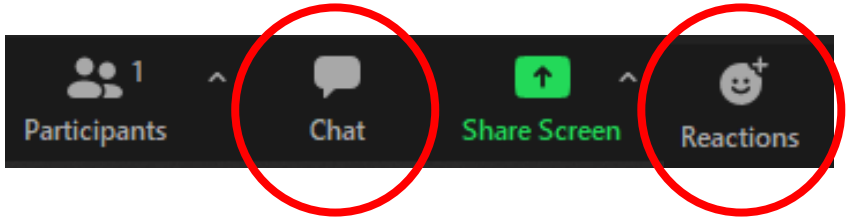
HCA Legislative Symposium

December 16, 2022

Washington State Health Care Authority

Welcome to Zoom!

- We're recording this webinar and muted all attendees.
- There will be time at the end for Q&A.
  - Submit comments through the **"Chat"** function
  - To verbally share your comments, raise your hand using the **"Raise Hand"** function (under "Reactions")



- View the slide deck and webinar recording at hca.wa.gov/about-hca/medicaid-transformation-project-mtp/meetings-and-materials.

Agenda

- Opening remarks
- Apple Health & Clinical Policy
- Behavioral Health Delivery
- Apple Health Financing
- Lunch and Keynote
- Health equity
- Employee and Retiree Benefits
- Closing remarks

Today's presenters

- **Sue Birch,** director, Health Care Authority (HCA)
- **Heather Howard,** professor and director, State Health and Value Strategies, Princeton University
- **Dr. Charissa Fotinos,** Medicaid director, HCA
- **Dr. Judy Zerzan-Thul,** chief medical officer, HCA
- **Keri Waterland,** assistant director, behavioral health and recovery, HCA
- **Dave Iseminger,** director, employees and retirees benefits, HCA
- **Megan Atkinson,** chief financial officer, financial services, HCA
- **Jason T. McGill,** assistant director, Medicaid programs, HCA
- **Michael Brown,** director, program integrity, HCA

Today's presenters continued

- **Michael Langer,** deputy division director, behavioral health and recovery, HCA
- **Teesha Kirschbaum,** deputy division director, behavioral health and recovery, HCA
- **Quyen Huynh,** health equity director, policy, HCA
- **Moderator: Evan Klein,** special assistant, policy and legislative affairs, policy, HCA

Opening Remarks

Sue Birch, Director

Washington State Health Care Authority

Apple Health (Medicaid)

Dr. Charissa Fotinos, Medicaid Director

Jason T. McGill, Deputy Division Director, Medicaid Programs

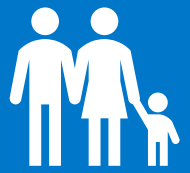
Washington State Health Care Authority

What is Medicaid?

Medicaid & CHIP: state-federal partnership

Entitlement

Eligible individuals are entitled to a defined set of benefits



States are entitled to federal matching funds

Federal

Sets required coverage for 26 groups and mandatory benefits

Partnership

State

Flexibility to administer the program within federal guidelines

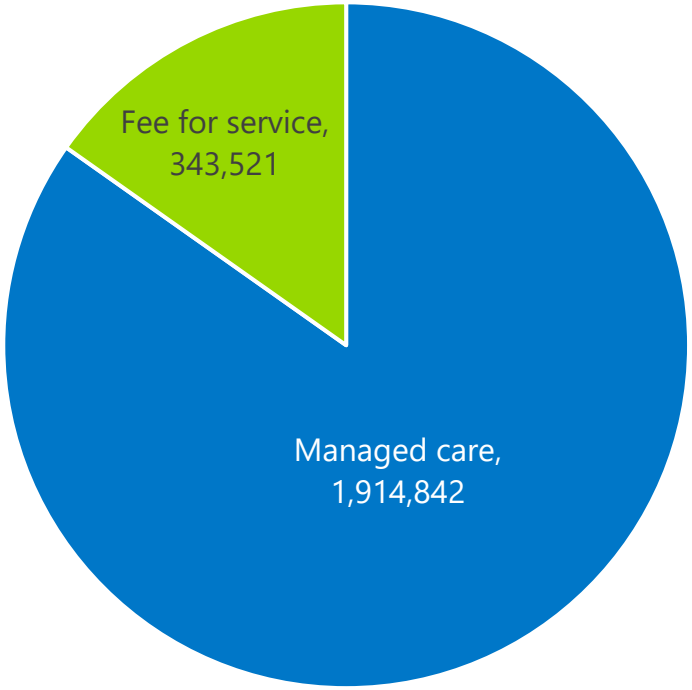
The structure

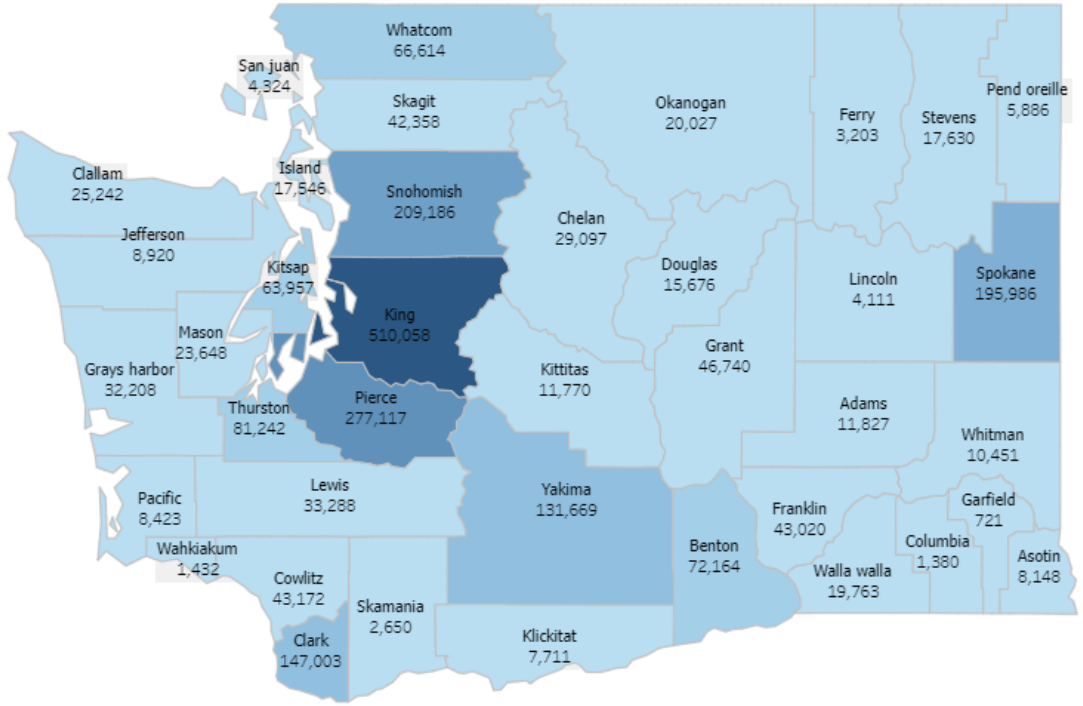
- The Medicaid State Plan is the contractual agreement between the state and the federal government authorizing Medicaid.
- Each state plan designates a single agency to administer or supervise the administration of the state plan, of which in Washington state
- The Health Care Authority is designated the single state agency in Washington state, responsible to:
  - Oversee & monitor the state plan and program functions to ensure system cohesiveness and effectiveness (e.g., managed care, behavioral health personal care, discharge transitions, etc.)
  - Determine eligibility
  - Act as state spokesperson with CMS for waiver and other major decisions (e.g., Medicaid Director issues final orders)
  - Maintain a process to ensure Indian Health Programs and Tribal Health Organizations are consulted
  - Administer and decide upon fair hearings
  - Delegate a limited set of responsibilities to other agencies (DSHS primarily)

Washington State Plan ID WA-18-0017

Who is covered by Medicaid?

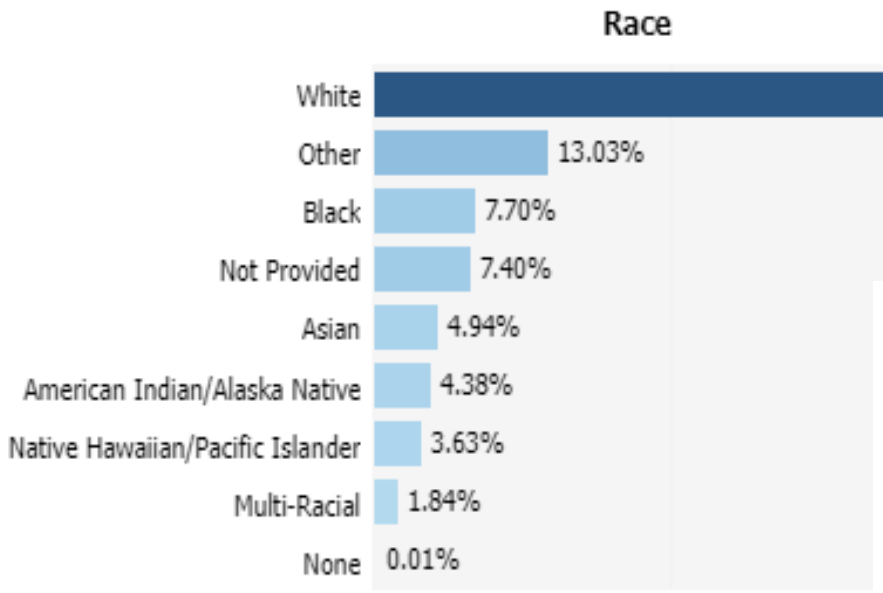
Current Apple Health enrollment

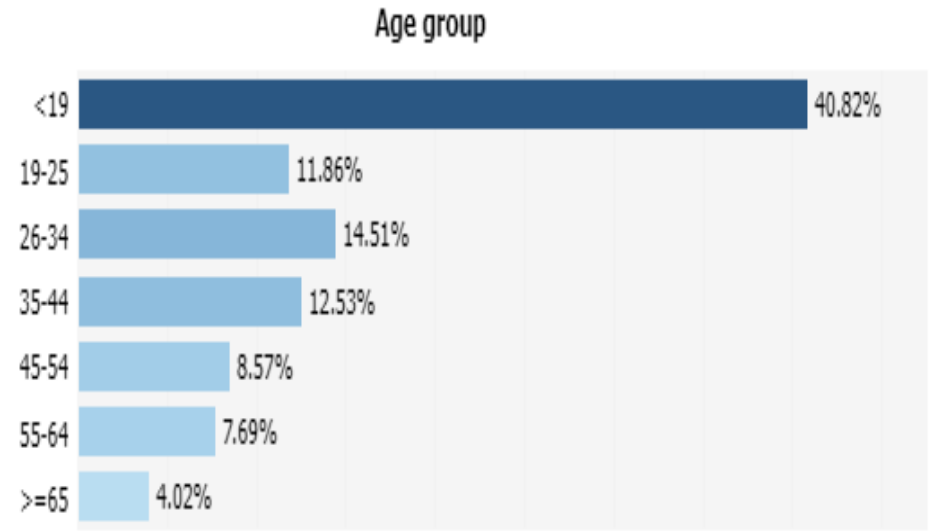




Fee-for-service chiefly American Indian/Alaskan Native and dually eligible Medicare and Medicaid population (with behavioral health offered under managed care)

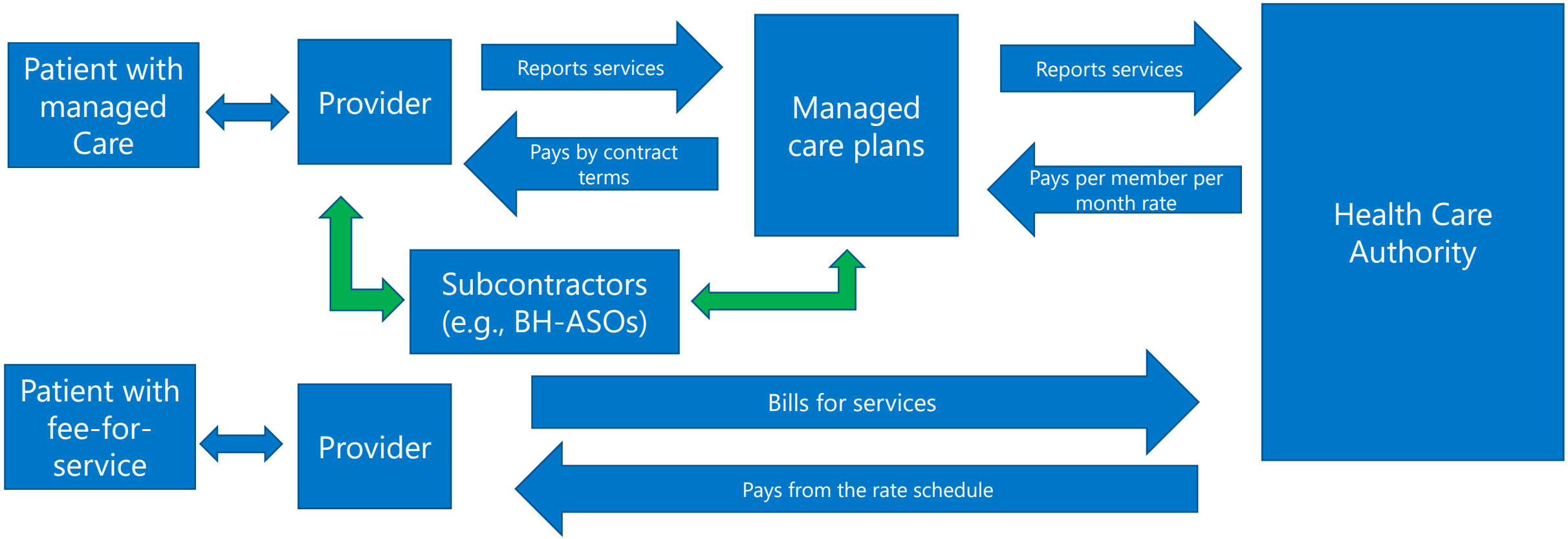
Race, Age and Languages





Preferred Written Language	Number of Clients
Summary	**2257304**
English	1942468
Spanish; Castilian	202523
Russian	21657
Vietnamese	13707
Chinese	11034
Ukrainian	8819
Dari	5674
Arabic	4896
Korean	4528
Somali	3556
Amharic	2368
Panjabi; Punjabi	2037
Cambodian/Khmer	1991
Other Language	1858
Tigrinya	1761
Pushto	1671
Farsi	1486
Portuguese	1456
Burmese	1088
French	1015
Tagalog	1004
Romanian	718
Chuukese	572
Oromo	562
Swahili	519

Managed Care Vs. Fee for Service



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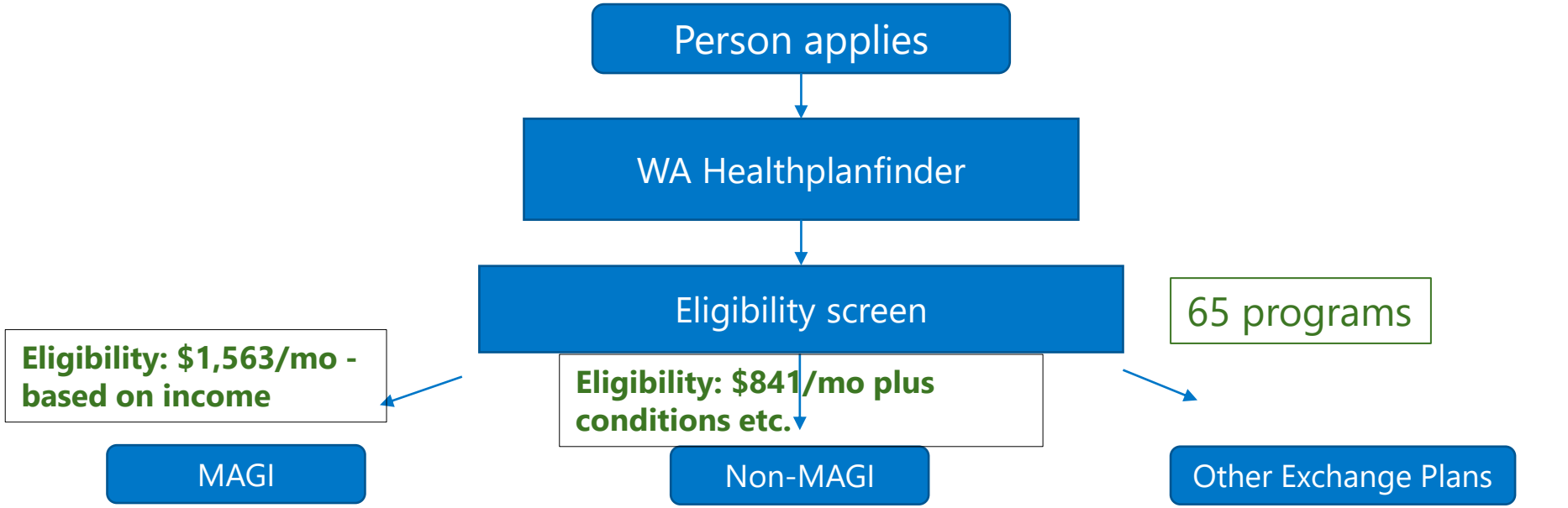
Determining eligibility



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Medicaid benefits & services

Apple Health offers complete physical and behavioral health coverage for eligible individuals, including:

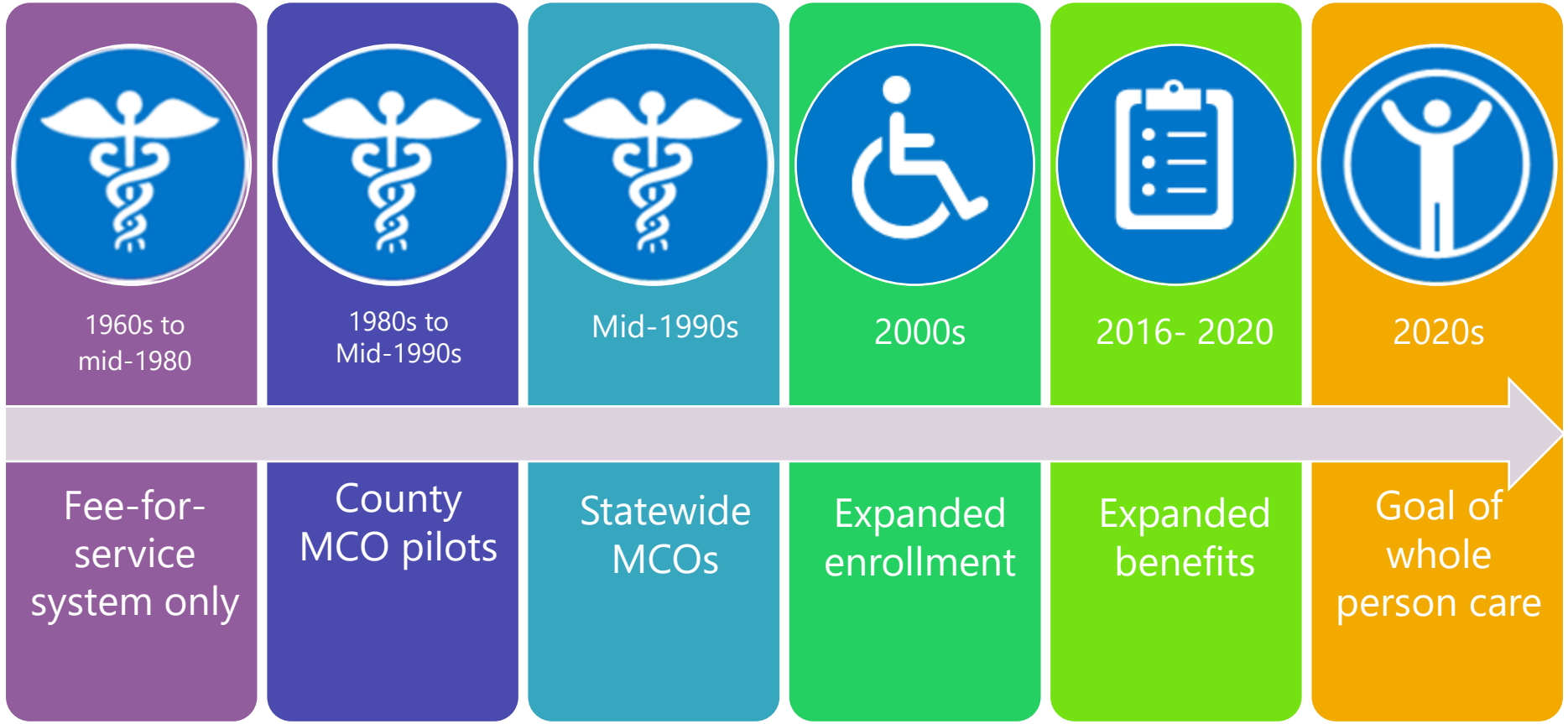
- Appointments with a doctor or health care professional for necessary care
- Medical care in an emergency
- Maternity and newborn care
- Mental health services
- Treatment for chemical or alcohol dependence
- Pediatric services, including dental and vision care
- Limited dental and vision care for adults
- Prescription medications
- Laboratory Services
- Hospitalization
- Non-Emergency Medical Transportation (NEMT)
- Interpreter Services

