

As of December 31, 2006, MMIP had fewer than 75 enrollees. When samples were pulled for the measurement year for the above-mentioned measures, the sample size was smaller than that required for reporting purposes; thus, results are not published. The first year of conducting performance measurements established the foundation for evaluating this program and may serve as baseline measurement.

Discussion and Recommendations

The purpose of this annual report is to summarize the overall performance of Washington's Medicaid managed care plans in measures of access, timeliness, and quality and in meeting state and federal standards for Medicaid managed care. The synthesis of data in this report offers an opportunity to examine the results of individual EQR activities from a systems point of view. The resulting picture of the strengths and shortcomings of Washington's Medicaid program should help HRSA define QI expectations for the health plans and design effective incentives and rewards for improvement. The health plans, in turn, could encourage providers to use a systems approach in delivering care for all enrollees. Improvement efforts should focus on providing evidence-based care.

What's working well in Washington

Focus on children. Recognizing the need to improve healthcare services for children, the legislature enacted the Children's Health Care Act (SBB 5093) in March 2007. SB 5093 expands children's access to health care, increases primary care payments, and calls for system changes to ensure that all children get regular care from a medical home that provides preventive and WCC services and referral to needed specialty services. State agencies must collaborate with parents, schools, communities, health plans, and providers to identify health improvement goals for children and to adopt innovative purchasing strategies to achieve those goals.

SBB 5093 raises the family income threshold for Medicaid coverage for children under age 19 from 200 percent of the Federal Poverty Level (FPL) to 250 percent. Beginning January 1, 2009, the threshold will rise to 300 percent of the FPL, to the extent that funds are available, although families with incomes above 200 percent of the FPL will have to pay premiums for coverage. The primary mechanism for purchasing coverage will be through managed care.

DSHS recognizes that expanding access and funding without improving infrastructure, performance accountability, and responsiveness to consumers will not lead to an improved system of care. In response to SBB 5093, DSHS has developed a draft recommendation to the legislature for a five-year program called the Children's Healthcare Improvement System (CHIS), aimed at ensuring the delivery of care within a medical home.¹⁸ The guiding criteria for CHIS are:

1. Select evidence-based indicators that are linked to improved child health.
2. Measure and monitor physician and clinic performance using outcomes instruments that produce valid and consistent data.
3. Reward physicians and clinics that demonstrate adherence to best practices and clinical improvement of their patients.

DSHS-HRSA will link provider rate increases to QI measures related to provision of a medical home and will determine how to apply contract incentives for providers and health plans that achieve sustained improvement in those measures through use of evidence-based practices.

Value-based purchasing. Washington's efforts to align provider payments with quality improvements through contract incentives for health plan performance have led to gains in measures of childhood immunizations and WCC visits. As identified in previous annual reports,

several Healthy Options plans have passed these incentives downstream, either to providers for improving care or to enrollees for obtaining care.

DSHS's blueprint for the CHIS describes an incentive system based on the California Integrated Healthcare Association model.¹⁹ Beginning in 2009, Washington Medicaid providers will be reimbursed at higher rates for a subset of historically underused procedures or billing codes, such as a fourth dose of the DTaP vaccine, dental disease prevention services, and WCC visits. DSHS-HRSA also will begin reimbursing for selected services not currently paid by Medicaid, including developmental surveillance and screening of young children, vaccine administration, maintenance of after-hours clinics, depression screening, development of asthma action plans, group WCC visits, care coordination, and provision of medical home resources. DSHS recommends initiating financial incentives for clinic-based performance in 2011.

Improving clinical care. Healthy Options plans continue to perform at or above the national average Medicaid performance in several clinical measures. For example, the Washington plans compare favorably to the nation in providing *access to PCPs* for child and adolescent enrollees, as measured by annual visits, and in providing *diabetes care*, as measured by the HbA1c testing indicator. Washington's success in providing timely *prenatal and postpartum care* has been evident for some years—more than 8 out of 10 female enrollees receive timely prenatal care and nearly two-thirds receive timely postpartum care—although gains have slowed in this area. Two-thirds of Medicaid children are receiving *Combo 2 immunizations*, and that average has risen steadily since 2002. These improvements have stemmed from focused QI efforts through health plan PIPs, HRSA's special initiatives and partnerships, and contract incentives.

