

Case Study

Washington State Medicaid: An Evolution in Care Delivery

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States are often referred to as “laboratories for innovation,” and Washington State’s Medicaid agency embodies that characterization. On the surface, its agency looks like many others: its beneficiaries with complex and high-cost health needs are similar to people with chronic needs in many states. Yet, the Medicaid agency relentlessly designs and tests ways of improving care for its beneficiaries and controlling costs for the state’s taxpayers.

This case study examines how Washington’s Medicaid “laboratory” is different, even though its aged, blind, and disabled (ABD) beneficiaries with complex needs, as illustrated below, are essentially the same as those seen in other states across the country. Mainly served in fragmented, fee-for-service delivery systems, they include:

- The 60-year-old obese man with congestive heart failure, chronic open leg ulcers, and substance abuse problems;¹
- The patient with diabetes, schizophrenia, and alcoholism; and
- The chronic pain client with bipolar disease who is on high-dose narcotics from multiple providers.

Like most states, Washington’s beneficiaries with complex needs represent only a fraction of the Medicaid population, yet their costs account for a large percentage of program dollars. What makes Washington unique is the state’s adaptable “learn as you go” approach to designing, testing, evaluating, and refining multiple strategies to improve the quality and cost-effectiveness of care for these high-need beneficiaries.

The state’s pilot efforts run on a parallel track, offering a setting to test different models of care delivery and learn from both program successes and “productive failures” to refine program design. The pilots are aimed at various population subsets (beneficiaries with targeted chronic conditions, those with complex needs, and dual eligibles) and use different financing strategies, from full-risk capitation to fee-for-service. Following is a discussion of Washington’s multi-pilot approach to identify and develop effective chronic care management strategies for beneficiaries with complex needs.

This case study is part of a CHCS series reporting on innovative strategies to improve the quality and cost effectiveness of care for Medicaid populations with complex and special needs. For additional information, see the external Evaluation of Washington State Medicaid Chronic Care Management Projects², which also includes information about the Aging and Disability Services Administration Chronic Care Management Project.

Washington State: From Disease to Chronic Care Management

Washington Disease Management Program

In 2002, Washington became one of the first states to implement a disease management pilot program for Medicaid beneficiaries. The program, which operated on a statewide basis until 2006, was open to fee-for-service ABD beneficiaries with targeted chronic conditions — end-stage renal disease, chronic

¹ Patient examples provided by Jeffery Thompson, MD, MPH, chief medical officer, Washington Medicaid Program.

² Available at, <http://fortress.wa.gov/dshs/maa/healthyoptions/newwho/reports/FinalReport.pdf>.

kidney disease, congestive heart failure, asthma, diabetes, and/or chronic obstructive pulmonary disease (added in 2005). Children with asthma were also eligible to participate. By improving care coordination for these target populations, the program set an overall goal to decrease medical expenditures by five percent.³

Through the program, two vendors — Renaissance Health Care and McKesson Health Solutions — provided disease management services for approximately 20,000 eligible beneficiaries with any of the eight targeted conditions. Participating beneficiaries received an initial health assessment to determine their risk level and establish a baseline. The frequency of contact between the contractor and the beneficiary was determined by the risk level. Telephonic education and disease management services were provided for beneficiaries at the lowest risk, while in-home visits were provided for those with the highest risk. Attempts were also made to involve providers in the program. At the local level, providers were encouraged to give feedback on beneficiaries' care plans, prescriptions, etc. At the state level, providers were represented on advisory committees and provided feedback on the process through which the state and its contractors identified beneficiaries for enrollment.

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While the program raised the quality of services available to some chronic care patients, and reduced hospital days for children with asthma and beneficiaries with end-stage renal disease, it did not generate the cost savings that were agreed to in the contract. The state believes that cost savings may have been hindered for two reasons: (1) the population may not be as stable in terms of eligibility for services, turnover, etc., as originally assumed; and (2) participating beneficiaries were encouraged to use preventive care for their chronic conditions, which may have driven up the use of provider services in the short term.⁴ Furthermore, and perhaps most importantly, the state recognized that given the complexity of its Medicaid population and the predominance of multiple chronic conditions, the single-diagnosis model did not necessarily reach the state's highest-risk populations.