Program benefit packages and scope of services | Washington State Health Care Authority

Managed care today and into the future

- 1.9 million members receive services from five managed care organizations (MCOs)
- Values of managed care
  - The MCOs are at risk for over-utilization, whereas the state is at risk under fee-for-service.
  - MCOs are not held to a strict fee schedule, but have the flexibility to pay providers based on needs like network, access, quality achievement, reduction of ER and hospital utilization, including value-based purchasing approaches such as capitation and bundled payments.
  - Improve stability and predictability such as for access to care
  - Test new ways of purchasing health care such as for behavioral health
  - Improve quality and accountability
  - Improve care coordination – offers a care coordination benefit whereas fee-for-service does not, except we have a Health Homes program for people who are dually eligible
  - Claims management, timely payment
  - Complex case management, care coordination, disease management, and health education
  - Utilization management – right care: medically necessary
- Program integrity is key – more on that later

Whole-person care (physical and behavioral health integration – 2016 legislation) – *Timeline to Integrated Care (prior to Covid 19):*



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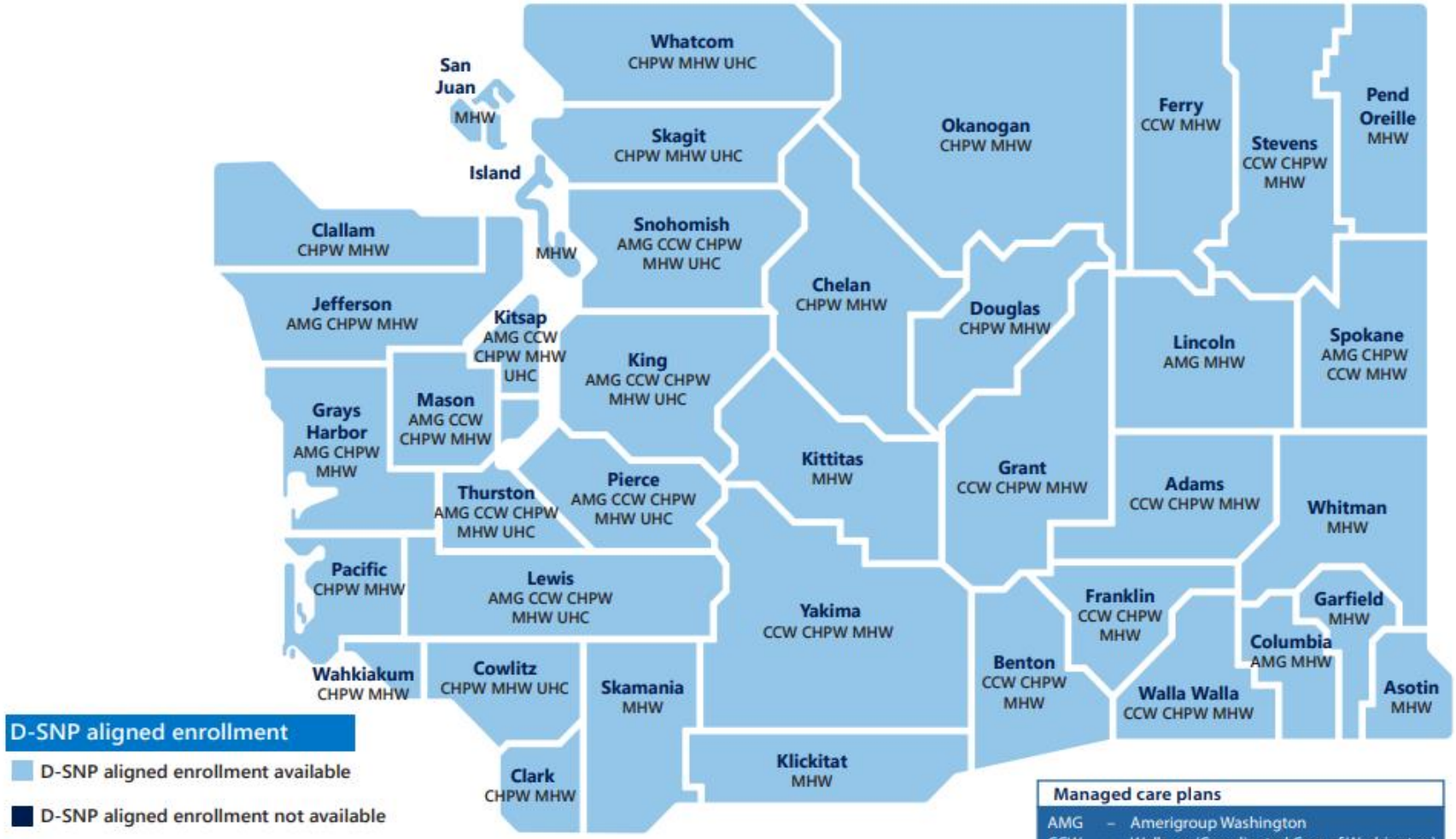
Network adequacy is critical for access to care

- HCA oversees MCO networks to ensure they are meeting timely access and distance standards for enrollees for all medically necessary services.
- Managed care contracts now define mental health and substance use providers, and youth and adult behavioral health agency providers, as critical provider types.
- HCA continues to focus on improvements to behavioral health network standards through a major taskforce effort.

Dual-Eligible Special Needs Plan (D-SNP)

Aligned enrollment map - January 2023



Use this map to choose a managed care plan that aligns your D-SNP and Behavioral Health Services Only (BHSO) coverage. D-SNP aligned enrollment is now available in every county.

Visit **hca.wa.gov/d-snp** for more information on enrollment, D-SNP, and what plans are available in each county.

Network across MCO markets

QHP and D-SNP coverage is critical too

- Important for coverage as members move in and out of programs
- Medicare Advantage plans (D-SNP is one)
- MCOs moving into regions consistent with Medicare and QHPs - gaps should be filled by next year
- Important for preparing for Public Health Emergency unwind because people will move from Medicaid to Medicare or QHP

Quality oversight is key for managed care

- Plan report cards and star ratings using HEDIS and CHAPS
  - VBP metrics – 2% withhold
- TEAMonitoring is our key program to ensure contract compliance, accountability and corrective action

2022 Washington Apple Health Plan Report Card

Washington Apple Health

This report card shows how Washington Apple Health plans compare to each other in key performance areas. You can use this report card to help guide your selection of a plan that works best for you.

Performance areas	Amerigroup Washington	Coordinated Care of Washington	Community Health Plan of Washington	Molina Healthcare of Washington	United Healthcare Community Plan
Getting care	★★★	★★★	★★★	★★★	★★★
Keeping kids healthy	★★★	★★★	★★★	★★★	★★★
Keeping women and mothers healthy	★★★	★★★	★★★	★★★	★★★
Preventing and managing illness	★★★	★★★	★★★	★★★	★★★
Ensuring appropriate care	★★★	★★★	★★★	★★★	★★★
Satisfaction of care provided to children	★★★	★★★	★★★	★★★	★★★
Satisfaction with plan for children	★★★	★★★	★★★	★★★	★★★

KEY: Performance compared to all Apple Health plans	
Above average	★★★
Average	★★★
Below average	★★★

These ratings were based on information collected from health plans and surveys of health plan members in 2021. (some of the data used in the Getting Care category is from 2020).

The information was reviewed for accuracy by independent auditors.

Health plan performance scores were not adjusted for differences in their member populations or service regions.

Performance area definitions

Getting care
- Members have access to a doctor
- Members report they get the care they need, when they need it

Keeping kids healthy
- Children in the plan get regular checkups
- Children get important immunizations
- Children get the appropriate level of care when they are sick

Keeping women and mothers healthy
- Women get important health screenings, such as cervical cancer screenings
- New and expecting mothers get the care they need

Preventing and managing illness
- The plan helps its members keep long-lasting illness under control, such as asthma, high blood pressure or diabetes
- The plan helps prevent illnesses with screenings and appropriate care

Ensuring appropriate care
- Members receive the most appropriate care and treatment for their condition

Satisfaction with care provided to children
- Members report high ratings for doctors, specialists and overall health care

Satisfaction with plan for children
- Members report high ratings for the plan's customer service and the plan overall

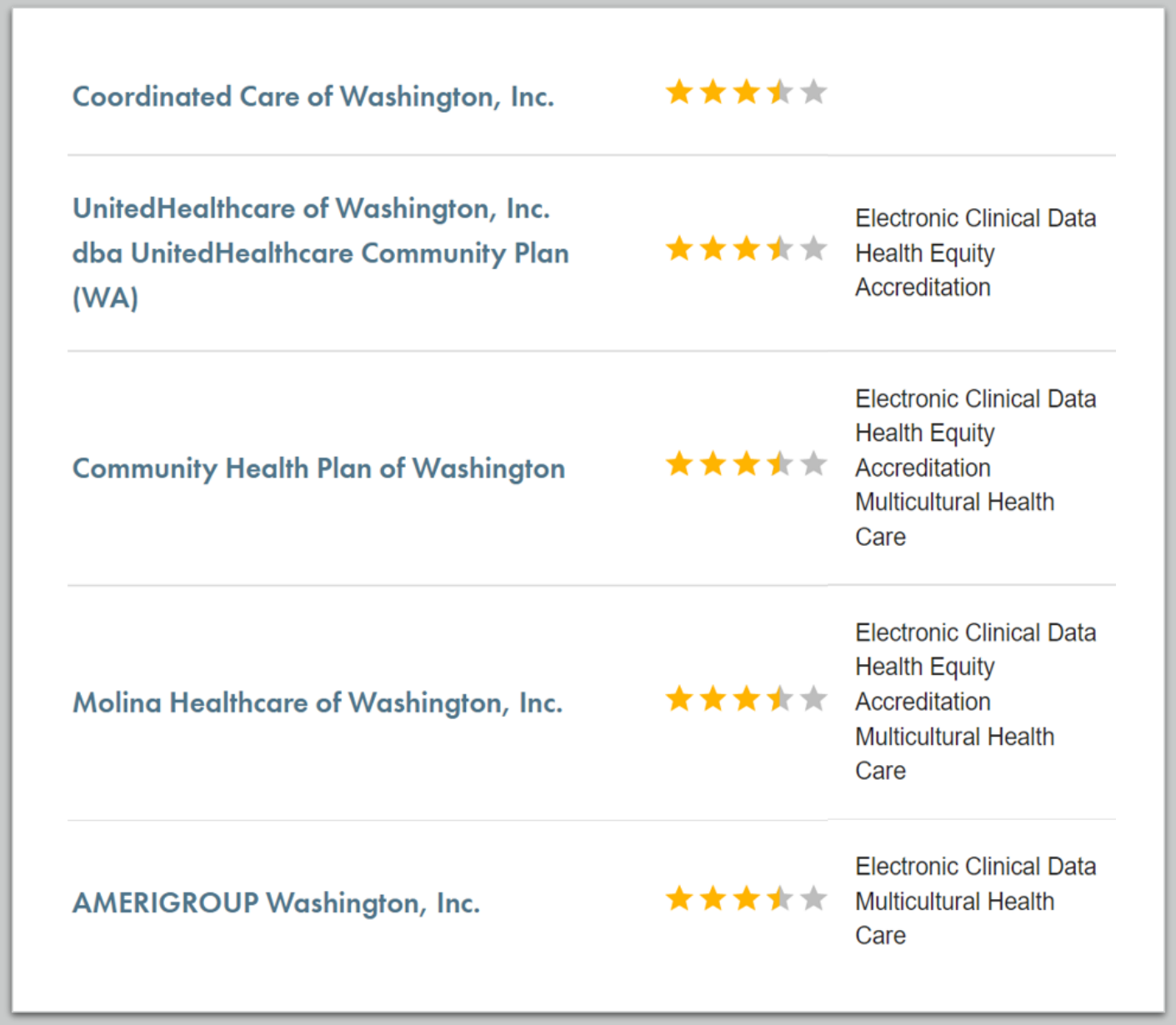
HCA 19-057 (9/22)

Washington State Health Care Authority

washington healthplanfinder

National Committee for Quality Assurance (NCQA)

- Plan Accreditation Star rating (2022)
  - Every three years as each plan first receives accreditation
- This is an MCO contract requirement
  - Health equity and multicultural adds are discretionary but highly encouraged – MCOs are making good progress
- More about clinical quality in our next discussion



Coordinated Care of Washington, Inc.	★★★½☆	
UnitedHealthcare of Washington, Inc. dba UnitedHealthcare Community Plan (WA)	★★★½☆	Electronic Clinical Data Health Equity Accreditation
Community Health Plan of Washington	★★★½☆	Electronic Clinical Data Health Equity Accreditation Multicultural Health Care
Molina Healthcare of Washington, Inc.	★★★½☆	Electronic Clinical Data Health Equity Accreditation Multicultural Health Care
AMERIGROUP Washington, Inc.	★★★½☆	Electronic Clinical Data Multicultural Health Care

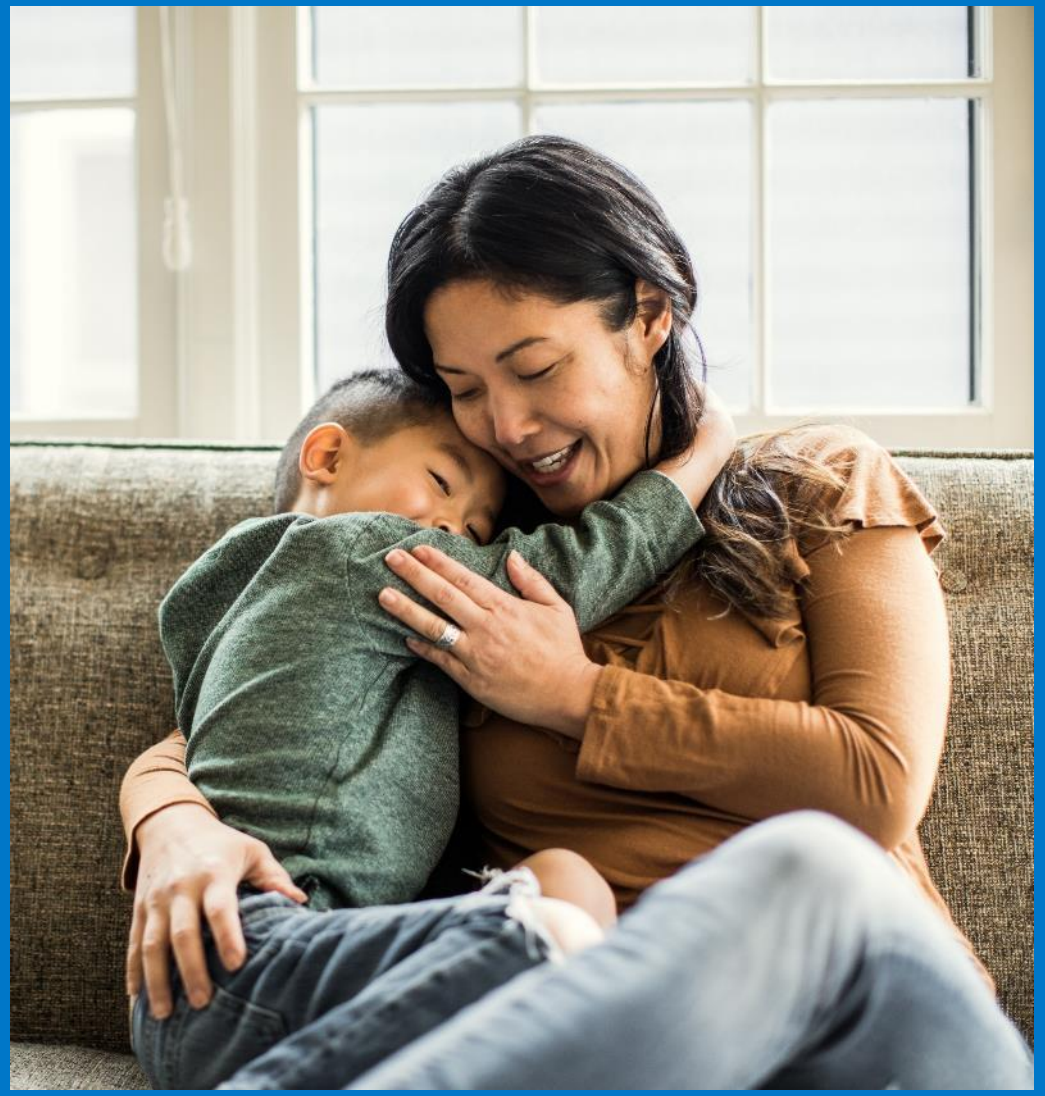
https://reportcards.ncqa.org/health-plans

Customer satisfaction is high

- 99 percent said Apple Health helps them and their families
- 95 percent said they received clear explanations from their providers about their health care
- 94 percent were satisfied with services
- 94 percent say staff who helped them when they called the 800 number listen to what they had to say
  - A three percent increase over 2019
- 92 percent say it's easy to access services
  - A five percent increase since 2019 and the highest-ever score

Upcoming areas of focus

- Public Health Emergency unwind
- Managed care procurement
- Negotiation with CMS and implementation of the transformation waiver (housing, health-related services, reentry etc.)
- Continued integration across physical and behavioral health
- Acute ⇨post-acute transitions of care
- Partner to build an IT infrastructure that supports providers, health systems, plans and community-based organizations
- Support the clinical and social determinant needs of Medicaid clients
- Incredible workforce and volume of other system changes stemming from the pandemic and major systemic shifts (e.g., difficult to discharge and multi-system work)



Contact us

Dr. Charissa Fotinos, charissa.Fotinos@hca.wa.gov

Jason T. McGill, jason.McGill@hca.wa.gov

hca.wa.gov
@WAHealthCareAuthority
@WA_Health_Care

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Clinical policy development in Apple Health

Dr. Charissa Fotinos, State Medicaid Director

Dr. Judy Zerzan, Chief Medical Officer

Washington State Health Care Authority

Clinical Quality and Care Transformation Division

- Chief Medical Officer leads a team of physicians, nurses, pharmacists, other clinicians and policy experts
  - Collectively share decades of experience providing direct care to patients
  - Provide clinical expertise across HCA's programs and varied topics
- Vision is to create an equitable, measurable standard of evidence-informed, high-quality care
- Work to ensure the provision of safe, effective, high-value care based on best available information, including scientific information and community input

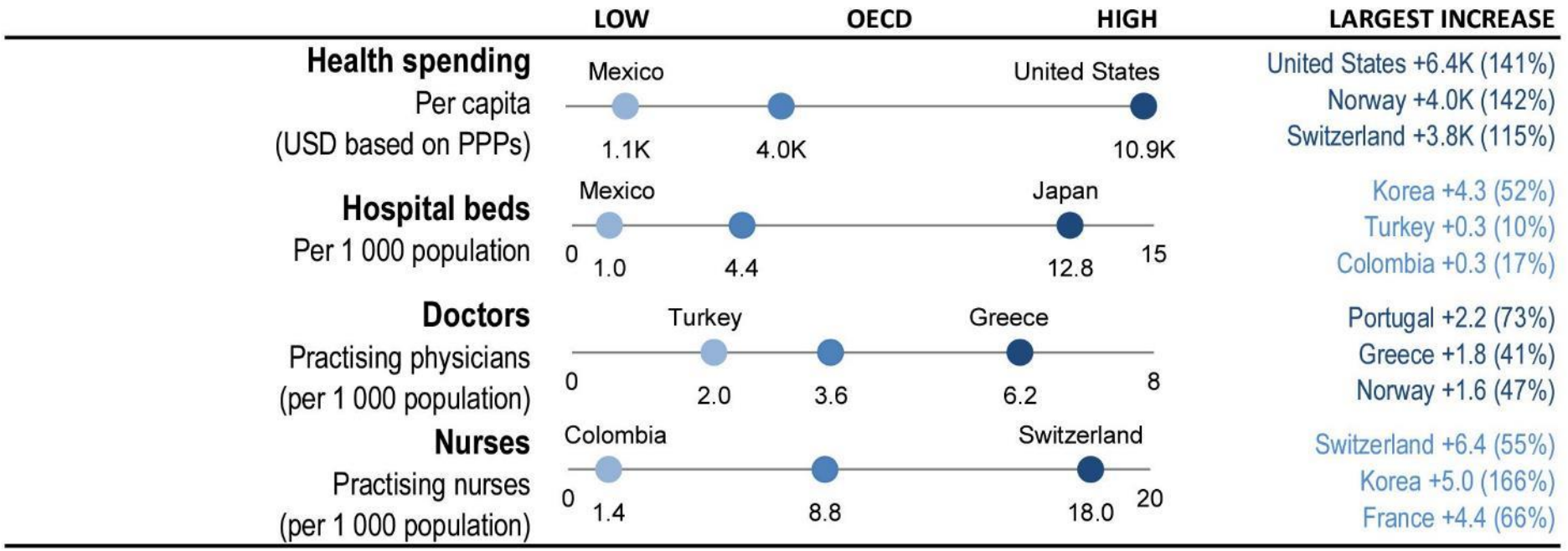
Clinical policies in Medicaid

- HCA is the single state agency for administering the Medicaid program
- Federal dollars can only be used to pay for care deemed **medically necessary** through utilization review programs, including prior authorization and program integrity functions

