SENATE BILL REPORT
ESSB 5523

As Passed Senate, March 13, 2019

Title: An act relating to improving managed care organization performance in caring for medicaid clients.

Brief Description: Improving managed care organization performance in caring for medicaid clients.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Braun, Rivers and Frockt).

Brief History:
Committee Activity: Ways & Means: 2/13/19, 2/25/19 [DPS, w/oRec].
Floor Activity:
Passed Senate: 3/13/19, 48-0.

Brief Summary of Engrossed First Substitute Bill

- Requires the Health Care Authority to contract with an external quality review organization (EQRO) to evaluate managed care plans under the Medicaid program.
- Makes Medicaid managed care funding contingent upon for each of seven performance measure areas evaluated by the EQRO.
- Allows HCA to waive the performance requirement once every five years.
- Adds standard reporting for performance measures for Managed Care Organizations.

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Substitute Senate Bill No. 5523 be substituted therefor, and the substitute bill do pass.

Signed by Senators Rolfes, Chair; Frockt, Vice Chair, Operating, Capital Lead; Mullet, Capital Budget Cabinet; Braun, Ranking Member; Brown, Assistant Ranking Member, Operating; Honeyford, Assistant Ranking Member, Capital; Bailey, Becker, Carlyle, Liias, Palumbo, Rivers, Schoesler, Van De Wege, Wagoner, Warnick and Wilson, L..

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Minority Report: That it be referred without recommendation.
Signed by Senators Billig, Conway, Darneille, Hasegawa, Hunt, Keiser and Pedersen.

Staff: Sandy Stith (786-7710)

Background: Managed care is a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty, and ancillary health services. Washington Apple Health is the Medicaid managed care program for low-income people in Washington. Washington Apple Health offers eligible families, children under age nineteen, pregnant women, and certain blind or disabled individuals, a complete medical benefits package.

The HCA establishes standards for managed care organizations that seek to contract to provide services to clients in the Washington Apple Health program. The standards include:

- obtaining a certificate of registration from the Office of the Insurance Commissioner to provide the health care services;
- accepting the HCA's managed care contract;
- demonstrating the ability to meet the HCA's network and quality standards; and
- being awarded a contract through a competitive process or an application process.

There are currently five managed care organizations participating in Washington Apple Health. The Washington Apple Health contract requires all contractors be accredited with the National Committee on Quality Assurance (NCQA). NCQA is a private, non-profit organization that maintains accreditation programs for several types of health care entities, including health plans, managed behavioral healthcare organizations, accountable care organizations, and wellness and health promotion programs.

Federal regulations set forth the parameters states must follow when conducting an external quality review (EQR) of its contracted managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs). An EQR is the analysis and evaluation by an EQRO of aggregated information on quality, timeliness, and access to the health care services that an MCO or PIHP, or their contractors, furnish to Medicaid recipients.

Summary of Engrossed First Substitute Bill: The HCA is required to contract with an EQRO to compare managed care outcomes with those of other states. The EQRO must share its results with HCA, the Governor and the Legislature beginning November 2019.

Beginning in plan year 2020, Medicaid managed care funding is contingent upon performance in three common measures across each managed care organization, including:

- at least one common measure weighted toward having the potential to impact managed care costs; and
- at least one common measure weighted toward population health management, as defined by the measure.

Medicaid managed care funding is additionally contingent upon performance in four quality measures specific to a managed care organization chosen by HCA. These measures must:

- be chosen from the total measures the managed care organizations are required to report;

- reflect specific measures whether the managed care organization has poor performance; and
- be substantive and clinically meaningful in promoting health status.

The total amount withheld from managed care organizations will be 3 percent. Managed care organizations may earn back funds by making statistically significant improvement in each of the defined measures or by scoring in the top quartile of the performance measure. The amount withheld shall be proportional to the findings of statistically significant improvement or top quartile improvement. HCA may use an alternate methodology for approximating top quartile performance for two of the four measures where no national measurement exists.

HCA will notify MCOs of any required remittances by January 30th for the preceding plan year.

HCA may waive these performance requirements for an MCO if there is an adequate reason for missing the target. This may be done once every five years.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Original Bill: *The committee recommended a different version of the bill than what was heard.* PRO: We need to look at the way our managed care organizations are delivering care. We need to make sure we are getting suitable and available care to all of our citizens. I believe there are some improvements we can make to the bill to address the technical challenges. We can not sit by and see rates increase by nearly 9 percent, but care that falls below the 50th percentile.

OTHER: We share an interest in assuring there is accountable care from the managed care plans. We have five managed care plans. We require them to be NCQA accredited. This looks at 56 different performance measures and looks at these against quality, access, and timeliness of care. We have an EQRO that does an independent review. We also have TEAMonitor that looks at plans annually. Beginning in 2017, we have a withhold that started out at 1 percent and has now gone up to 1.5 percent of plan per member per month costs. Plans have to earn this back by performing against quality measures. This is a way to motivate plans to do better. We do have concerns about the 1 percent of premium withhold that falls below the 50th percentile. We would like to work with you because this is something that would not be deemed to be actuarially sound. This is something that is required by our federal authorizing environment. We understand the concerns. We see the HEDIS measures as an opportunity for continuous learning. Managed care organizations have various opportunities for learning and process improvement plans (PIPs). We have looked at ways to improve prenatal care, how to get women into needed care, and how to do this when we do not know the client is pregnant. We have offered various incentives such as free car seats and breast pumps. We take quality improvement and continuous learning

seriously. The nine performance measures in our contracts are effective. We support the intent of this bill, but we need to work on the language. Our experience is with integrated care in southwest Washington. We have managed our 23 assigned inpatient beds at Western State Hospital and have managed these down to 16 as a result of discharge planning and appropriate diversion into the community. We have also improved our immunization rates for adolescents. Withholding is an important tool with providers in value-based purchasing (VBP) contracting. The state currently requires 70 percent of contracts to be VBP contracts. Amerigroup has over 80 percent. We work with clients on access and getting clients into the care they need. We support Section 1 and the outcomes outlined there. We have concerns with Section 2 being a duplication of the quality review process. We also have a concern with remitting 1 percent as opposed to withholding at the beginning. We are concerned with how this is structured, but we like the policy.

Persons Testifying: PRO: Senator John Braun, Prime Sponsor.

OTHER: MaryAnne Lindeblad, Health Care Authority; Patricia Seib, Molina Healthcare of Washington; Andrea Tull-Davis, Coordinated Care; Dave Knutson, Community Health Plan of Washington; Caitlin Safford, Amerigroup.

Persons Signed In To Testify But Not Testifying: No one.