Performance measurement. HRSA continuously reviews and refines its performance measurement program, adding or removing required measures according to their relevance to the Medicaid population and to the resources required to conduct each measure. For example, in 2008, HRSA plans to drop the requirement for health plans to report the prenatal care measure. That measure is one of the most costly for health plans to conduct because the plans must rely on medical chart review to collect a high percentage of the necessary data. HRSA has dropped the prenatal care measure because the health plans have demonstrated sustained improvement over the past five years and because DSHS's Research and Data Analysis Division already collects the data for that measure.

HRSA continues to invest resources to conduct more detailed analysis, such as member-level and trend analysis, to examine health plan performance over time. Future analysis will examine performance across the Medicaid system as a whole, encompassing FFS as well as managed care.

Voice of the consumer. By requiring the Healthy Options plans to conduct the annual CAHPS survey and incorporating the results into its monitoring, HRSA prioritizes the voice of the consumer in the evaluation of access, quality, and timeliness of care. Results of the adult survey suggest that customer satisfaction with the Healthy Options plans as a group compares favorably with nationwide scores. In 2006, more than 87 percent of respondents for Healthy Options adults said they were satisfied with how well doctors communicated, and more than 80 percent said they got care quickly when it was needed.

Preventive care for children with chronic conditions. The HRSA-funded Children's Health Improvement Collaborative (CHIC), now in its fourth year, combines the QI efforts of local clinics and the Healthy Options plans to improve preventive care for children with chronic conditions. The goal is to help clinics adopt and use best practices in delivering care for low-

income children who suffer from asthma, attention deficit/hyperactivity disorder (AD/HD), and overweight. Participating teams are asked to select two outcome measures, five process measures, and one balancing measure (used to ensure that improvement in one part of the system does not cause new problems in another part of the system), with additional optional measures. In November 2007, the learning collaborative reported the results of third-year activities involving 20 practice teams.

- The asthma team measures of improved care included severity classification, self-management goals, increasing symptom-free days, and evaluating environmental triggers. Severity assessment increased from 16 percent at baseline to 54 percent at the end of the collaborative. Documentation of current self-management goals increased from 1 percent to 23 percent. Since the final learning session, several of the clinic teams have begun using spirometry testing to assess asthma conditions, and two teams have each held their first “asthma clinic.”
- The AD/HD team measures included behavioral changes and self-management goals. Documentation of current self-management goals rose from 20 percent to 55 percent, and behavioral improvement increased from 73 percent to 80 percent of pediatric patients. Since the final learning session, four clinics have developed a statewide AD/HD registry through CDEMS, the public domain electronic medical record used by most community clinics and many private practices.
- The overweight team measures included body mass index (BMI) measurement, self-management goals, follow-up for patients at risk of being overweight, and delivering lifestyle messages to patients. BMI measurement increased to almost 100 percent by the end of the collaborative; in contrast, current literature indicates that many clinical sites measure BMI about 40 percent of the time. Since the last learning session, participating clinics have shared results and have initiated improvement projects with several clinics that did not participate in the collaborative.

Quality oversight. HRSA has restructured to improve its oversight of QI activities—first by forming a quality oversight committee to review TeaMonitor results, recommend corrective actions for health plans, and follow up on issues identified by EQR activities, and more recently by creating the Office of Quality and Care Management. The new quality monitoring section will examine EQR results across the Medicaid managed care system as the state begins to integrate the delivery of medical and mental health services.

The path to future improvements

Previous annual reports have offered recommendations for HRSA and the Healthy Options plans, aimed at improving access to care and the quality and timeliness of care. Many of those recommendations remain valid for Healthy Options and for the WMIP and MMIP. Equally important, however, is the continuity of partnership and collaboration between HRSA and the health plans to improve care for enrollees. Those efforts have led to the statewide gains evident in areas such as childhood immunizations and infant WCC visits over the past five years.