"Medically necessary" is a term for describing requested service which is **reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions** in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is **no other equally effective, more conservative or substantially less costly course of treatment available or suitable** for the client requesting the service. – WAC 182-500-0070

Health expenditures in the U.S. are higher while outcomes are poorer

Health system capacity and resources across the OECD, 2019 (or nearest year)



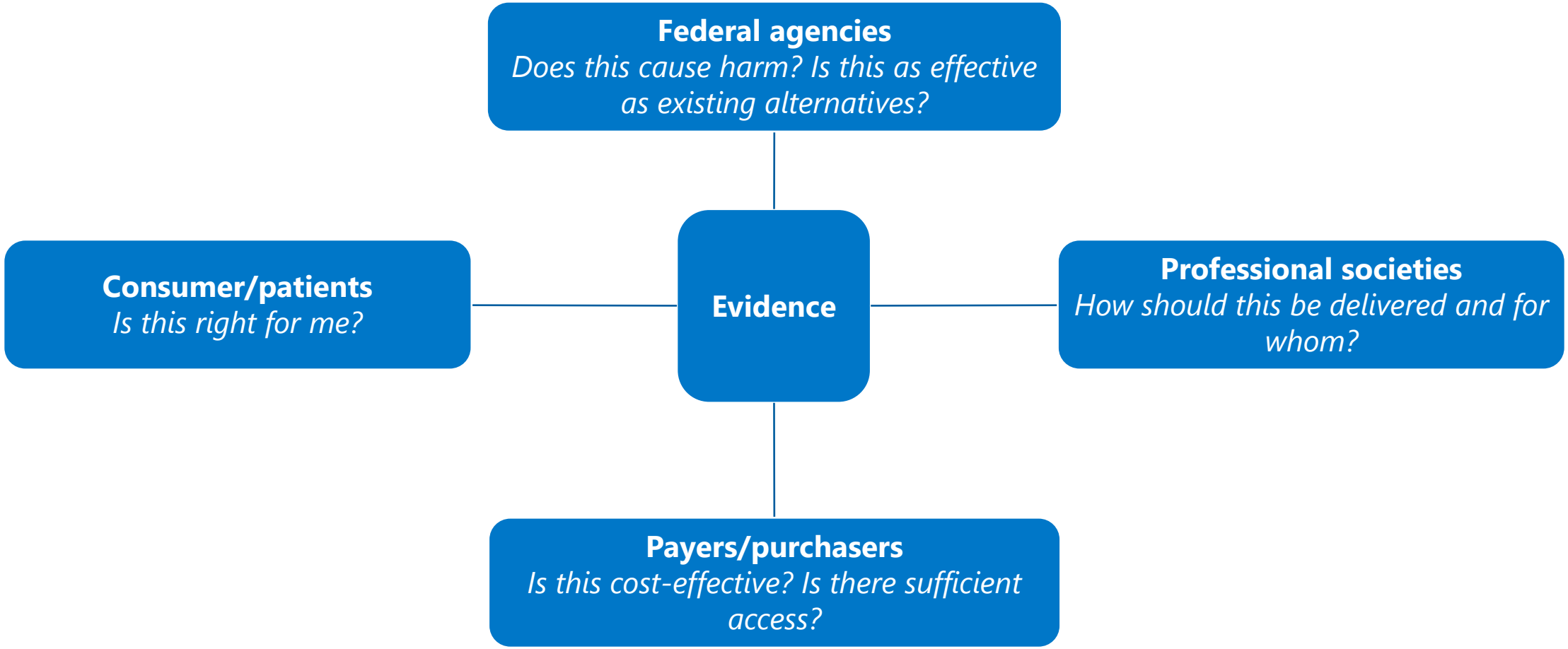
Note: Largest increase shows countries with largest changes in absolute value over time (% change in brackets).
Source: OECD Health Statistics 2021.

OECD: Organisation foe Economic and Co-Operation and Development, with 38 member countries

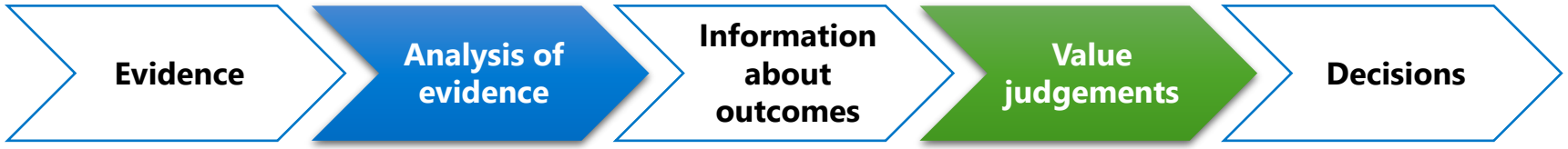
Paying for value

- Fee-for-service and managed care arrangements are ways in which providers are paid
- Managed care allows the flexibility to support care delivery in a way fee for service can't
- Just because a test or treatment can be provided to a person, doesn't mean it should
- Judicious stewardship of tax-payer dollars requires paying for the right intervention at the right time for the right person
- Evaluating the 'evidence' and putting into place clinical policies that assure quality and outcomes is the work of CQCT

How does evidence inform care delivery?



Evidence-informed policy making

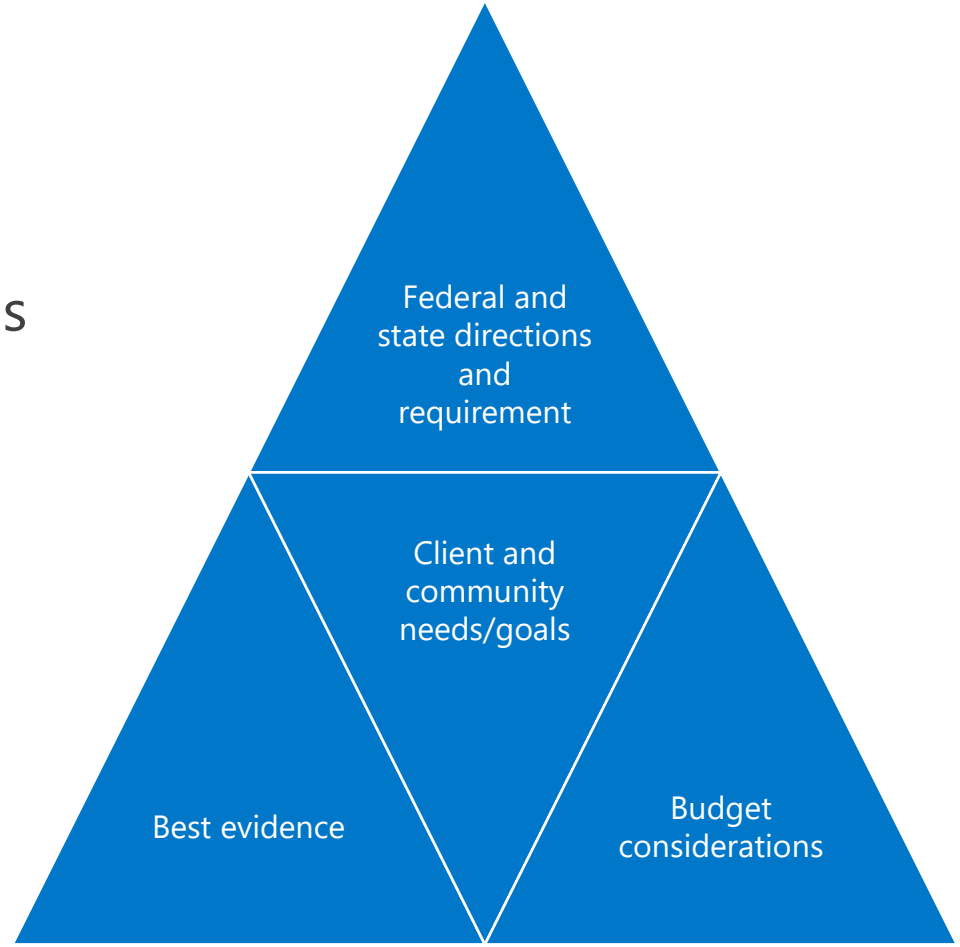


Modified from a graphic published in D.M. Eddy, (1990). "Clinical Decision Making: From Theory to Practice—Anatomy of a Decision." Journal of American Medical Association, 263(3): 441-3.

- Review and determine strength of highest quality evidence available
- Factor in other considerations
  - State/federal requirements
  - HCA/state purchasing experience (data)
  - Patient preferences
  - Equity and access
  - Budget and cost

Policy inputs

- Enrollee needs and goals
  - What are the policy goals and targeted outputs?
- Evidence
  - What is available and what is does it support?
- Federal directives, requirements and limitations
- Budget considerations
  - How do we model and fund policy initiatives?
  - Innovation at new cost versus equally effective alternatives
- Implementation
  - Operationalizing policy requires resources
  - Complex system requirements
- Evaluation
  - Measuring changes, revising when necessary



Examples of evidence-informed policy making

- HCA's Health Technology Assessment (HTA) Program
  - HTA Program created in 2006 (HB 2575) to use an evidence report and a clinician panel to make coverage decisions based on:
    - Safety
    - Efficacy/effectiveness
    - Cost-effectiveness
  - Multiple state agency programs participate to identify topics and implement policy decisions:
    - Health Care Authority
    - Uniform Medical Plan
    - Medicaid
    - Labor and Industries
    - Corrections
  - Agencies implement determinations of the HTA Program within their existing statutory framework
- Robert Bree Collaborative (2011 ESHB 1311)
  - Process for public and private health care purchasers, health plans, providers, hospitals, and quality improvement organizations to improve health care quality and outcomes
  - Collaborative develops evidence-based strategies
  - Recommendations are targeted to various health system actors (e.g., payors, insurers, state agencies, providers)

Implementing clinical policies

- Clinical policies support the goal of applying high evidentiary standards to the provision of care, while providing the ability to apply medical necessity on an individualized basis
- In many cases, this manifests as prior authorization to enable the clinical team to ensure that the service being provided is medically necessary for the client
- Recognizing that this may cause administrative burden for providers, the intent is never to delay care or cause frustration
- Our strategy to reduce administrative burden includes:
  - Harmonizing policies across managed care organizations (MCOs) where appropriate
  - Requiring MCO compliance with National Committee for Quality Assurance (NCQA) standards
  - Engaging providers and partners through Administrative Simplification Workgroup
  - Using technology to support goals, including modernization of prior authorization and exploring available options for standardized workflows and tools

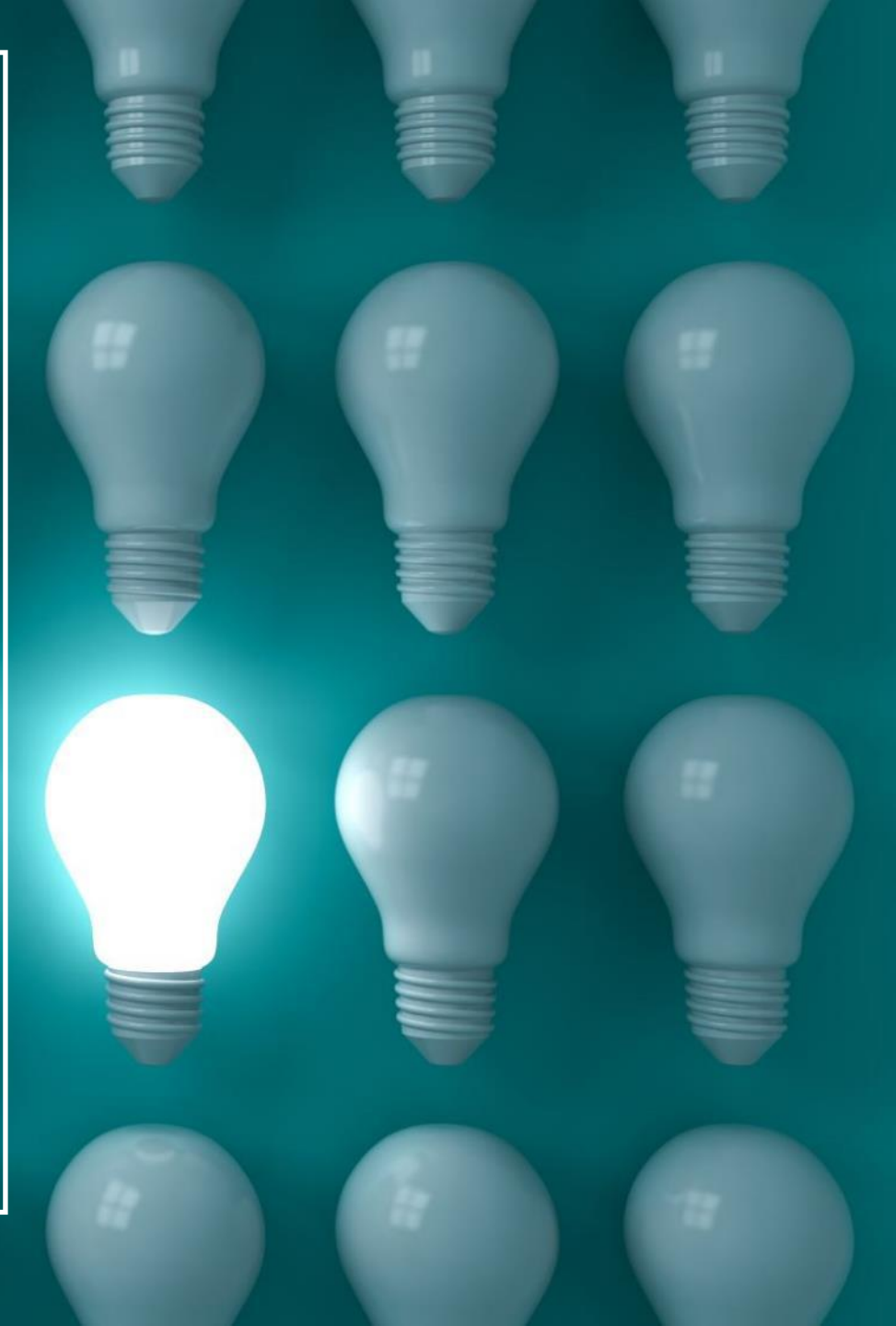
Prior authorization considerations

- Variability in the practice community
- Concern for overuse
- Safety issues for certain conditions and treatments
- For some services, there are clear indicators of when expensive treatments are needed
- Equally effective and less costly alternatives are potentially appropriate

HCA works with providers and the Administrative Simplification Workgroup to determine what information is relevant and needed in order to evaluate prior authorization requests while minimizing administrative burden.

Performance Measures Coordinating Committee

- 2014: ESHB 2572 established Performance Measures Coordinating Committee
  - Goals: reduce variation/administrative burden, focus on key priorities
  - Selected a list of 52 nationally approved measures (HEDIS, etc.) to be prioritized in Washington, including HCA contracts with value-based purchasing
  - Development/creation of measures is not within the mandate or skill set of PMCC
- While the legislative mandate and funding were only to create the initial list, all measures lists need to evolve over time
  - Some measures are retired/changed by stewards (HEDIS/NCQA, etc.), new measures and measure techniques emerge
  - State priorities and focus evolve
- PMCC has continued to meet on a volunteer basis, convened by HCA staff, to curate the measure set (now 60 measures)



How does HCA use the Common Measure Set to promote quality?

- "North Star" of measure selection for use in HCA contracts
  - Reporting
    - All relevant measures from the Washington State Common Measure Set are required for reporting in most HCA contracts (Medicaid MCOs, PEBB and SEBB carriers, Cascade Care contracts, etc.)
  - Value-based purchasing
    - HCA value-based purchasing measures are always selected from the Common Measure Set unless there is a compelling reason to do otherwise
    - MCO value-based purchasing measures
    - Performance guarantees in PEBB and SEBB carrier contracts
    - Incentivized measures in Accountable Care Program contracts
    - Multi-payer Primary Care Initiative
  - Moving forward
    - Considering opportunities to address health equity through measurement

Contact us

Dr. Charissa Fotinos, charissa.fotinos@hca.wa.gov

Dr. Judy Zerzan, judy.zerzan@hca.wa.gov

hca.wa.gov
@WAHealthCareAuthority
@WA_Health_Care

Washington State Health Care Authority

Behavioral health delivery

The status of behavioral health access and integration in Washington

Washington State Health Care Authority

Agenda

- Background: Behavioral health primary care bidirectional integration
- Overview of HCA's Division of Behavioral Health and Recovery (DBHR)
- Behavioral health services and programs
- Office of Recovery Partnerships
- Behavioral health services for American Indian/Alaskan Native populations
- Behavioral health service delivery: contracts
- Funding sources
- Behavioral health workforce

Background: Behavioral Health - Primary Care Bidirectional Integration

Overview of the Division of Behavioral Health and Recovery

Single State Authority (SSA)

- Formally designated the SSA for more than 40 years
- In 2009, the Division of Alcohol and Substance Abuse and Mental Health Division combined to become the Division of Behavioral Health and Recovery, which moved from the Department of Social and Health Services to HCA 2018
- Safety net
  - HCA treatment resources are a safety net for those who do not have private insurance to pay for critical treatment services.
  - Prevention, outreach and engagement, and recovery support services are available to Washingtonians regardless of insurance status

The Office of Recovery Partnerships

Behavioral health services program categories

- Substance use prevention and mental health promotion
- Prenatal through age 25 behavioral health treatment services
- Mental health and substance use disorder treatment services
- Problem gambling services
- Recovery support services

Substance use prevention and mental health promotion

- Prevention works upstream before problems occur, or before they boil over, to:
  - Reduce substance use and misuse
  - Reduce the prevalence of substance use disorder
  - Promote mental health
- Programs are community-driven efforts, research and evidence-based practices
- Community coalitions help drive prevention through school-based services focused on prevention and early intervention

Prenatal through 25 behavioral health

- Ensures equitable, high-quality behavioral health services and strategies for children, youth, and young adults (prenatal to age 25) and their families
- Working through a family-driven, youth guided/directed framework that emphasizes the importance of community-based services and the delivery of cultural and linguistic humility to address issues of diversity and disparity

Substance use disorder and mental health treatment and crisis services

- Administering and enhancing crisis services to people in Washington state across their lifespan, regardless of insurance
- Supporting recovery-oriented substance use disorder and mental health treatment services (outpatient, residential, inpatient), including innovative models and programs to divert people from state psychiatric hospitals and the criminal court system
- Working to increase access to low-barrier, harm reduction-based programming to address morbidity and mortality associated with substance use

Problem gambling

- Administering and enhancing problem gambling prevention and treatment services to individuals experiencing a problem gambling addiction

Problem gambling

- Administering and enhancing problem gambling prevention and treatment services to individuals experiencing a problem gambling addiction

Washington State Health Care Authority

Recovery Support Services

- Programs and initiatives that support whole-person recovery and supports that address:
  - Home
  - Purpose
  - Community
- Strives to strengthen systems capacity and access by:
  - Reducing rates of homelessness and create pathways out of poverty
  - Promoting self-sufficiency and health equity
  - Working to grow our system capacity to support developmentally appropriate outreach and design for the lifespan
- Not only does this improve quality of life for Washingtonians, but also reduces the cost of larger health care system.