Washington Medicaid Integration Partnership

Since Washington's Disease Management program focused only on beneficiaries with single chronic conditions, the state sought an additional, more comprehensive approach to identify and address the disproportionate use of services by ABD beneficiaries with multiple chronic conditions and high costs. ABD beneficiaries are the fastest growing segment of the state's Medicaid population, comprising 15 percent of the total population, but accounting for 35 to 40 percent of total fee-for-service expenditures.⁵ After issuing an RFP, the state contracted with Molina Healthcare of Washington to run the program.

The resulting Washington Medicaid Integration Partnership (WMIP), launched in January 2005, was designed based on the premise that increased access to and better coordination of mental health, chemical dependency treatment and long-term care services would lower medical costs and reduce mortality.⁶ The program integrates primary care, mental health and substance abuse services, long-term care and disease management for ABD beneficiaries in Snohomish County using case management provided by Molina. Care coordination includes a health risk assessment, monitoring of patient

³ A. Lind. "Disease to Chronic Care Management."

⁴ Washington Department of Social and Health Services. "Medicaid Disease Management Program Winds Down as DSHS Prepares New Approach for 2007."

⁵ Mathematica Policy Research, Inc. *Evaluation of the Medicaid Value Program: Health Supports for Consumers with Chronic Conditions*. Center for Health Care Strategies, August 2007.

⁶ Ibid.

symptoms, and patient education. Coordinated Care Teams (CCTs), which include a registered nurse or licensed mental health counselor and a care coordination specialist, coordinate all care for WMIP beneficiaries. The degree of contact between the CCT and patients depends on each beneficiary's conditions and associated level of risk. Beneficiaries with the lowest level of risk are contacted at least once per quarter, while those with the highest level of risk are contacted at least twice a month.

WMIP's various components were phased in gradually, promoting successful implementation by focusing resources and attention on one component at a time. The initial implementation in January 2005 included primary care and substance abuse services; mental health services were added in October 2005, and long-term care services were added in October 2006.

The state took advantage of the gradual roll-out to identify what was not working and adjust program features accordingly. For example, rate setting was initially too complicated, so the state opted to blend rates. When large numbers of potential enrollees were overlooked, a data systems analyst was hired to manually comb through data for eligible members. And when the state realized early on that it had put too little emphasis on external relationships, it strengthened WMIP's focus on building partnerships to support client-centered care. This approach to seeking out potential problems and refining program design in real time has helped Washington to continuously evolve its programs.

As a result of this ongoing fine tuning, the program, which currently serves approximately 3,000 beneficiaries, has demonstrated positive initial results for key measures. Inpatient admissions and days in state mental hospital facilities have decreased compared to fee-for-service beneficiaries, and patient satisfaction with aspects of care delivery (e.g., shorter wait times for routine care appointments) and care coordination has improved.⁷ As a result of these successes, the Washington State legislature is continuing its authorization for enrollment into WMIP with funding for up to 6,000 total beneficiaries.

Medicare-Medicaid Integration Project

In 2005, Washington also introduced the Medicare-Medicaid Integration Project (MMIP) to integrate medical and long-term care and financing for dual eligible seniors in two counties. Through the pilot program, dual eligible seniors in King and Pierce counties could voluntarily enroll in both Evercare's Medicaid contracted state plan (MMIP) and its Medicare Advantage Special Needs Plan, for Medicare and Medicaid long-term care supports and services.

The program got off the ground slowly for a variety of reasons. It was marketed through its provider networks and thus relied heavily on providers to identify and refer clients. Those enrolled tended to be healthier than the average dual without long-term care needs. In addition, due to some pushback from the case management community, long-term care beneficiaries were not presented the program enrollment option at the time of assessment. Additional efforts to garner buy-in from case managers and consumers may have been helpful. However, because the timing paralleled the launch and promotional muscle of Medicare Part D, it may have been difficult to deliver clear messages about the benefits of MMIP.

Although the state had set a goal of 500 enrollees by the end of 2007, only 225 dual eligibles were enrolled in the program at year end, reflecting the ongoing difficulty in ramping up enrollment. Beneficiaries participating in MMIP gave it positive reviews, but because of the small enrollment numbers, the state and Evercare made a mutual decision to disband the program in early 2008.