The following discussion highlights HRSA’s progress in responding to the previous EQR recommendations and recaps recommendations that remain valid to sustain long-term improvement in the delivery of Medicaid services.

Quality strategy. HRSA has not updated its managed care quality strategy since 2003. Acumentra Health recommends that HRSA

- **update the quality strategy** to reflect HRSA’s new organizational structure—in particular, the planned integration of physical and mental health care and the creation of HRSA’s new quality monitoring section

Value-based purchasing. Contractual pay-for-performance incentives have focused the Healthy Options plans on working to improve immunization and preventive care rates for children. Early results of this strategy have been positive, and moving the incentives downstream may lead to further improvement. Acumentra Health recommends that HRSA continue pay-for-performance incentives. As discussed above, CHIS, once implemented, will extend value-based purchasing to the clinic and provider level.

Improving preventive care. While most children in Healthy Options have access to primary care, the majority of children still are not receiving preventive care regularly when they visit their PCPs. HRSA has responded to the previous EQR recommendations as follows:

- **consider planning additional focused studies of ways to improve preventive care for children.** During the 2008-2010 EQR scope of work, HRSA plans to invest in clinical studies that focus on state-level performance, comparing the managed care population with the FFS population.
- **collaborate with health plans to provide performance feedback to clinics and providers regarding preventive services.** HRSA’s five-year plan for the CHIS includes providing performance feedback as well as financial incentives to clinics.
- **continue support for CHIC** to help providers collaborate in their efforts to improve care for children. HRSA continues to seek a source of sustained funding for this collaborative project.

Performance improvement projects. The Healthy Options plans invest considerable resources in conducting PIPs to meet state contractual requirements that exceed the federal requirements. BBA regulations require managed care contractors to conduct two PIPs per year; HRSA requires the Healthy Options plans to conduct five. HRSA has responded to previous EQR recommendations as follows:

- **reduce the number of PIPs required.** HRSA’s 2008–2009 contract with the health plans reduces the number of required PIPs to a minimum of two and a maximum of four, depending on corrective actions for each plan.
- **consider conducting a statewide PIP.** HRSA has indicated that health plan participation in the ongoing CHIC project fulfills the requirement for one PIP.

Compliance review. HRSA’s incremental approach to oversight during BBA implementation has resulted in refinements to TeaMonitor’s compliance review process over the past three years. HRSA has taken steps to implement previous EQR recommendations by providing a clear summary of the compliance findings to guide the health plans in correcting any deficiencies. Although progress is evident, Acumentra Health again recommends that HRSA

- *continue to refine and standardize TeaMonitor procedures and scoring methods* to define clear expectations for the health plans and to make year-to-year comparisons more meaningful and reliable
- move beyond a narrow focus on regulatory compliance to *offer health plans more technical assistance and support*. The TeaMonitor process offers an opportunity for the state to identify specific technical assistance needs for each health plan.

Data improvements. The 2007 HEDIS report noted that because of inadequate encounter data, the Healthy Options plans must devote considerable resources to medical chart reviews to collect some of the necessary measurement data. Better encounter data would enable the plans to redirect some of the resources spent on data collection toward providing better care for enrollees.

Acumentra Health again recommends that HRSA

- *continue to help health plans study and overcome barriers to collecting adequate administrative data for HEDIS measures*. HRSA could consider conducting an optional study aimed at improving or validating encounter data, as provided by the EQR protocols.
- *encourage health plans to serve as a resource* to support clinics as they implement electronic medical record and data systems or engage in related QI activities

EQR follow-up. Future improvements will result from the interplay of the managed care quality strategy, QI activities, and annual reporting. The EQR results, reported annually, should inform the quality strategy, which is deployed through contract requirements and QI activities. Acumentra Health recommends that HRSA

- *implement contractual requirements for the Healthy Options plans to address the specific recommendations in this report*

HRSA has pursued an incremental approach to quality improvement, preserving the activities that have proved to work well and phasing out activities that have proved less valuable. The above recommendations are intended to help HRSA and the health plans continue to strengthen the foundation for excellence in Medicaid managed care, comply with federal standards, and improve the quality of care by using resources as efficiently as possible.

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