FINAL BILL REPORT

SSB 5125

C 34 L 97
Synopsis as Enacted

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).

Senate Committee on Health & Long-Term Care
House Committee on Health Care

Background: The Medical Assistance Administration 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 Aid to Families with Dependent Children (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, 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 DSHS determines the upper and lower limits of the expected cost of providing health services; and DSHS must obtain a large number of contracts with providers of health services ...– within the Medicaid program.

In addition, current law allows DSHS to contract with health maintenance organizations to serve Medicaid patients, but prohibits 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 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.–

DSHS has stated that current law should be updated to give 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: The Department of Social and Health Services' authority to contract with managed care organizations providing health services to Aid to Families with Dependent Children recipients is altered in several ways.

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

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

DSHS is allowed such disproportionate enrollment of AFDC recipients in a single managed care plan as may be allowed under waivers DSHS may receive from federal requirements on this issue.

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

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

The prohibition against 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 DSHS in its *Healthy Options* managed care purchasing efforts. They involve assuring the opportunity for all managed care systems to compete based on commitment and experience in serving low-income populations, quality, accessibility, capability to perform services, payment rates, and other factors.

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

All regulated health carriers must meet state minimum net worth requirements as established in law. 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.

Votes on Final Passage:

Senate	47	0
House	92	0

Effective: April 16, 1997