Behavioral health contracting

Behavioral health contracting

Prevention

Delivered through contracts with counties, CBOs, and Tribes

Outreach / Engagement

Delivered through contracts with BHASOs, CBOs

Crisis

Delivered through contracts with BHASOs

Treatment

Delivered through contracts with BHASOs, MCOs, fee-for-service, and Tribes

Recovery

Delivered through contracts with BHAOs, MCOs, CBOs, and Tribes

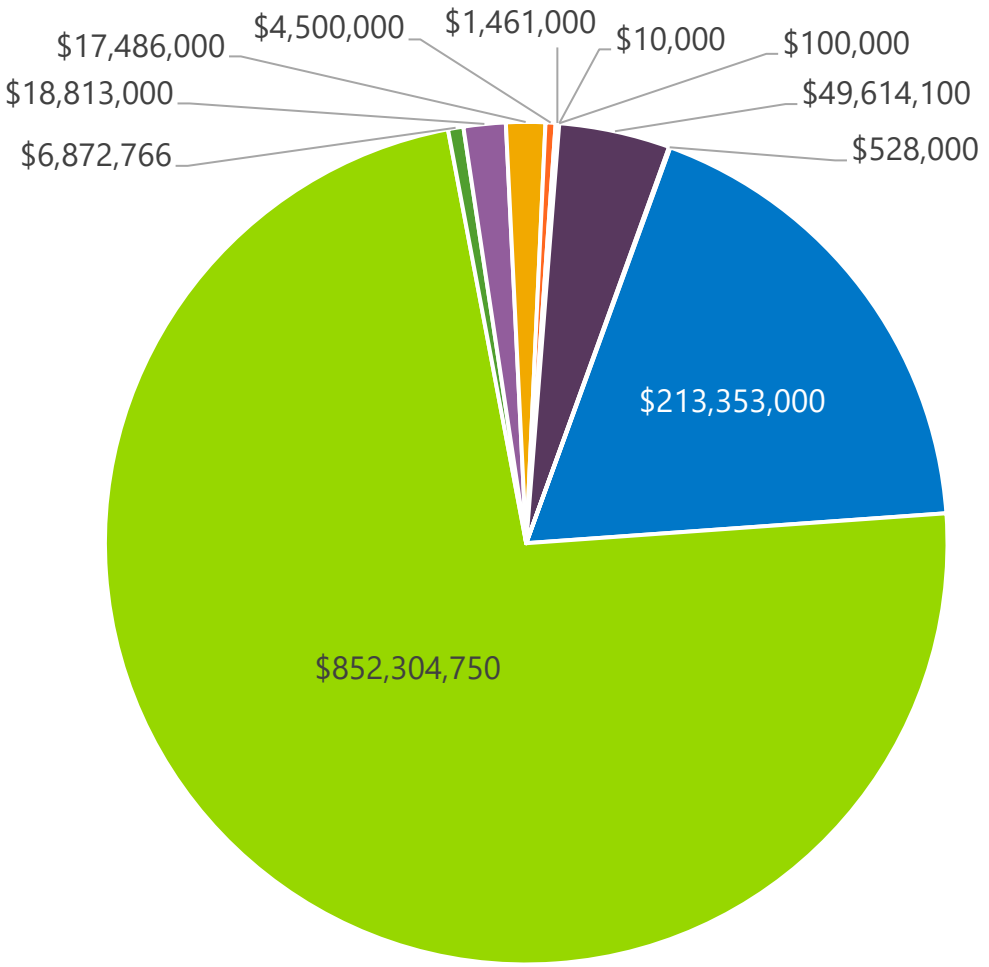
Behavioral health funding sources

Behavioral health funding sources

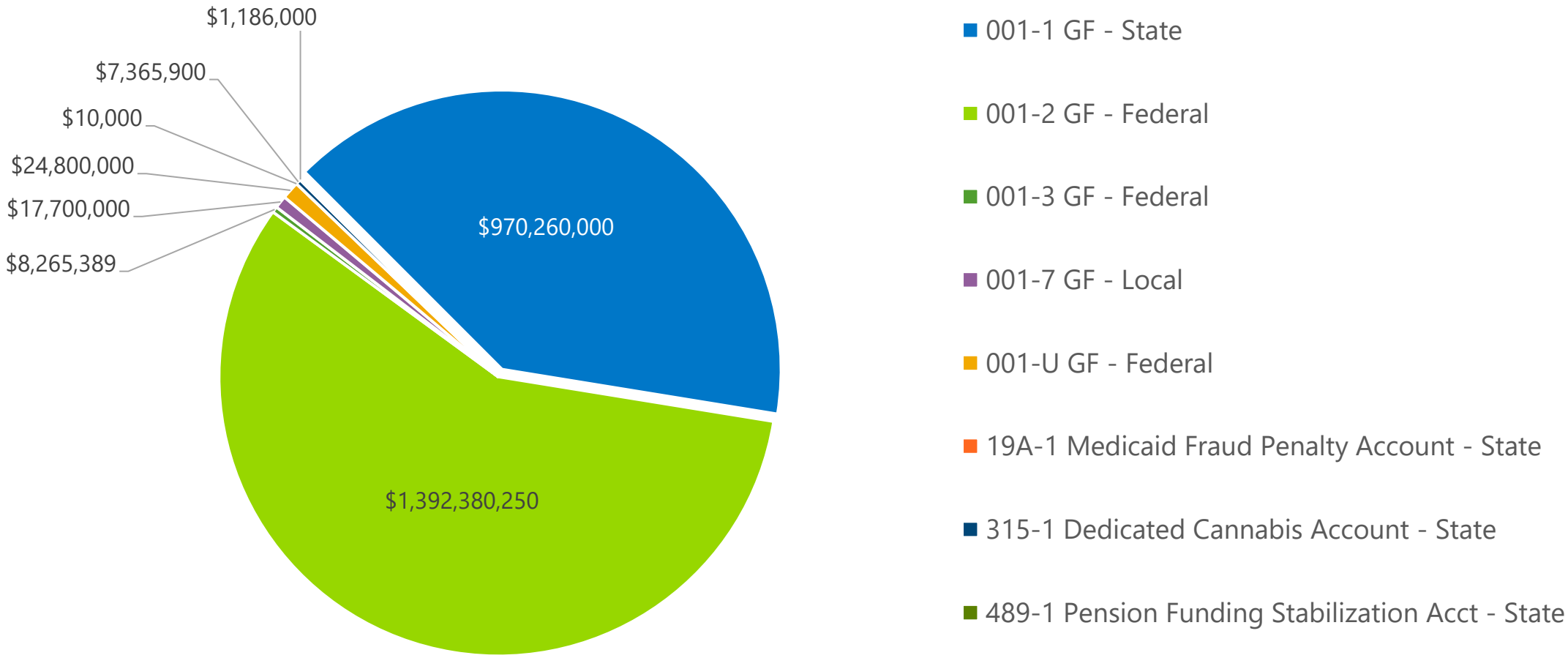
- Medicaid
- State allocated funding
- Federal block grants
- Federal discretionary grants
- Local tax funding

Substance use disorder budgeted amounts for the 2021-2023 biennium

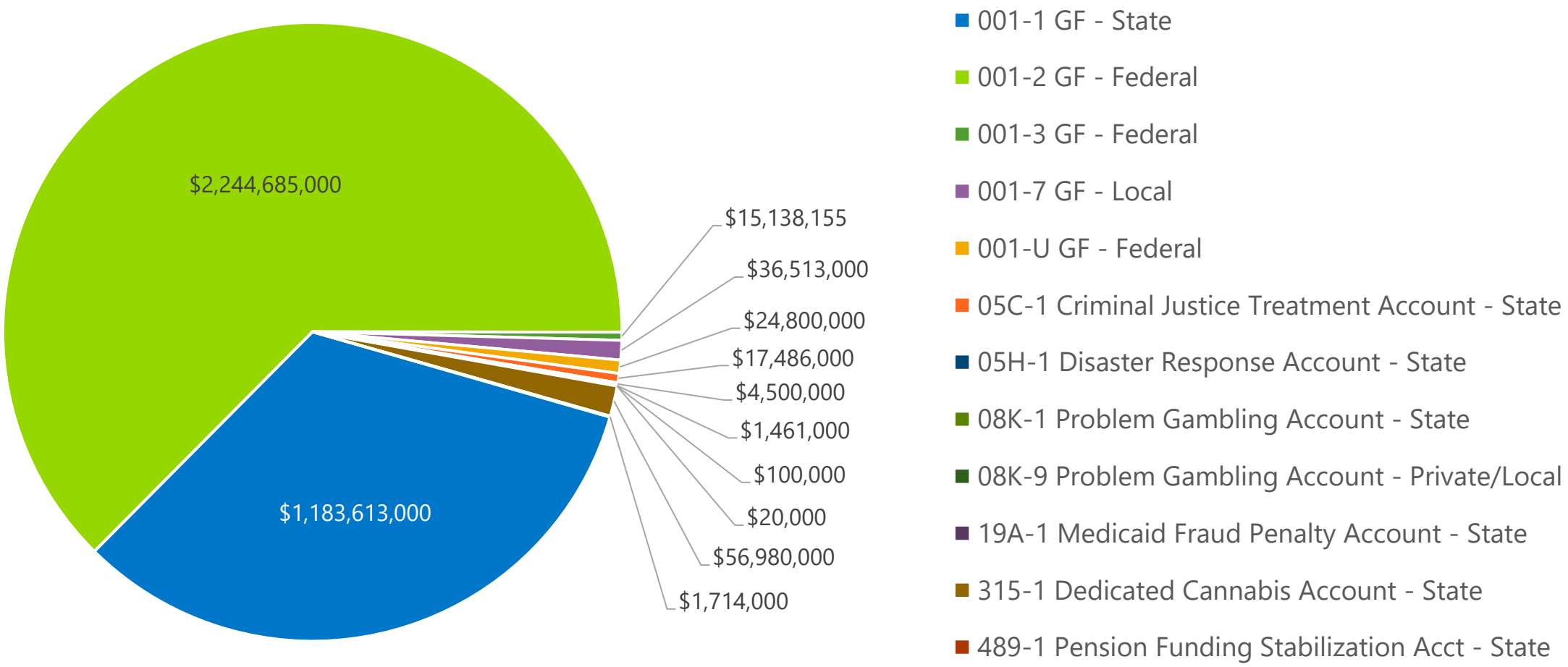
- 001-1 GF - State
- 001-2 GF - Federal
- 001-3 GF - Federal
- 001-7 GF - Local
- 05C-1 Criminal Justice Treatment Account - State
- 05H-1 Disaster Response Account - State
- 08K-1 Problem Gambling Account - State
- 08K-9 Problem Gambling Account - Private/Local
- 19A-1 Medicaid Fraud Penalty Account - State
- 315-1 Dedicated Cannabis Account - State
- 489-1 Pension Funding Stabilization Acct - State



Mental health budgeted amounts for the 2021-2023 biennium



Community behavioral health budgeted amounts for the 2021-2023 biennium



Behavioral health workforce

Workforce challenges

- Demands for service exceeds the supply of available workers
- Workforce shortages span prevention, treatment, and recovery support service careers, affecting provider recruitment and retention efforts for critical roles, including clinical, administrative and other support roles
- Training continues to be necessary to build capacity, but difficult to schedule due to staffing shortages
- COVID-19 impact has declined, but agencies still feeling the impact with workforce
- Fentanyl is adding to the complexity of the clinical work

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Workforce opportunities

- Behavioral health careers marketing campaign at startyourpath.org
- Investments in workforce technical assistance and continuing education
- Investments in UW Behavioral Health Institute
- Teaching clinic enhancement rate

Current workforce investments

$100 million in provider relief to behavioral health providers contracted with a BH-ASO or MCO

7% increase to all behavioral health providers coming in 2023

HCA has certified more than 6,000 peer specialists, with more than 70 trainings in 2022; BIPOC peer recruitment efforts continue

Contact us

Keri Waterland, keri.waterland@hca.wa.gov
Michael Langer, Mmichael.langer@hca.wa.gov
Teesha Kirschbaum, teesha.Kirschbaum@hca.wa.gov

Division of Behavioral Health and Recovery webpage

Behavioral Health Program fact sheets

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Washington State Health Care Authority

BREAK

Washington State Health Care Authority

Apple Health financing

Megan Atkinson, Chief Financial Officer

Washington State Health Care Authority

Who pays for Apple Health services?

- Medicaid and the Children's Health Insurance Program (CHIP)
  - Federal/state partnership.
  - Overarching rules set by CMS. States have discretion within those parameters on what populations to cover and what services to offer.
  - Federal Medical Assistance Percentage (FMAP): the share of costs that the federal government pays. Varies by client and services type.
- State only programs
  - The state pays all the costs associated with these clients.
  - Programs include Children's Health Program, non-citizen pregnant people in their post partum period, Medical Care Services program.

How does Washington estimate the cost of Apple Health services?

- HCA's services costs depend on:
  - The cost per person
  - The number of people that receive services
- Cost per person
  - HCA works with OFM and legislative fiscal staff to produce a per capita forecast that estimates the cost per person for physical health services.
  - A similar process estimates costs for behavioral health services.
- Number of people
  - The Caseload Forecast Council forecasts the number of people by broad eligibility group.
- These two elements form the basis for HCA's maintenance level budget.

How does Washington pay for Apple Health services?

- HCA purchases and delivers health care services on either a fee-for-services (FFS) basis or through risk-based contracts with managed care plans
- Fee-for-service: HCA pays health care providers directly for each service delivered to a client.
  - 15% of clients enrolled in fee-for-service, including
    - Dual eligible for physical health services (clients with both Medicaid and Medicare coverage)
    - Certain foster care clients
    - Alaskan Native, American Indian clients who choose to opt out of managed care
- Managed care: HCA pays managed care organizations a predetermined monthly payment to provide a specific set of services to enrolled clients.
  - 85% of clients are enrolled in managed care
  - MCOs have flexibility in how they contract with providers
- 73% of expenditures are paid through managed care.
- Some services are carved out of managed care and paid fee-for-service, regardless of client enrollment.
  - Examples include dental, transportation, and interpreters

Medicaid managed care rates and rate setting

Washington State Health Care Authority

What are Medicaid managed care rates?

- Managed care rates are the projected monthly costs for all services and activities included in the Medicaid managed care contracts.
- Managed care rates
  - Are based on MCO, not provider, costs.
  - Are developed and paid at a rate cell level.
  - Are a risk-based arrangement.
  - Include both an administrative and service component.
- HCA contracts with a third-party actuarial firm (Milliman) to develop the rates.
- Managed care rates *are not the same as provider reimbursement rates*.

Rate development overview

Develop base	Apply program changes	Apply trend	Apply non-benefit load
• Gather data (managed care encounters, health plan financials, MCO reported supplemental information) • Process and validate • Incorporate non-claim benefit components	• **Legislatively directed changes.** (example: rate increase, benefit changes) • HCA identified program changes (example: carving dental services provided in a pediatric office into managed care) • New facilities opening • Necessary adjustments to the base period	• Develop unit cost trends • Develop utilization trends	• Administrative • Premium tax • Washington State Health Insurance Pool (WSHIP) assessment

Simplified rate timeline

June: Data gathering and validation. Finalize assumptions and program changes to be incorporated into January cycle year rates

July-September: **Rate development** and meetings with stakeholders (legislative fiscal staff, OFM, MCOs, providers)

September 15-20: Review draft rates with stakeholders (legislative fiscal staff, OFM, MCOs, providers)

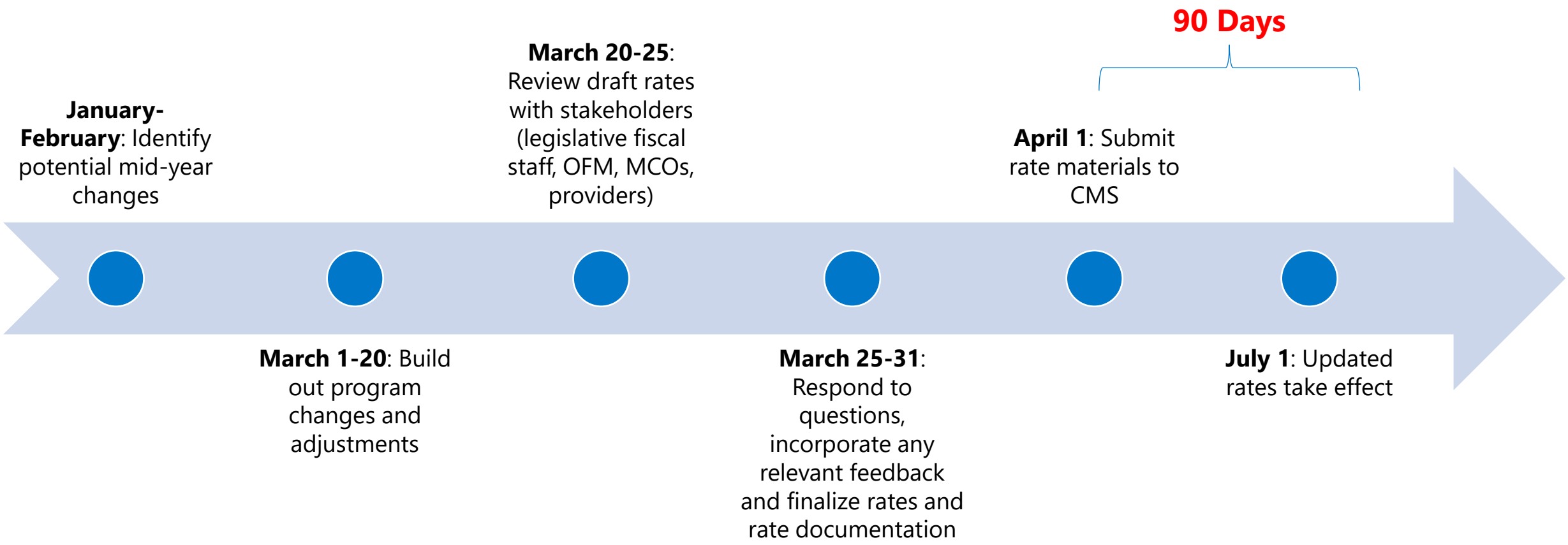
September 20-30: Respond to questions, incorporate any relevant feedback and finalize rates and rate documentation

90 Days

October 1: Submit rate materials to CMS

January 1: Cycle year rates take effect

Example: mid-year rate update timeline



Rules governing managed care rate development

- Federal Rule – 42 CFR 438
- Centers for Medicare and Medicaid Services (CMS) managed care rate development guidelines
  - Published annually
- Actuarial standards

State directed payments

- Any instance in which the state directs how a managed care organization pays for services is considered a "directed payment."
- Federal rule allows for four broad types of directed payments:
  - Uniform dollar increases
  - Uniform percent increases
  - Maximum fee schedules
  - Minimum fee schedules
- CMS must approve state directed payments.
- CMS requires states to justify rate increases and demonstrate how changes advance at least one of the state's quality strategy goals.
- Directed payments impact the reimbursement for a service but remain only one component of broader managed care rate development.

Transparency requirements directed by the Legislature

- Legislature passed HB 2584 in during the 2019 session requiring HCA to work with its contract actuaries to:
  - Verify that targeted behavioral health rate increases are used for the objective stated in the original appropriation
- Budget proviso language further directs HCA to provide opportunities for MCOs, behavioral health administrative service organizations, and behavioral health providers to review and comment on proposed rate changes

Fee-for-service rates and rate setting

Washington State Health Care Authority

How are fee-for-service rates developed?

- Under fee-for-service, HCA pays providers directly for each services delivered. Most payments are based on published fee schedules.
- Fee schedules are organized by categories of service (ex. dental, physician-related professional services, durable medical equipment, etc.).
- Rates are calculated and updated periodically using various methodologies.
- Rate setting methodologies are approved by CMS and described in Washington's State Plan and WAC.
- Most professional service rate updates are budget neutral, while most supplies (durable medical equipment) are directly related to CMS rates. Professionally administered drugs with CMS published rates are updated quarterly by CMS.
- Rates that use budget neutral rate setting methodologies are only explicitly increased when the Legislature directs HCA to make a targeted provider rate increases.

Hospital rates and rate setting

Washington State Health Care Authority

Types of hospitals by payment

- Prospective payment system (PPS) hospitals
  - Paid based on a fixed predetermined amount
- Certified public expenditure (CPE) hospitals
  - Public PPS hospitals that certify local expenditures as the non-federal share of match
  - Receive additional supplemental funding and cost settled
- Critical access hospital (CAH)
  - Rural community hospitals that meet certain federal qualifications and receive cost-based reimbursement

How are hospitals paid?

Base payments

Inpatient

- Diagnosis related groups (DRG)
- Per diem
- Ratio of cost to charges (RCC)
- Outlier payments

Outpatient

- Enhanced ambulatory patient groups
- Outpatient fee schedule
- Weighted cost to charge ratio (WCC)

Supplemental payments

- Disproportionate share hospital (DSH)
- Safety Net Assessment Program (SNAP)
- Trauma
- Starting January 1, 2023: Outpatient Directed Payment Program

Managed care plans can pay more than our rates but never less for inpatient and outpatient hospital services.

Hospital supplemental payments

Disproportionate Share Hospital (DSH)

- Allotment of dollars from federal DSH program
- Requires certain qualifications, including providing birthing services
- Voluntary, annual application
- 2022: $223 million

Safety Net Assessment Program (SNAP)

- Mandatory participation in a hospital assessment (tax)
- Provides supplemental payments to hospitals
- Current law sunsets the program in FY 26. State has renewed this program several times.
- 2022: $528 million

Trauma

- Level I-III trauma centers
- Receive a quarterly, proportional payment based on their number of trauma claims
- 2022: $11 million

Outpatient Directed Payment Program

- Starts January 1, 2023
- University of Washington and Harborview
- Pays the difference between Medicaid payment and Average Commercial Rate
- Estimated $217 million each year

Clinic rates and rate setting

Washington State Health Care Authority

Types of clinics

Federally Qualified Health Centers (FQHCs) are federally designated safety net providers that treat a predominantly Medicaid population in underserved urban and rural communities.