⁷ Ibid.

Chronic Care Management Program

With the discontinuation of the Medicaid Disease Management pilot in 2006, the state sought a new strategy to progress from a disease-specific focus to a more holistic approach for its most complex and costly populations. In particular, state officials felt it was critical to target beneficiaries who would benefit most from care management techniques to prevent the disease progression that results in increasingly expensive care and poor quality of life.⁸ As a result, the state developed the Chronic Care Management Program (CCMP). This program, launched in January 2007, pairs the techniques refined in the state's Disease Management program with a predictive modeling tool that identifies beneficiaries at highest risk for service use.⁹

CCMP provides case management, education and support, as well as assistance accessing health resources, for fee-for-service ABD beneficiaries who are identified as high risk.¹⁰ The state contracts with two vendors for CCMP. The King County Care Partners (KCCP) project is a local care management program that provides medical home and care management services to enrolled beneficiaries in a limited geographic area. United Healthcare Services/AmeriChoice is a statewide vendor responsible for the predictive modeling tool that is used to identify potential beneficiaries for its program and for KCCP. This vendor also provides more traditional telephonic disease management and care management services. This two-pronged approach allows the state to test different models of care to see what works best and continuously improve program quality.

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Both contractors are expected to provide the following care management activities for participating beneficiaries:

- Screen/assess risk factors such as health status, self-management skills, adherence to treatment plan and prescribed medications, and individual needs such as limited English proficiency and health literacy;
- Develop a personalized care plan that includes a focus on self-management skills;
- Link beneficiaries to a medical home; and
- Refer beneficiaries to medical, mental health, chemical dependency service providers, and other social services as needed.¹¹

To ensure continuous quality improvement, the state will evaluate CCMP using a randomized controlled design to achieve more rigorous comparisons of quality and cost-savings.

Conclusion

The evolution of Washington Medicaid's care models for beneficiaries with complex needs illustrates how a state can function as a "learning laboratory." Rather than waiting for the perfect solution to be developed, Washington's "learn as you go" philosophy allows the state to incorporate the lessons of one program into the development of new ones, with simultaneous programs testing a variety of different models at any given time.

⁸ Ibid.

⁹ Washington Department of Social and Health Services. Request for Proposals: Chronic Care Management Program, July 2006.

¹⁰ Those using long-term supports and services through the Aging and Disability Services Administration are excluded from CCMP participation.

¹¹ Washington Department of Social and Health Services. Request for Proposals, op cit.

Washington's efforts to improve care for beneficiaries with the most complex care needs continue to evolve. Given its early success, the state is exploring the possibility of expanding the Washington Medicaid Integration Partnership into an additional county in the future. While expansion is closely linked to stakeholder and political buy-in, the final evaluation of WMIP will help determine its viability. The state is also open to exploring additional program options that might work better for different subsets of the ABD population. For example, the state would like to expand or build on the local care management model, like the one currently being piloted in King County, to test the feasibility of adding a contracted medical home component. The medical home component would give the state and its contractor(s) additional influence over provider behavior and access to care. Based on the success of the CCMP and the planned medical home model, the state would like to see an expansion of local care management models into additional counties.

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Maintaining a fluid and creative approach to improving care management has afforded Washington State room to test new models, learn, and continually refine strategies to more effectively address the needs of beneficiaries with complex chronic needs. Other states can learn from this flexible mentality, which successfully gleans lessons from both program achievements and productive failures to shape future innovations for the state's high-need populations.

Resources

Following are online resources that provide more detail about Washington's programs:

- **Evaluation of the Medicaid Value Program: *Washington State Case Study*:** Describes interventions implemented in the Washington Medicaid Integration Partnership for beneficiaries with multiple chronic conditions. www.chcs.org/usr_doc/Washington_State-CaseStudy.pdf
- **Evaluation of the Integrated Care Program:** Documents the activities of five states in the *Integrated Care Program*, including Washington State, in integrating care for dual eligibles. www.chcs.org/usr_doc/ICP_Final_Evaluation.pdf
- **Washington Medicaid Integration Partnership Website:** Provides background, contact, and research information on Washington's pilot project, as well as patient and provider information. <http://fortress.wa.gov/dshs/maa/MIP/>

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies and health plans to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.