HOUSE BILL REPORT
SSB 5125

As Passed House
April 8, 1997

Title: An act relating to statutory authority to revise medical assistance managed care contracting under federal demonstration waivers granted under section 1115.

Brief Description: Authorizing revisions in medical assistance managed care contracting under federal demonstration waivers.

Sponsors: Senate Committee on Health & Long-Term Care (originally sponsored by Senators Deccio, Wojahn and Winsley; by request of Department of Social and Health Services).

Brief History:
Committee Activity:
Health Care: 3/25/97, 3/28/97 [DP].
Floor Activity:
Passed House: 4/8/97, 92-0.

HOUSE COMMITTEE ON HEALTH CARE

Majority Report: Do pass. Signed by 10 members: Representatives Dyer, Chairman; Backlund, Vice Chairman; Cody, Ranking Minority Member; Murray, Assistant Ranking Minority Member; Anderson; Conway; Parlette; Sherstad; Wood and Zellinsky.

Staff: Bill Hagens (786-7131).

Background: The Medical Assistance Administration (MAA) within the Department of Social and Health Services (DSHS) currently contracts with 19 managed care health insurance carriers (including health care service contractors and health maintenance organizations) to provide services to about 437,000 children, pregnant women and AFDC recipients. The program is widely known as *Healthy Options.*

Each *Healthy Options* enrollee must choose one of these 19 carriers, unless the enrollee obtains an exemption for good cause. However, under current federal requirements, an enrollee may change carriers each month. Also, under current federal requirements, a managed care carrier that becomes a *Healthy Options* carrier may have no more than 75 percent of their total enrollment covered by Medicare or Medicaid.

Under state law (RCW 74.09.522), the DSHS does not have explicit authority to administer its programs according to waivers it may obtain from federal requirements, a Medicaid enrollee may not be locked into– a plan for longer than six months, a managed care contract may only be negotiated after the DSHS determines the upper and lower limits of the expected cost of providing health services, and the DSHS must obtain a large number of contracts with providers of health services– within the Medicaid program.

In addition, RCW 48.46.150 allows the DSHS to contract with health maintenance organizations to serve Medicaid patients, but prohibits the DSHS from engaging in mandatory enrollment of Medicaid recipients in health maintenance organizations.

The 1996 Supplemental Operating Budget for the state of Washington (ESSB 6251) required the DSHS to take several actions in order to achieve an actual reduction in the per capita rates paid to managed care plans in calendar year 1997 . . . including . . . a) selectively contracting with only those managed care plans in a given geographic area that offer the lowest price, while meeting specified standards of service quality and network adequacy; (b) revising program procedures through a federal waiver if necessary, so that recipients are required to enroll in only one managed care plan during a contract period, except for documented good cause; and (c) disproportionately assigning recipients who do not designate a plan preference to plans offering more competitive rates.–

The DSHS has stated that current law should be updated to give the DSHS "necessary authority to implement restrictions on clients' ability to change plans without good cause; contract with certain plans that have a disproportionate number of Medicaid or Medicare enrollees; and clarify. . . [DSHS's] contracting authority.–

Summary of Bill: The Department of Social and Health Services' authority to contract with managed care organizations to provide health services to recipients of Aid to Families with Dependent Children is altered in several ways.

The definition of managed care is modified to include programs that meet waivers granted to the DSHS by the federal government for the program.

The maximum time within which the DSHS may require managed care enrollees to remain in one plan is doubled from six months to one year and is to be set by the DSHS in rule, so long as this time period is consistent with federal law or waivers granted to the DSHS from federal requirements.

The existing exception from the requirement that the DSHS not enroll a disproportionate share of AFDC recipients in a single managed care plan is expanded to allow such disproportionate enrollment as may be allowed under waivers the DSHS may receive from federal requirements on this issue.

The requirement that the DSHS determine a range of the expected costs of providing health services before negotiating managed care contracts to provide them is eliminated.

The requirement that the DSHS contract with a large number of health providers for services to AFDC recipients is eliminated.

The prohibition against the DSHS mandating enrollment in health maintenance organizations is repealed.

The Legislature finds that competition in the managed care market place is enhanced, in the long run, by the existence of a large number of managed care systems from which Medicaid enrollees can choose. When improved health status is the goal, it is important to retain continuity of enrollee relationships with these systems and to minimize disruption. To these ends, a series of principles are established to guide the DSHS in its *Healthy Options* managed care purchasing efforts. They involve assuring the opportunity for all managed care systems to compete based on their commitment and experience in serving low-income populations, their capability in performing services, and their quality accessibility, payment rates and other factors.

Significant weight should be given to quality, accessibility and commitment in serving low income populations.

All regulated health carriers must meet state minimum net worth requirements as established in law. The DSHS may establish net worth requirements for contractors who are not regulated carriers.

The department must establish negotiation and dispute resolution mechanisms for the *Healthy Options* contracting process after giving strong consideration to those employed by the Health Care Authority.

The department may apply the principles established for *Healthy Options* contracting to its efforts to contract for services on behalf of clients receiving supplemental security income.

Appropriation: None.

Fiscal Note: Not requested.

Effective Date: The bill contains an emergency clause and takes effect immediately.

Testimony For: The bill is needed to clarify the DSHS's authority to operate within federal waivers, to extend the period for which mandatory enrollment in a plan may be enforced once an enrollee selects a plan, to negotiate with health systems without

first determining the actual cost of services, and to do other things to implement managed care contracting for the Medicaid population.

Testimony Against: None.

Testified: Jane Beyer, Medical Assistance Administration, Department of Social & Health Services (pro); and Diane Stollenwerk, Providence Health System and Peace Health (pro).