- Offer access to primary and comprehensive care services, such as medical, dental, mental health, substance use disorder, and maternity support, regardless of ability to pay
- Serve nearly 40% of Medicaid enrollees in the state
- 31 FQHCs with a combined 447 locations

Rural health clinics (RHCs) are hospital-based or freestanding facilities located in a rural area that is designated as a shortage area.

- Provide outpatient primary care and dental services
- 134 RHCs in Washington State

How are clinics paid?

- Per federal and state rules, FQHCs and RHCs receive an encounter rate.
- Encounter rates are cost-based Medicaid reimbursement in return for serving medically underserved areas and/or populations.
- FQHC and RHC encounter rates can be captured by the following formula:
  Allowable Costs ÷ Visits = Encounter Rate
- Allowable costs must be reasonable and necessary and may include practitioner compensation, overhead, equipment, space, supplies, personnel and other costs incidental to the delivery of FQHC/RHC services.

Clinic type	Services provided	Average 2022 encounter rate
FQHC	Medical, mental health, dental, SUD, maternity support	**$299.61**
RHC	Medical & dental	**$237.12**

How are encounter rates updated?

- Annual Medicare Economic Inflation (MEI) inflation factor update
  - On January 1 of each year, HCA updates FQHC and RHC encounter rates by the CMS Medicare Economic Inflation
- Change in scope (CIS): FQHCs and RHCs can update their encounter rate by submitting a CIS application to HCA if:
  - Their costs have significantly changed in the previous year (retrospective change in scope), or
  - Will significantly change in the coming year (prospective change in scope).
- HCA reviews and approves CIS rate change applications if they:
  - Demonstrate that changes to the type, intensity, duration, or amount of services have resulted in an increase or decrease in the clinic's cost of providing covered health care services to eligible clients.
- No more than one CIS application can be submitted per year

Contact us

Megan Atkinson, megan.atkinson@hca.wa.gov

hca.wa.gov
@WAHealthCareAuthority
@WA_Health_Care

Washington State Health Care Authority

Medicaid program integrity

Michael Brown, Director, Division of Program Integrity

Washington State Health Care Authority

Medicaid program integrity

- CMS defines program integrity simply:

Pay it right.

Medicaid program integrity

An integrated system of activities to ensure compliance with federal, state, and agency rules, regulations, and policies	Encourages compliance where providers and managed care entities can self-disclose improper payments
	Holds managed care entities accountable to prevent improper billing and payments
	Recognizes areas of vulnerabilities that adversely affect Apple Health programs
	Ensures providers and clients meet program participation requirements
	Ensures Apple Health is the payor of last resort, except for an eligible client covered under Indian Health Service (IHS)
	Investigates evidence of potential fraud, waste, or abuse
	Conducts activities to detect and prevent fraud, waste, and abuse, and identify any associated improper payments

Division of Program Integrity

- Approximately 70 staff
  - Recent legislative investments have allowed for the creation of a new program integrity managed care oversight team
  - The investments have allowed for compliance with the 2019 CMS review and recommendations
  - Medicaid Provider Enrollment team recently integrated into program integrity
  - Continue to explore and develop new oversight opportunities with the legislative investments and recent direction

Audits, investigation & clinical review

- Review and investigate fraud or improper payment referrals from internal or external sources, and managed care plans
- Coordinate with law enforcement partners
- Audit *all* Medicaid providers identifying improper payments across all payers
  - Data only audits
  - Clinical record review audits
- Perform data mining activities

Managed care oversight

- Review program integrity activities that are conducted by the managed care organization
  - Ensure recoveries are occurring and encounter data is reflecting recoveries
  - Coordinate program integrity activities among managed care organizations
- Enforce federal program integrity requirements
  - Audit encounter and financial data of the managed care organization
- Enforce contractual requirements
  - Levy sanctions or impose liquidated damages when appropriate

Provider enrollment

- Manage provider application process for the Medicaid program
  - Initial application for billing and servicing providers
  - Revalidation of providers every five years
  - Support addition of new provider types serving Medicaid
- Support in enrolling fellow agency providers into ProviderOne
  - Labor and Industries
  - Department of Corrections
  - Department of Social and Health Services

Compliance and oversight

- Ensure HCA is complying with all program integrity requirements
- Payment Error Rate Measurement (PERM) audit
- Medicaid Eligibility Quality Control (MEQC) audit work
- Fellow state agency oversight of Medicaid expenditures
- Federal grant subrecipient monitoring

Contact us

Michael Brown, michael.brown@hca.wa.gov

Referrals: hottips@hca.wa.gov

hca.wa.gov
@WAHealthCareAuthority
@WA_Health_Care

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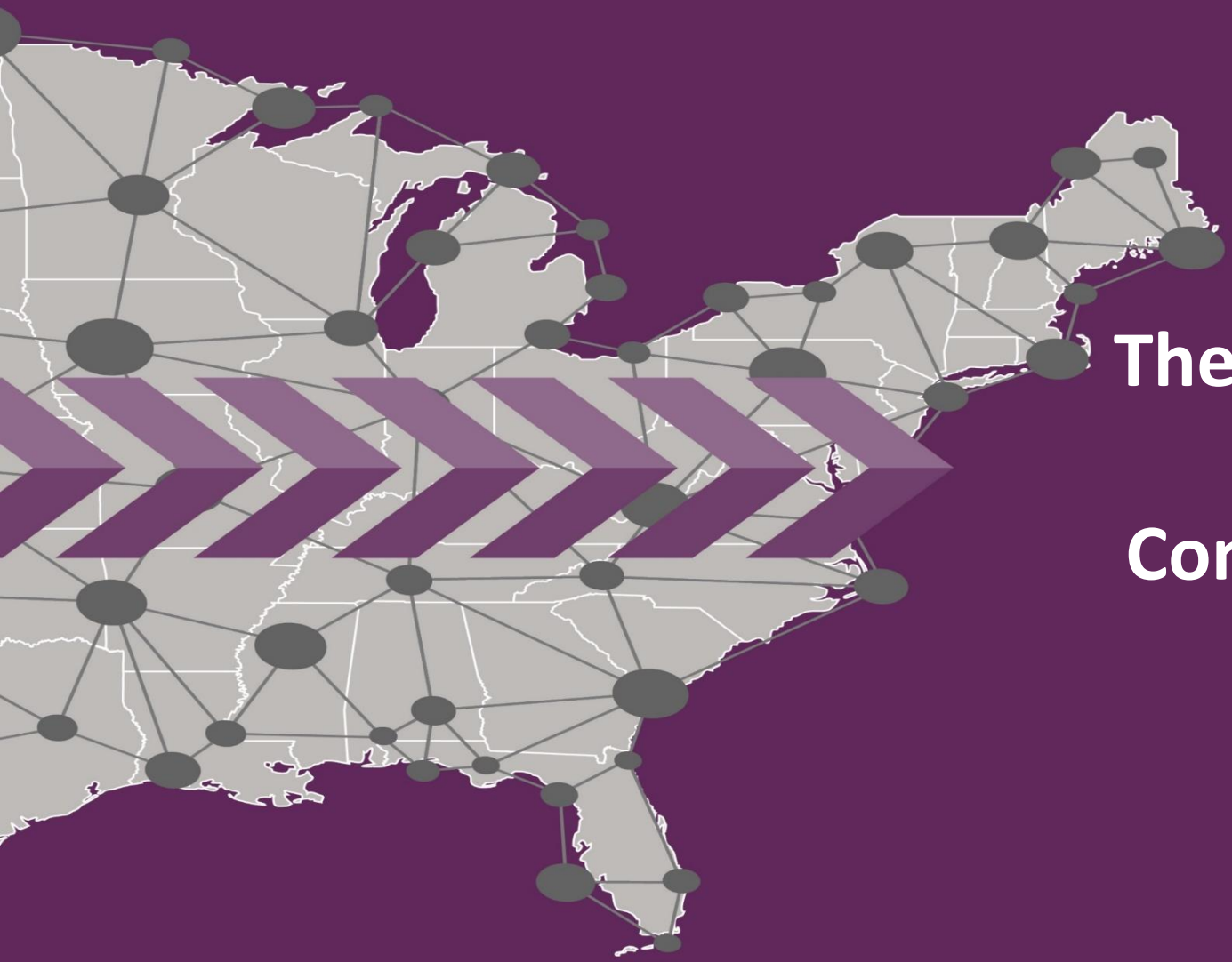

The National Landscape of Healthcare Cost Containment Strategies

Heather Howard

December 16, 2022

STATE Health & Value STRATEGIES

Support for this presentation was provided by the Robert Wood Johnson Foundation.
The views expressed here do not necessarily reflect the views of the Foundation.

Today's Presentation

- Healthcare spending in the U.S.
- Impact on consumers
- National landscape of cost containment efforts
  - All-payer claims databases
  - Cost growth benchmarks
  - Prescription drug affordability boards
  - No Surprises Act
  - Other efforts

Healthcare Spending in the U.S.

International Comparison

The U.S. spends more on healthcare per capita than any other wealthy country

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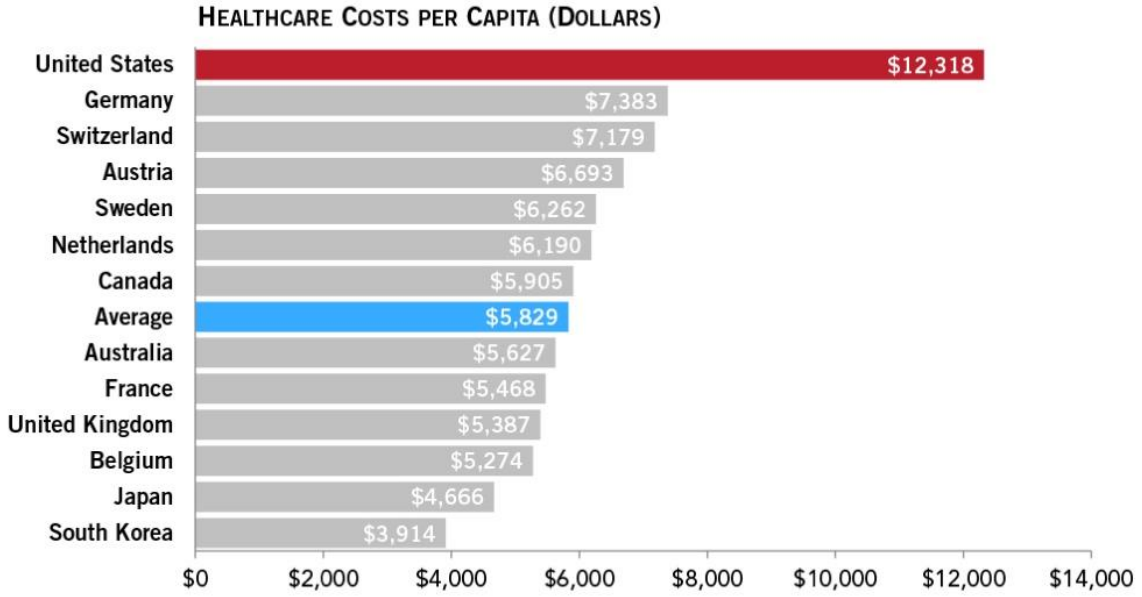
U.S. per capita healthcare spending is over twice the average of other wealthy countries



SOURCE: Organisation for Economic Co-operation and Development, *OECD Health Statistics 2022*, July 2022.
NOTES: Data are latest available, which was 2019, 2020, or 2021. Average does not include the United States. The five countries with the largest economies and those with both an above median GDP and GDP per capita, relative to all OECD countries, were included. Chart uses purchasing power parities to convert data into U.S. dollars.

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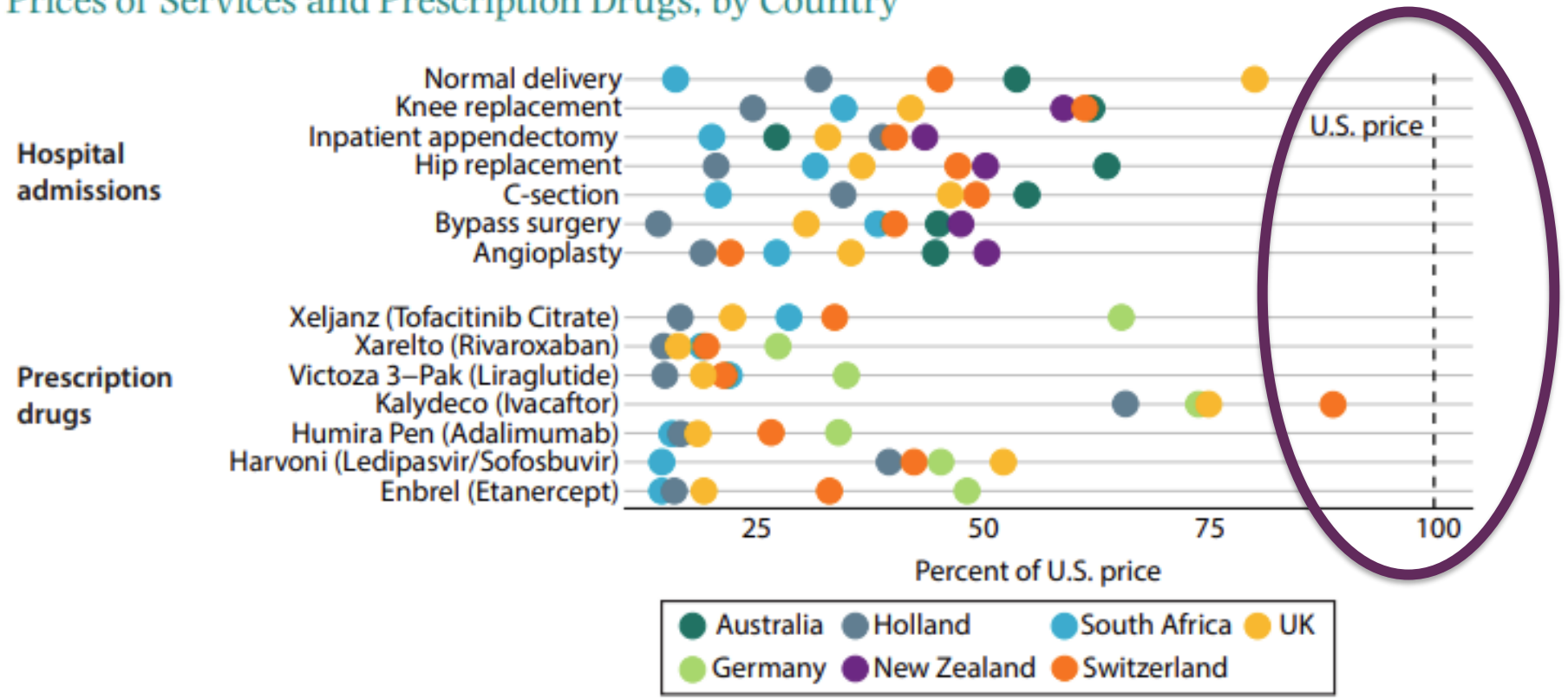
The U.S. spent $4.3 trillion on healthcare in 2021

International Comparison

Higher spending in the U.S. is due to higher prices for healthcare services and prescription drugs

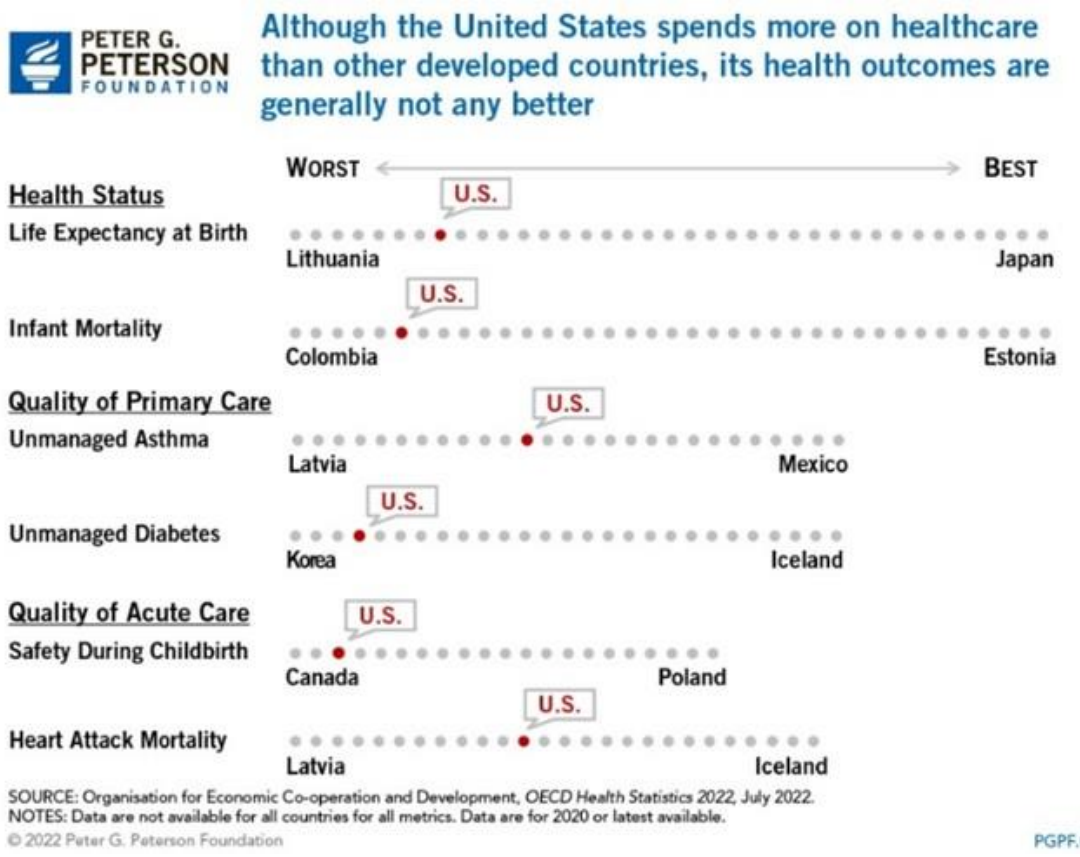
FIGURE 8.

Prices of Services and Prescription Drugs, by Country



International Comparison

Higher spending in the U.S does not lead to better health outcomes



The U.S. performs worse on common health metrics like life expectancy, infant mortality, and unmanaged diabetes.

Healthcare Spending Growth in the U.S.

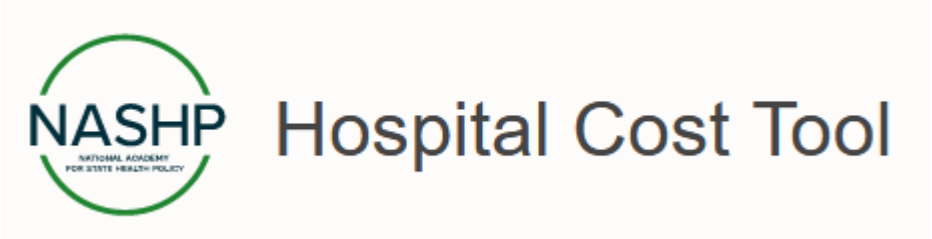
- Total U.S. health spending grew from 6.9% of GDP to 17.7% from 1970 to 2019
- Health spending accounted for nearly one-fifth (19.6%) of U.S. GDP in 2020
  - Pre-pandemic analysis did not project spending to reach this level until 2028
- National health spending is projected to grow more rapidly than GDP
- Spending is expected to reach $6.2 trillion by 2028

Utilization rates in the U.S. do not differ significantly from other wealthy countries, therefore price appears to be the main driver of the cost difference between the U.S. and other countries

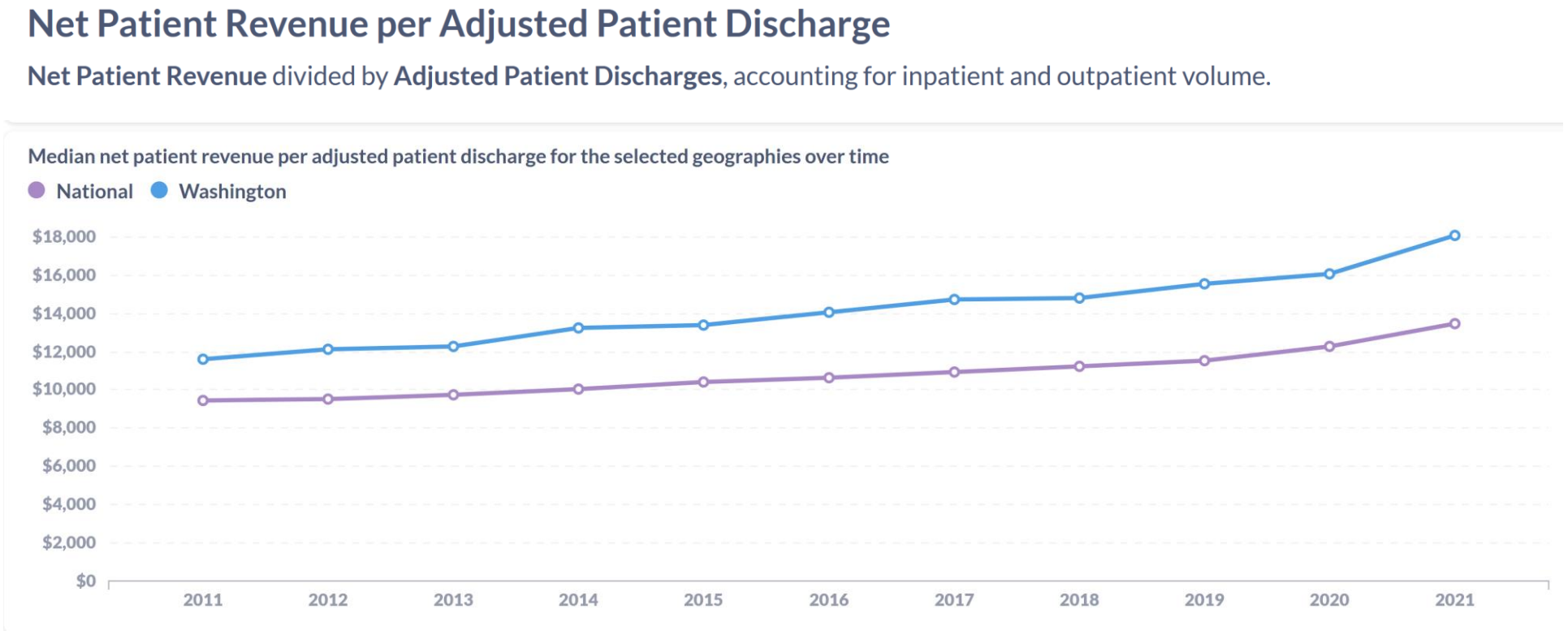
Sources: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected
https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01763
https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet

Hospital Spending: NASHP Hospital Cost Tool

- Dashboard designed to provide state policymakers and researchers with analytical insights into:
  - How much hospitals spend on patient care services
  - How such costs relate to the hospital charges (list prices) and actual prices paid by health plans
- Features a range of measures for hospital revenue, costs, profitability, and break-even points, from 2011-2021
  - Can view data at hospital, state, and health system levels



Exploring the Hospital Cost Tool

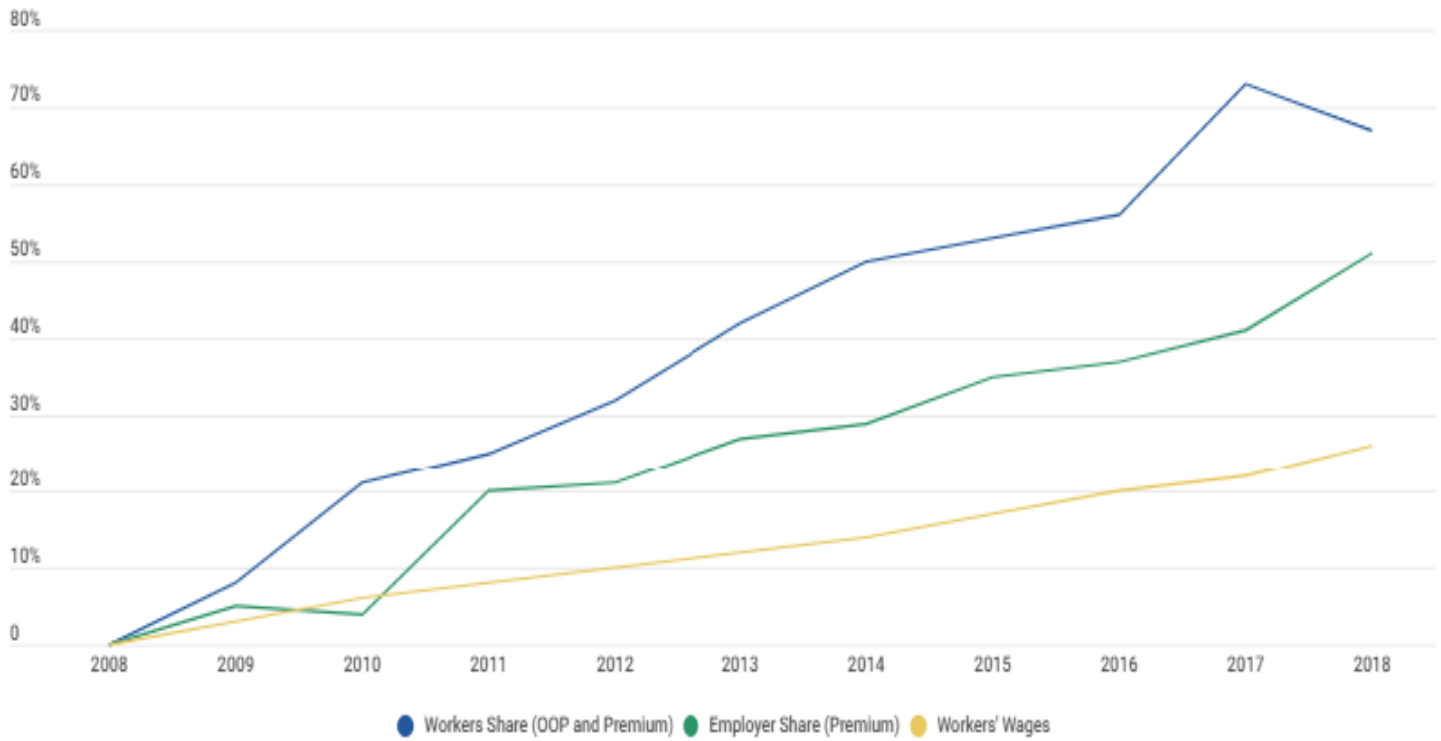


- National Academy for State Health Policy Hospital Cost Tool (tool.nashp.org)

Impact on Consumers

Consumers' Costs are Rising Faster than Wages

Cumulative growth in premiums and out-of-pocket spending for families with large employer coverage, 2008-2018



Source: KFF Analysis of IBM MarketScan Commercial Claims and Encounters Database and KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Impact of High Costs on Consumers

40%	Working age adults who were insured but had to skip or delay healthcare because of costs
37%	Struggled to pay medical bills or were paying off medical debt
60%	Reported delays in care due to cost
60%	Of those who did get care reported problems paying their medical bills

Source: Sara R. Collins, Lauren A. Haynes, and Relebohile Masitha, *The State of U.S. Health Insurance in 2022: Findings from the Commonwealth Fund Biennial Health Insurance Survey* (Commonwealth Fund, Sept. 2022). https://doi.org/10.26099/73zg-3432

Variation in Healthcare Prices

Prices paid for services often differ across the country and can differ within the same state, locality, or even hospital

FIGURE 7A.

Blood Test Prices within Selected Metropolitan Areas

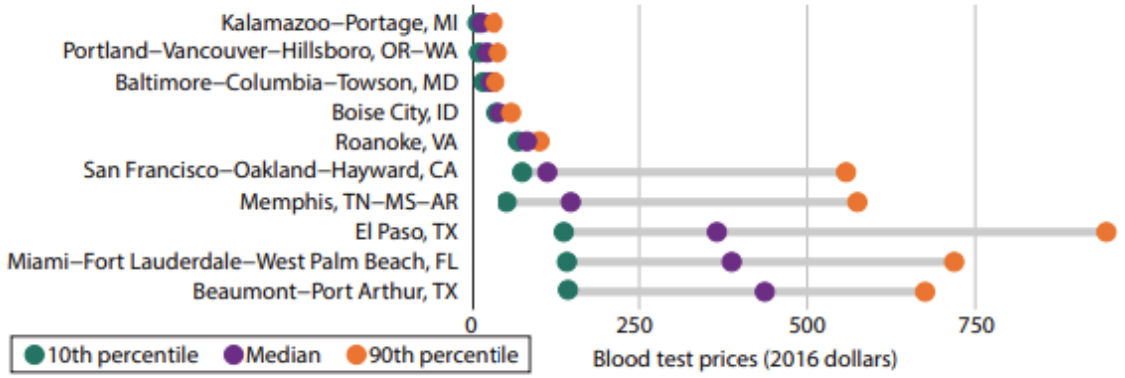
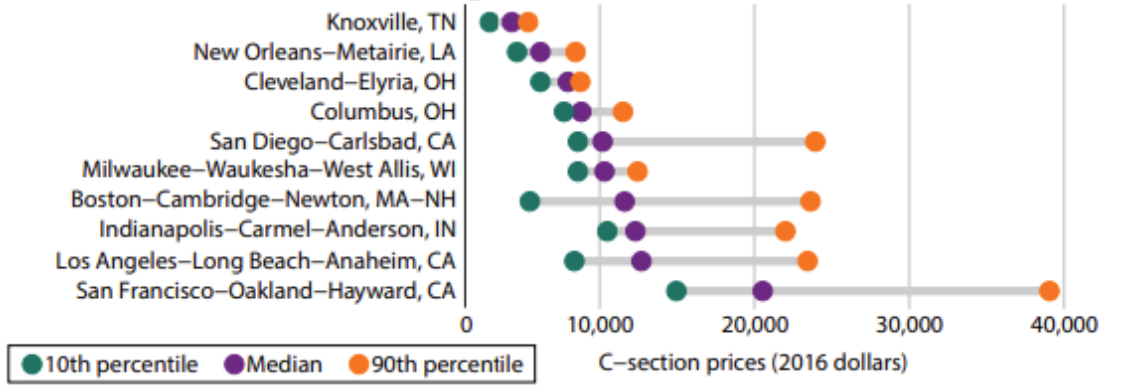


FIGURE 7B.

C-Section Prices within Selected Metropolitan Areas



National Landscape of Cost Containment Efforts

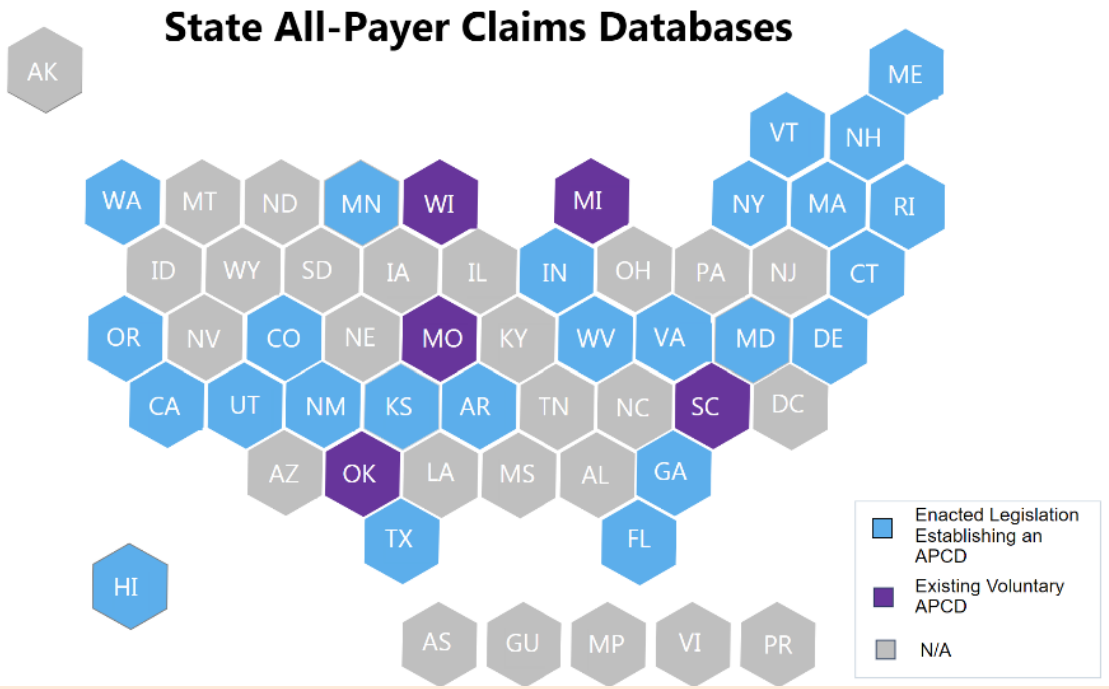
National Landscape of Cost Containment Efforts

- All-Payer Claims Database
- Cost Growth Benchmarks
- Prescription Drug Affordability Boards
- The No Surprises Act

All-Payer Claims Databases (APCD)

Tracking claims data is crucial for monitoring healthcare costs and cost growth overtime. APCDs also inform consumer-facing price comparison tools, which allow consumers to make more informed decisions about their healthcare

- Large state-based databases which collect healthcare claims data from Medicare, Medicaid, state employee health plans, and state regulated-private insurers



25 states have enacted legislation to implement an APCD system
5 states have existing voluntary efforts

Cost Growth Benchmarks

Cost growth benchmarks hold states accountable for limiting spending growth

- Limit how much a state's healthcare spending can grow each year
- Data driven, transparency-focused cost-containment initiatives that measure state healthcare spending growth in relation to established targets

Cost growth benchmarks serve as an anchor. To be effective, the target must be complemented by supporting strategies

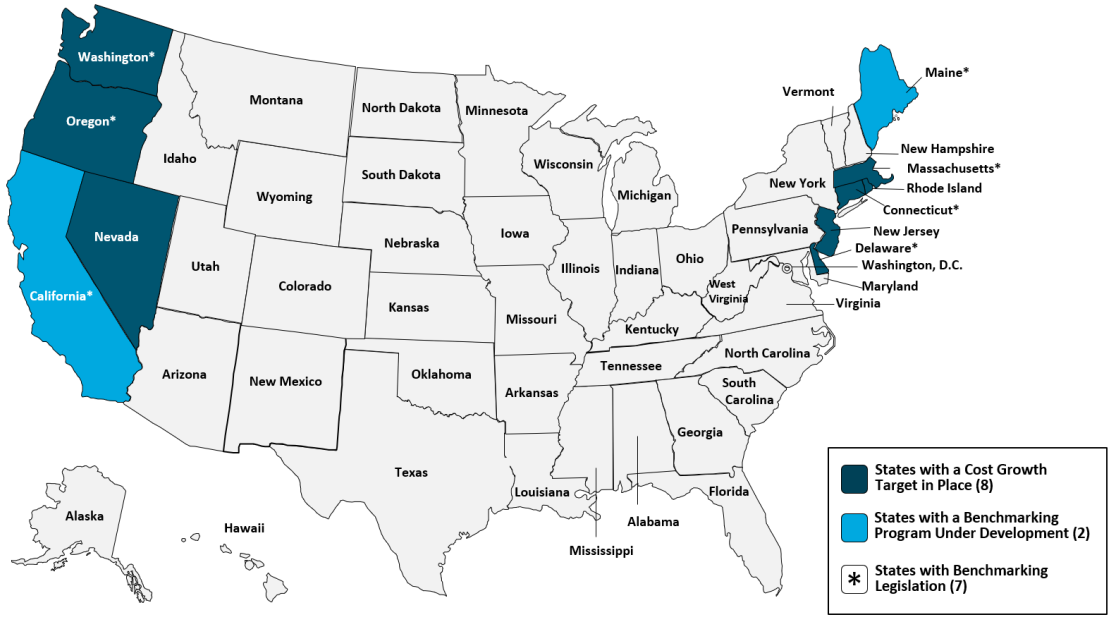
Benchmarks peg annual cost growth to a specific target, often between 2.4% to 3.8% per capita

More States Are Pursuing Benchmarking Programs

Ten states now have cost growth benchmarking programs in place or in development, covering over 70 million people – or one in five Americans.[1]

- ***Nevada*** and ***New Jersey*** established their cost growth targets in late 2021
- ***Connecticut*** established its cost growth and primary care targets and began measuring total healthcare spending
- ***Oregon*** hosted its first annual healthcare cost trends hearing in April 2022
- ***Washington's*** Health Care Cost Transparency Board is collecting data and developing infrastructure for their benchmark
- In late June, ***California*** established a new **Office of Health Care Affordability** with the authority to establish and hold entities accountable to a statewide health care cost growth target.[2]

Figure 1. States with a Benchmarking Program In Place / Under Development as of August 2022



manatt

Sources: [1] HPC Board Meeting, July 13, 2022. [2] California Senate Bill 184 (2021-2022 Regular Session. Map: Manatt analysis of state benchmarking programs and legislative activity.

Cost Growth Benchmarks in WA

Set by the Health Care Cost Transparency Board

Builds on the state's APCD system

Every year the board will set a benchmark for the annual rate of growth for total healthcare spending in the state

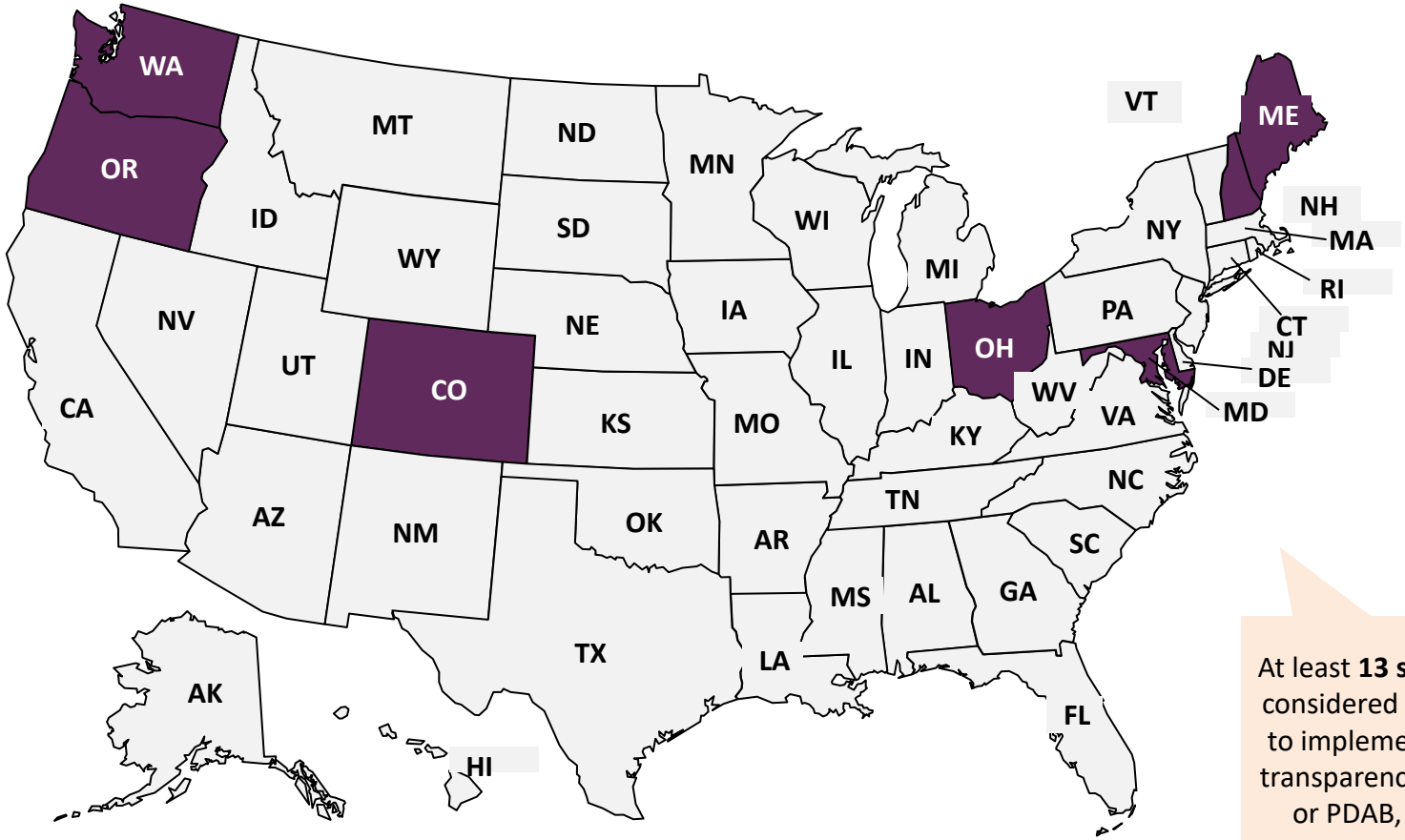
Reports to the Legislature with recommendations for lowering costs

Prescription Drug Affordability Boards (PDABs)

PDABs focus on efforts to reign in drug costs to reduce spending

- Independent bodies empowered to analyze the high cost of drugs and suggest effective ways to lower spending
- Set upper limits on certain drugs that apply throughout the state

Enacted Laws to Establish PDABs



At least **13 states** have considered legislation to implement a price transparency program or PDAB, or both

No Surprises Act (NSA)

Protects consumers from unanticipated and costly medical bills known as "surprise bills"

- Out-of-network surprise medical bills (also known as balance bills) arise when a consumer inadvertently or unknowingly receives care from a provider (such as a physician) or at a facility (such as a hospital) that is not within their insurance plan's network.
- NSA aims to protect patients from the most pervasive types of balance bills for emergency services (including by air ambulances, although not ground ambulances), including some services after the patient is stabilized, and non-emergency services at in-network facilities (unless a patient consents to treatment by an out-of-network provider).

No Surprises Act

Vehicles for State Regulation

- States with their own method for determining payment for out-of-network care (a "state specified law") can continue to use those processes for balance bills involving fully insured plans
  - But critical to avoid inflationary approaches
- **Insurance Depts.:** States are primary enforcers (can partner with federal government)
- **Medical Licensing Boards:** Occupational licensing codes may prohibit physicians (but not facilities) from sending balance bills, with authority to suspend or revoke license for failing to comply
- **Consumer Protection Agencies:** unauthorized bill could be enforced as violation of unfair trade practices or consumer protection laws
- States can go beyond the NSA, such as not allowing consent waivers or prohibiting balance billing from ground ambulances

Other Cost Containment Efforts

Public Option

- Health plan created by the government to offer consumers a high-value, affordable alternative to fully private plans
- May be a privately funded plan established pursuant to state law and subject to certain heightened requirements meant to improve value and advance state goals like cost containment

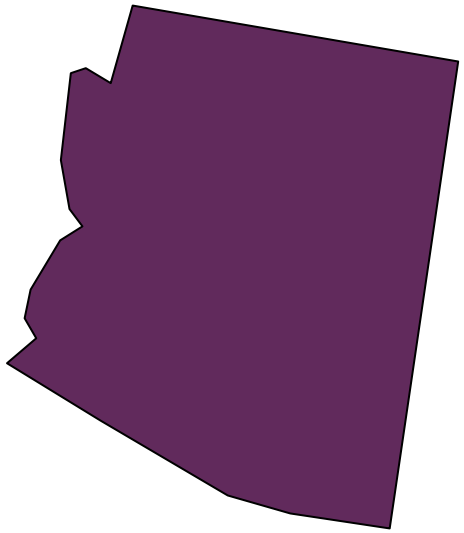
States with a Public Option

WA was the first state in the nation to offer a public option in 2021. The state has enacted several pieces of legislation to strengthen the program including efforts to expand state subsidies to lower out-of-pocket costs for consumers.

CO is offering its public option for the first-time for plan year 2023. The program **requires** plans to achieve premium rate reductions of 5% each year, beginning 2023 through 2025.

NV will offer its public option beginning in plan year 2026. Premiums for the public option must be at least 5% lower than ACA benchmark premiums with increases limited by Medicare index.

Addressing Medical Debt



- Arizona's *Predatory Debt Collection Act* Medical Debt Ballot Initiative (Prop. 209)
  - Overwhelming (75%) support from voters
- What it does:
  - Caps the interest rate for medical debt at 3%
  - Limit to 10% of wages that can be garnished (from 25%)
  - Additional protections for homes, furnishings, and cars from forced sale or seizure
- Will have important equity implications, as the percentage of Arizonans with medical debt is much higher for communities of color


Health Costs

Home // Health Costs // The Burden of Medical Debt in the United States

The Burden of Medical Debt in the United States

Matthew Rae , Gary Claxton , Krutika Amin , Emma Wager , Jared Ortaliza , and Cynthia Cox

Published: Mar 10, 2022


DIAGNOSIS: DEBT

100 Million People in America Are Saddled With Health Care Debt

By Noam N. Levey

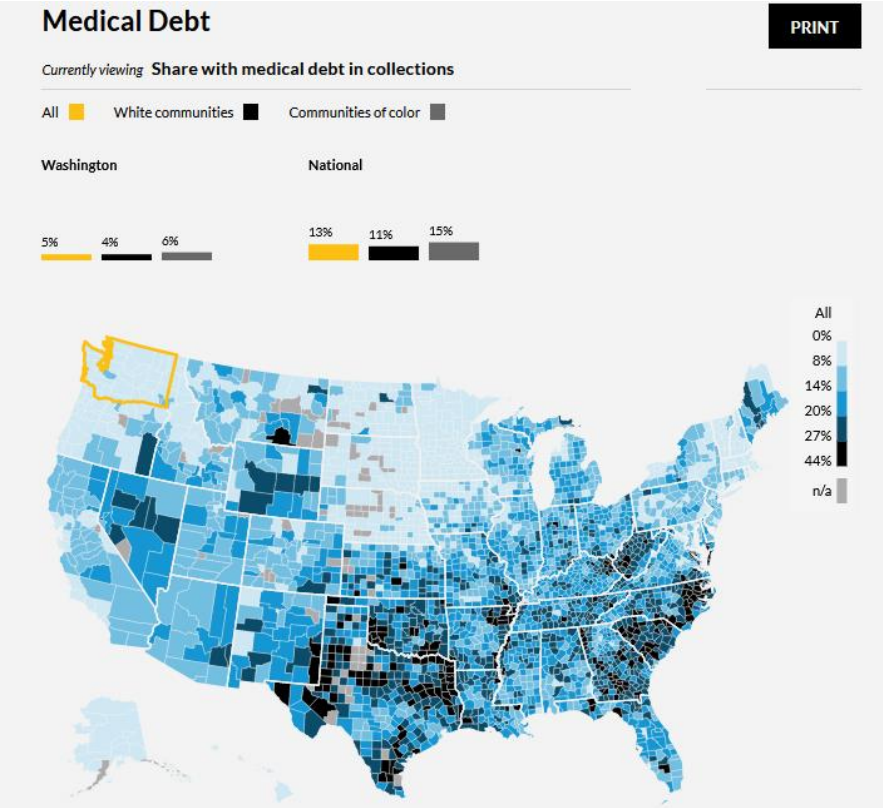
JUNE 16, 2022

REPUBLISH THIS STORY

DISPONIBLE EN ESPAÑOL

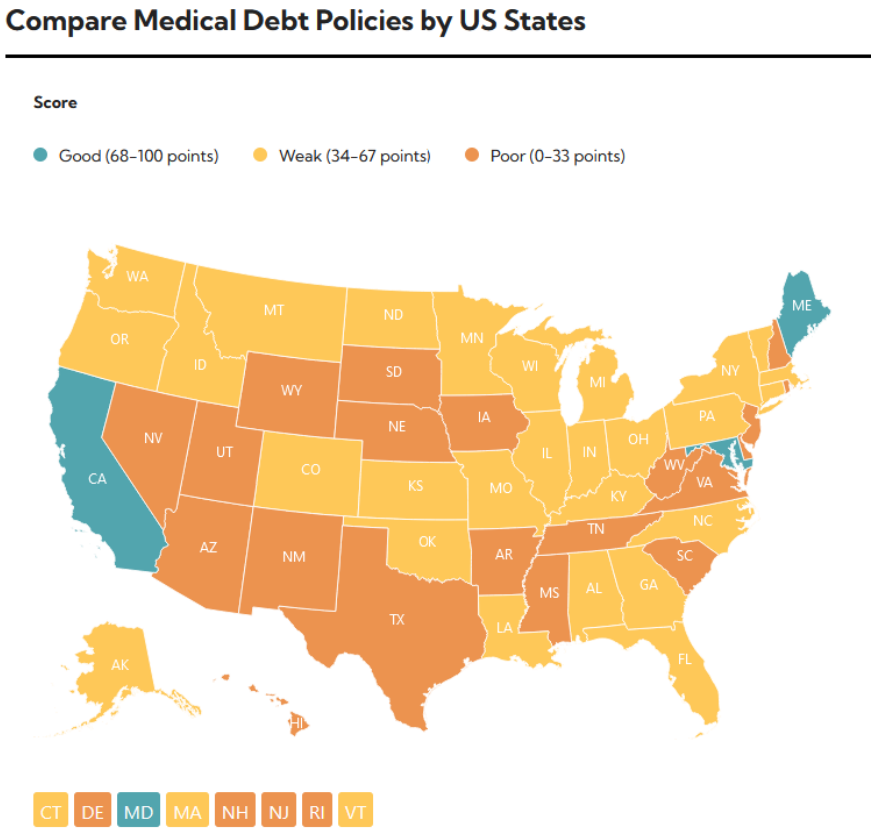
Washington State and Medical Debt

Urban Institute Geography of Debt Map



Source: Urban Institute's Debt in America: An Interactive Map
https://apps.urban.org/features/debt-interactive-map/?type=overall&variable=totcoll

Medical Debt Policy Score Card



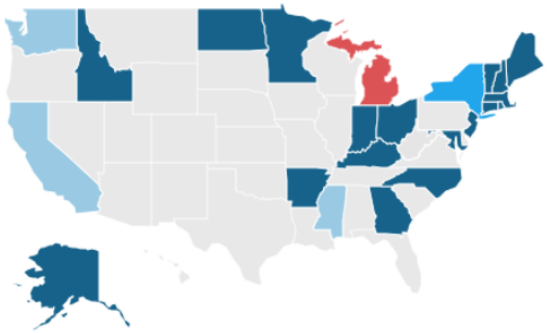
Source: Medical Debt Policy Scorecard
https://medicaldebtpolicyscorecard.org/

Anti-Competitive Practices

- Health systems can use their market power to impose anti-competitive provisions in contracts with insurers
  - Reduces consumer choices and increases costs
- Federal law banned the use of gag clauses in contracts (as of 1/1/22), but health systems use other provisions that restrict competition
  - "all or none" clauses that require a health plan to contract with all of the system's other providers,
  - "anti-steering" or "anti-tiering" clauses that prevent insurers from using cost-sharing strategies to steer patients to lower cost providers, and
  - "exclusive contracting" clauses that prevent the insurer from contracting with competing providers.
- Bipartisan federal legislation (Baldwin-Braun) would prohibit these types of anti-competitive contracting clauses, and federal regulators are trying to beef up anti-trust enforcement.
- In the meantime, several states are taking action through their own anti-trust enforcement and state-level legislation to ban anti-competitive practices

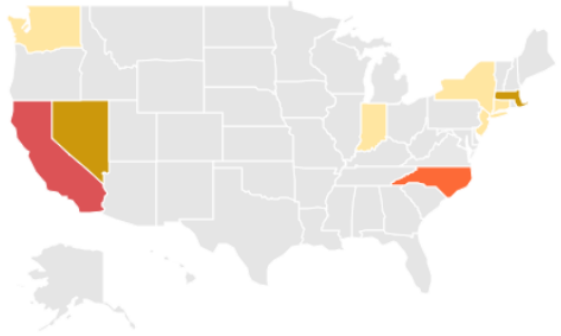
State Action on Anti-Competitive Practices

Restriction of Most Favored Nation Provisions in Provider Contracts



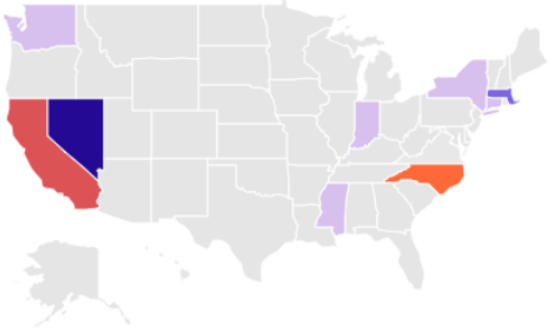
- Law/bill restricting MFN + Major lawsuit
- Law restricting MFN contract provisions
- Law discouraging MFNs/Current session bill to restrict MFNs
- Current session bill to restrict MFNs
- No restrictions on MFN contract provisions

Restriction of Anti-tiering or Anti-steering Provisions in Provider Contracts



- Legislation restricting anti-tiering/anti-steering provisions + Major lawsuit
- Major lawsuit alleging anticompetitive contract use
- Law restricting anti-tiering or anti-steering contract provisions
- Current session bill to restrict anti-tiering contract provisions
- No restrictions on anti-tiering or anti-steering contract provisions

Restriction of All-or-nothing Provisions in Provider Contracts



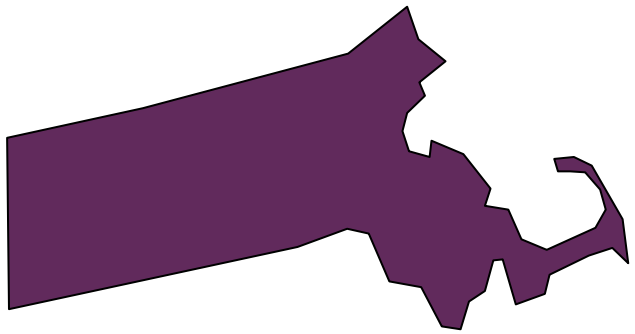
- Legislation restricting all-or-nothing provisions + Major lawsuit
- Major lawsuit alleging anticompetitive contract use
- Law banning all-or-nothing contract provisions
- Law restricting some all-or-nothing contract provisions
- Current session bill to restrict all-or-nothing contract provisions
- No restrictions on all-or-nothing contract provisions

Impact of Hospital Consolidation

- Research consensus that hospital consolidation generally results in higher prices.
  - Across geographic markets and different data sources.
  - When hospitals merge in already concentrated markets, the price increase can be dramatic, often exceeding 20 percent.
- Research also demonstrates that hospital competition improves quality of care and in contrast, physician-hospital consolidation has not led to improved quality.
  - Studies find that consolidation was primarily for the purpose of enhanced bargaining power with payers, and hence did not lead to true integration. Consolidation without integration does not lead to enhanced performance.
- Emerging research that hospital consolidation **across** markets may also lead to raised prices

Sources:
- "The Impact of Hospital Consolidation," Martin Gaynor and Robert Town, RWJF Synthesis Project
- "The Rise of Cross-Market Hospital Systems and Their Market Power in the US," Brent D. Fulton et al, Health Affairs

Addressing Hospital Consolidation



Massachusetts *Health Policy Commission*

- Monitors proposed changes to provider affiliations, assessing the cost and market impact of mergers and acquisitions
- Makes recommendations to the state Department of Public Health whether to approve mergers and expansions
- Can require providers and insurers to develop plans for reducing costs

Thank You

Heather Howard
Director, State Health and Value Strategies
Professor of the Practice
Princeton University School of Public and International Affairs
heatherh@princeton.edu
609-258-9709

About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

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The views expressed here do not necessarily reflect the views of the Foundation.

BREAK

Washington State Health Care Authority

Health equity

Quyen Huynh, DNP, FNP, ARNP, FAAN
Health Equity Director

Washington State Health Care Authority

Health equity vision

Employees embody a culture in which we openly recognize health inequities.

We are empowered to work together and with the people we serve to reduce inequities through fair and equitable distribution of programmatic, financial, and informational resources.

Background: HCA & equity

HCA is making intentional efforts to address diversity, equity, and inclusion (DEI) in all our practices.

Building internal infrastructure	Serving as experts for programs
• Added health equity language to position descriptions • Established the Collaborative Community for Health Equity • Created roles & scope: health equity liaisons & Think Tank • Created the health equity toolkit	• Medicaid Transformation Project (MTP) waiver renewal • Managed care organization (MCO) re-procurement • Value-based Purchasing Roadmap • School & Public Employees Benefits Boards (SEBB & PEBB)

Background: HCA & equity (cont.)

- External collaboration
  - Governor's Interagency Council on Health Disparities
  - Department of Health's (DOH's) Health Equity Zone
  - Health and Human Services (HHS) Interagency Equity Collaborative
  - BREE Collaborative
  - Center for Health Care Strategies – Health Equity

Health equity liaison committees

Health Equity Toolkit

- Created and implemented health equity tool
  - Applying the equity lens in all programs, processes, and policies

Process Design

- Ongoing creation of health equity processes, communications, training, and evaluations

Project Inventory

- Oversees development of the equity inventory—an agency-wide database of equity-related efforts—its submission process, and the Equity Inventory Dashboard.

Social determinants of health inform health equity

- Social determinants of health are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes
- Health care access and quality
- Education access and quality
- Social and community context
- Economic stability
- Neighborhood and built environment

Initiatives in social determinants of health

- Integrated eligibility
- Identification of need
  - MCO screenings, measuring disparities in quality measures, billing guidance for health-related social needs (HRSN), Z-codes (encounter codes used to document social determinant of health data)
- Financial incentives (e.g., the Medicaid Quality Improvement Program)
- Coverage of services
  - Traditional: transportation, interpreter services, Health Homes
  - Newer: Foundational community supports for housing and employment, medical respite
    - MCO value-added benefits (car seats, gym memberships, etc.)
- Core infrastructure: community information exchange

Pro-equity Anti-racism (PEAR) work streams

Washington State Health Care Authority

Executive orders

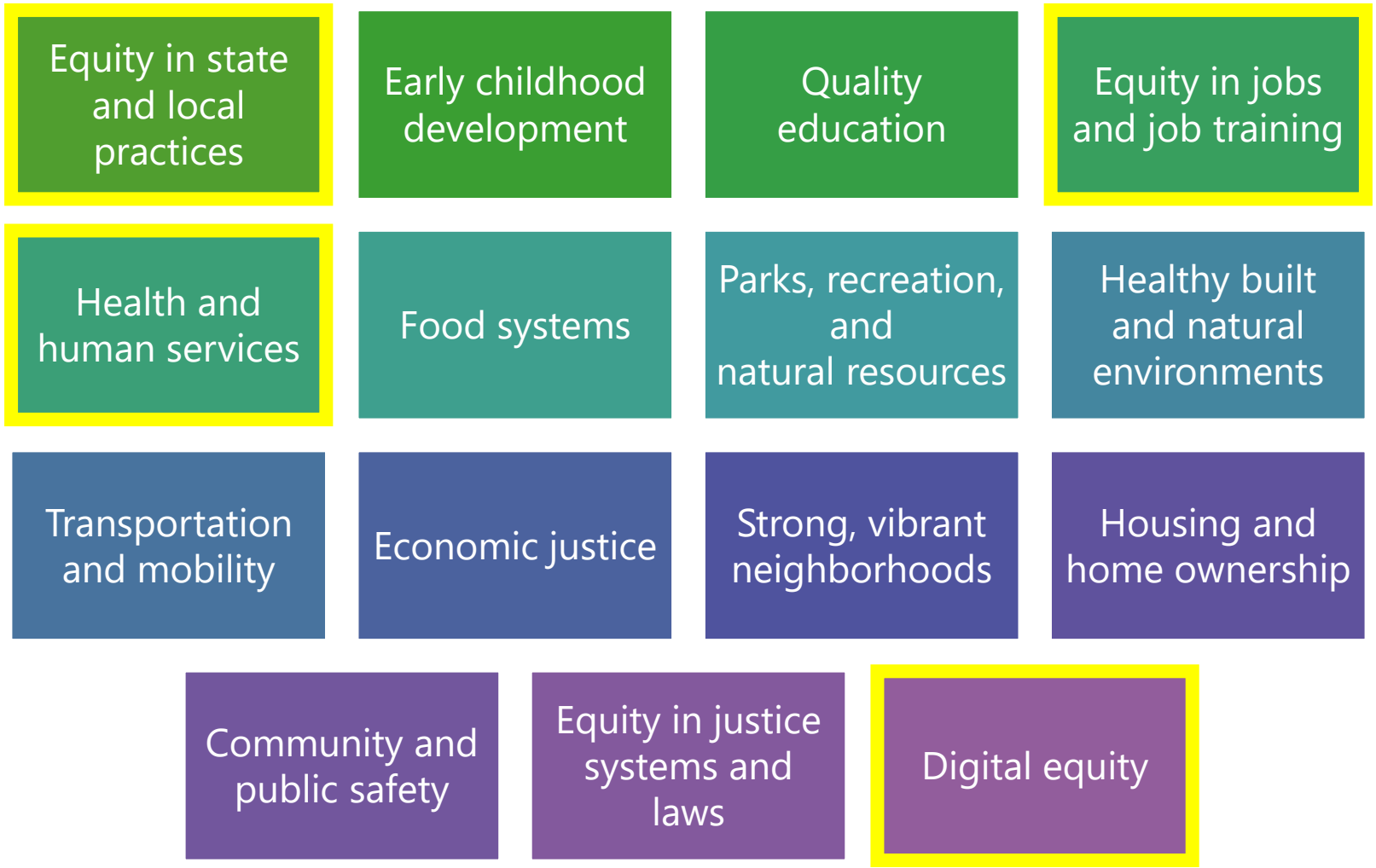
- 22-01: Equity in Public Contracting
  - Requires equitable contract practices
  - Ensures the success of minority-, women- and veteran-owned businesses
- 22-02: Achieving Equity in WA State Government
  - Focuses on human resources (HR)-related DEI
  - Follows up on 20-02 and 20-03 state HR directives
- **22-04: WA State Pro-Equity Anti-Racism (PEAR) Plan & Playbook**
  - Ensures all state agencies create a PEAR strategy to ensure equity in state government
  - Codifies 22-01 and 22-02

Goals

from the PEAR Plan & Playbook

- **Drive** pro-equity and social justice for all.
- **Center** racial justice.
- **Ensure** equitable access.
- **Build** a culture of belonging.
- **End** disparities, including racial and ethnic disparities, to achieve equitable outcomes.

15 determinants of equity
From the PEAR Plan & Playbook



Mapping existing work to equity competencies

Knowledge, understanding, and commitment

Self awareness and commitment to growth

Cultivating mutually beneficial and trusting, strategic partnerships

Equitable and accessible excellence and allyship

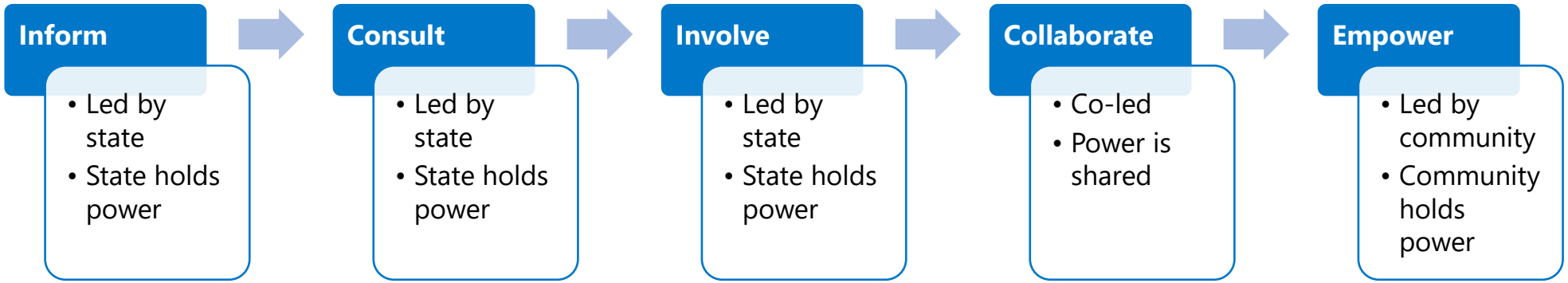
Measuring for success and improvement

HCA PEAR accomplishments

- Created internal PEAR team
- Successfully recruited initial PEAR Community Advisory Team (PEAR-CAT)
- Completed the equity impact review
- Completed 18 hours of white board sessions with 18 divisions
- Created PEAR strategic plan with four key business lines
- Drafted Community Engagement Guide
- Submitted equity decision package

PEAR Community Advisory Team (PEAR CAT)

- Comprised of community members who advise the PEAR Team
- We want to engage with and hear from unrepresented, underserved communities, including:
  - Black, Indigenous, and People of Color (BIPOC)
  - Non-English speakers/English as a second language
  - Immigrants/refugees
  - LGTBQ+
- Hold regular meetings to share information and discuss high-level strategies



Voted Year 1 PEAR service lines

- Engagement & Community Partnerships
- Data Strategy & Reporting
- Leadership & Operations
- Workforce Equity

Equity strategy

Washington State Health Care Authority

Three-year strategic plan

- Support new and ongoing work
- Align agency-wide efforts
- Innovate equity infrastructure
- Leverage existing work and teams

Support

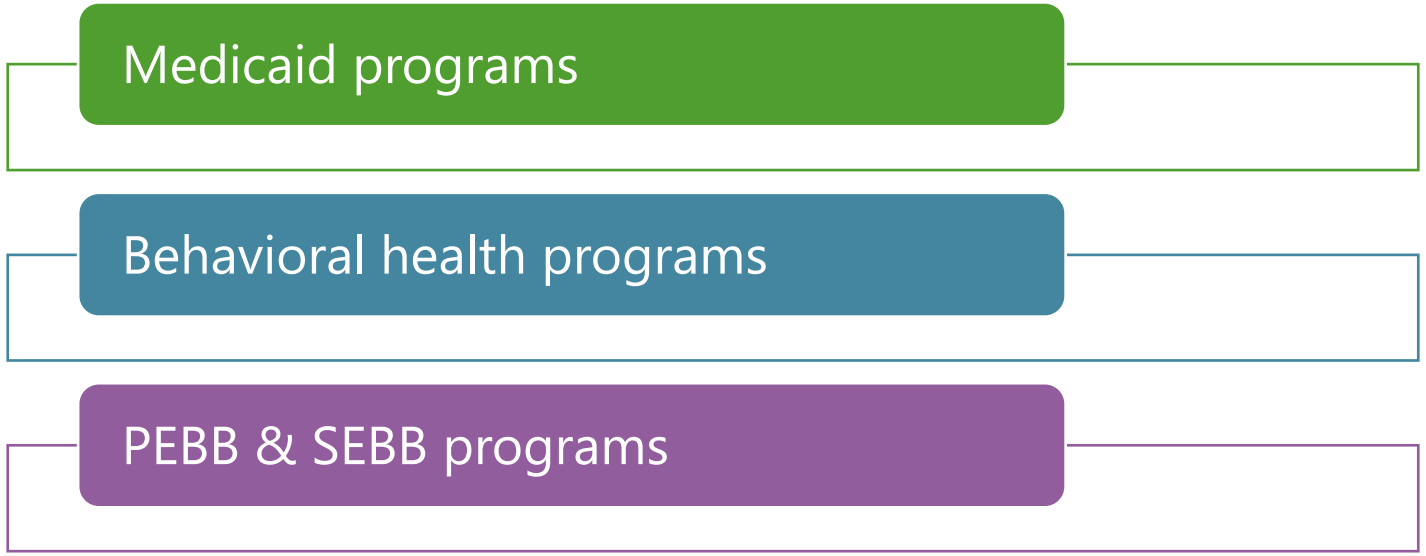
- Support:
  - PEAR workstreams
    - Workforce equity
    - Leadership & operations
    - Data strategy
    - Community & staff engagement
  - Medicaid waiver including:
    - Taking Action for Healthier Communities (TAHC): Community hubs

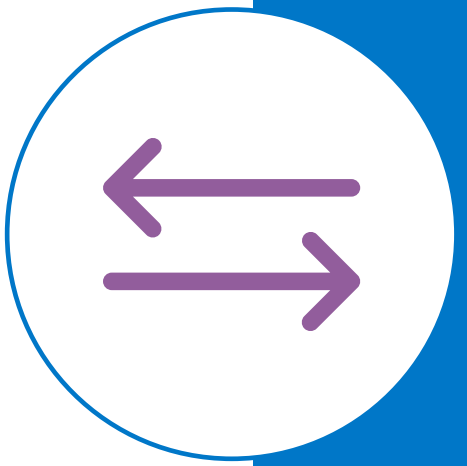
Support

- Support
  - PEAR workstreams
    - Workforce equity
    - Leadership & operations
    - Data strategy
    - Community & staff engagement
- Medicaid waiver, including
  - Taking Action for Healthier Communities (TAHC): Community hubs

Align

- Align: equity strategies between programs



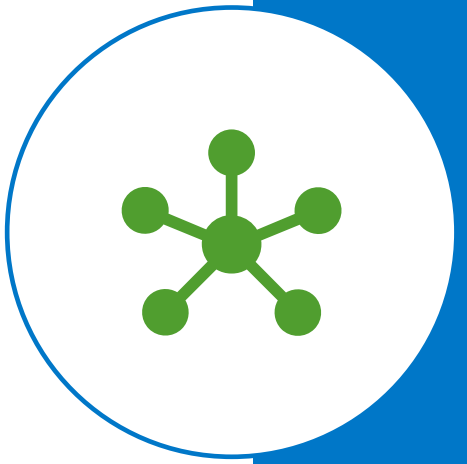


Innovate

- Innovate: HCA's equity strategies

Leverage

- Leverage
  - Interdivisional resources
    - Staff: health equity liaisons & PEAR Team members
    - Resources: HR training processes, communications, planning & performance
  - Passion & commitment
    - Health Equity Think Tank
    - Health Equity Liaisons
    - Collaborative Community for Health Equity



Contact us

Quyen Huynh, DNP, FNP, ARNP, FAAN
doquyen.huynh@hca.wa.gov

hca.wa.gov
@WAHealthCareAuthority
@WA_Health_Care

Washington State Health Care Authority

Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB)

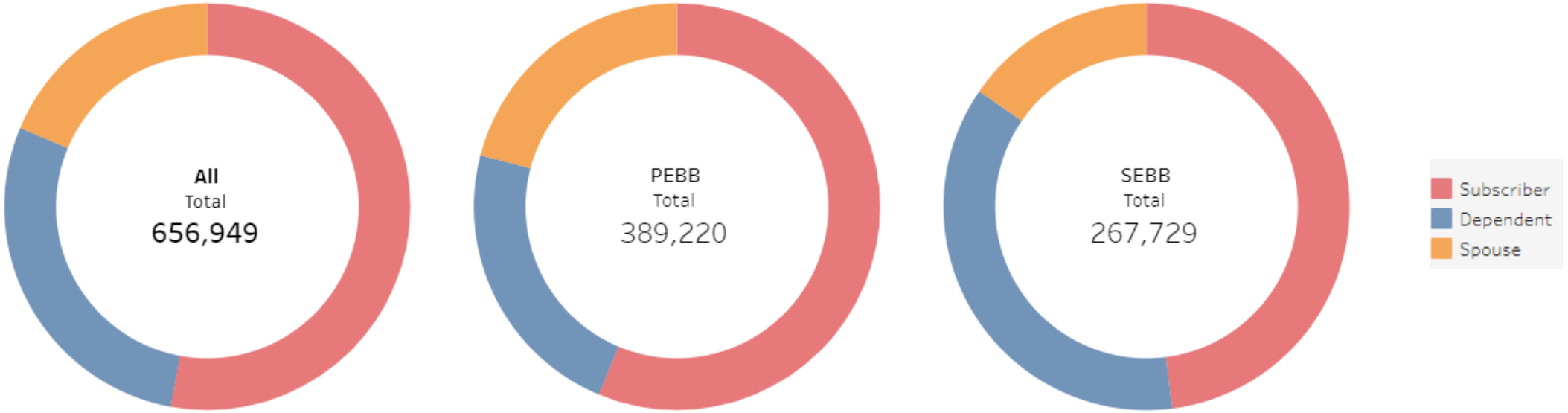
David Iseminger, JD, MPH
Director, Employees and Retirees Benefits Division

Washington State Health Care Authority

PEBB & SEBB programs

- The fundamentals of the PEBB Program have been relatively unchanged since the consolidation of K-12 retirees into the program in the early 1990s, except:
  - Collective bargaining impacts in the early 2000s
  - Substantial refinement of part-time eligibility in the early 2010s
- Action during the 2017 Legislative Session enacted the SEBB Program
  - Benefits coverage began January 1, 2020

PEBB & SEBB covered lives (October 2022)



Waived medical coverage		
30,787	12,550	18,237

There are an additional ~50,000 members enrolled only in dental and/or vision.

Washington State Health Care Authority

PEBB Program required employers

- State agencies, all higher education institutions, and elected officials (legislators, statewide elected officials, judges/justices)
- General Employee Eligibility Rules (RCW 41.05.065(4)):
  - Establish eligibility if "…anticipated to work least eighty hours per month and for at least eight hours in each month for more than six consecutive months…"
  - Maintain eligibility for benefits "…each month in which he or she is in pay status for eight or more hours…"
  - Eligibility for higher education and seasonal workers differs and is described in statute

PEBB Program voluntary employers

- Counties/municipalities/political subdivisions, tribal governments, employee organizations representing state civil service employees, and the Washington Health Benefit Exchange can contract with HCA for access to PEBB benefits
  - Educational Service Districts (non-represented employees only until December 31, 2023; mandatory SEBB Program participation as of January 1, 2024)
- Generally, eligibility rules align with the those applied to state agencies, but HCA can permit some variance (RCW 41.04.205)

PEBB Program covered retirees

- Retirees from state agencies, higher education institutions, elected officials, K-12 school districts, and some (not all) of the voluntary employers that contract with HCA for PEBB benefits
- Substantive eligibility varies by pension plan (plan 1, 2, and 3), but procedural eligibility requirements are standardized
- Deferring enrollment in retiree coverage to a later date is possible, but only if a deferral form is provided to HCA at the point of separation/retirement and certain requirements are fulfilled while in deferral status

SEBB Program covered employees

- All employees of school districts and charter schools, plus represented employees of Educational Service Districts (ESD)
  - Non-represented employees of ESD required participation effective
    January 1, 2024
- General Employee Eligibility Rules (RCW 41.05.740(6)(d))
  - A school employee anticipated to work at least 630 hours per school year
  - Eligibility determined each school year

PEBB & SEBB dependent coverage

- Legal spouses and state-registered domestic partners
- Children up to age 26
- Children of any age with disabilities
- Extended dependents

Financial insights

Washington State Health Care Authority

PEBB Program risk pools

Non-Medicare

Employees of state agencies, higher education institutions, and employer groups that voluntarily purchase health benefits in the PEBB Program; eligible retired or disabled school employees not eligible for Medicare Parts A and B; and eligible state retirees not eligible for Medicare Parts A and B

Medicare

Retired or disabled employees, separated employees, spouses, or children who are eligible for Medicare Part A and Part B; surviving spouses and surviving state-registered domestic partners of emergency service personnel killed in the line of duty

As required by state law (RCWs 41.05.022(2) & 41.05.080)

SEBB Program risk pool

As required by state law (RCWs 41.05.022(3))

Program funding rates

- Separately for each program, the state creates a “funding rate” with assumptions anticipating waivers and enrollment mix, to set an average funding rate for the entire system
  - Any surplus or deficit is addressed by changing assumptions prospectively in future funding rates
- The PEBB and SEBB separate funding rates appear directly in the operating budget

Flow of funding: PEBB Program

- For state agencies and higher education institutions in the PEBB Program, the funding rate is included in each entities budget allocation.
- HCA charges the agency/institution the funding rate for each **eligible** employee, depositing the employer contribution and employee premiums (deducted from paychecks) into the program account
- The funding rate is owed even for an eligible employee who waives enrollment, because the funding rate represents **an average**

SCHOOL EMPLOYEES BENEFITS BOARD PROGRAM

THE FUNDING PROCESS

FOR STATE-FUNDED POSITIONS

In the SEBB Program, the funding rate is built to cover the cost of insuring all eligible state-funded school employees. That funding rate is what the state provides the districts, and the amount the districts send to HCA for state-funded positions.

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

1 **The state sets the funding rate. This includes:**

+ The employer medical contribution (in a way that takes into account an assumed number of enrolled dependents)
+ Full premium contributions for dental, vision, basic life and accidental death and dismemberment (AD&D), and basic long-term disability insurance
+ The K-12 remittance fee
+ Administrative and other costs

2 **The number of state-funded full-time equivalent employees (FTEs) is then multiplied by the benefit allocation factor (BAF).**

This figure is based on the prototypical school funding model. The BAF helps address the difference between the number of state-funded FTEs and the actual number of benefits-eligible school employees. It also takes into account that multiple employees may be hired at part-time capacities. The monthly funding rate is multiplied by the district's state funded FTE as adjusted by the BAF to reach the total monthly insurance benefit allocation.

3 **The monthly insurance benefit allocation is sent to school districts and charter schools each month.**

→ The funding rate represents an *average*, and assumes a certain number of employees will waive coverage.

4 **Districts pay the Washington State Health Care Authority (HCA) the same amount for each employee's benefits, regardless of:**

Whether they enroll a spouse, state-registered domestic partner, or dependents

Whether they waive coverage

What plan they choose to enroll in

5 **School districts and charter schools pay HCA the funding rate, plus the employees' monthly medical premiums, and any applicable surcharges for each benefits eligible employee.**

Learn more at hca.wa.gov/sebb

HCA 20-0118 (5/19)

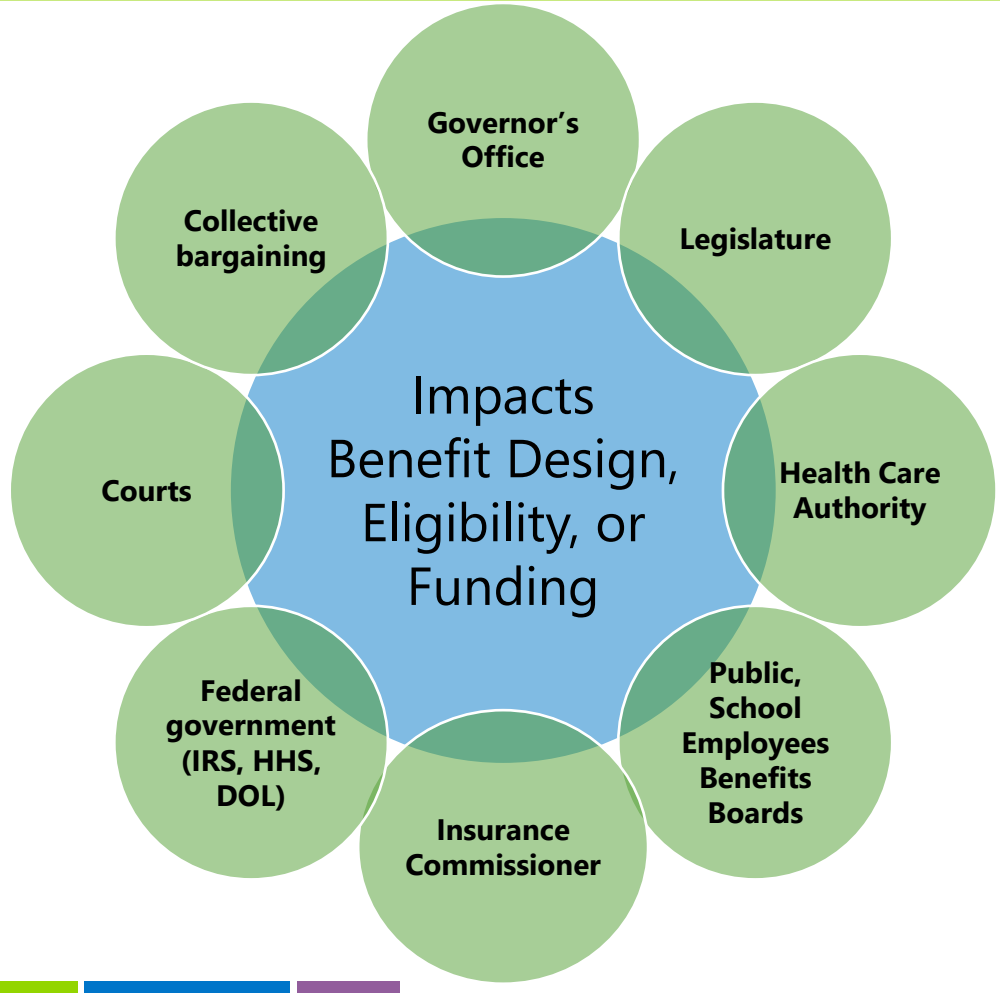
Eligible employees who waive benefits

- The funding rate is owed even for an eligible employee who waives enrollment.
- The funding rate represents an **average** employer contribution rate, which **already includes** anticipating waiver rates based on historical experience.
- Failing to pay the funding rate for waived employees would create shortfalls in program funds.

Authorizing environment

Washington State Health Care Authority

PEBB & SEBB authorizing environment



Washington State Health Care Authority

Authority nuances

- Both the Legislature and respective boards have authority on eligibility, enrollment policies, and benefit design
- HCA administers the programs, but benefit design authority over certain tax-advantaged benefits are heavily regulated by the IRS
- There is a single statewide table for PEBB health care collective bargaining; there is a separate single statewide table for SEBB health care collective bargaining
- The Office of the Insurance Commissioner has direct regulatory authority of fully insured plans, but not the self-insured plans or PEBB Medicare plans

Benefit offerings

Washington State Health Care Authority

Benefits and premium uniformity

- Benefit design within each program is the same (but not all medical plans are offered statewide)
  - There are more medical plan options in the SEBB Program
  - Vision hardware benefits are standalone in the SEBB Program, but embedded in the PEBB Program
- Employee premiums are the same regardless of geography and position type
- Family coverage premiums are based on fixed tier ratios in each program
  - SEBB Program: three times the single coverage premium for the same plan (3:1 ratio)
  - PEBB Program: a 2.75:1 ratio

PEBB Program benefits

- Major medical coverage (including vision and prescriptions)
- Dental coverage
- Wellness program (SmartHealth)
- Additional benefits:
  - Life and accidental death & disability (AD&D) insurance (basic and optional)
  - Long-term disability insurance (employer- and employee-paid)
  - Medical Flexible Spending Arrangement
  - Dependent Care Assistance Program
  - Health Savings Account
  - Voluntary Employees' Benefit Association Medical Expense Plan (VEBA MEP)
  - Auto and home insurance

* For state agency and higher education employees, the state pays a significant portion of the premium for medical, and the entire premium for dental, basic life and AD&D, and employer-paid long-term disability (LTD) insurance.

SEBB Program benefits

- Medical coverage (including prescriptions)
- Vision coverage (hardware)
- Dental coverage
- Wellness program (SmartHealth)
- Additional benefits may include:
  - Life and AD&D insurance (basic and optional)
  - Long-term disability insurance (employer- and employee-paid)
  - Medical Flexible Spending Arrangement
  - Dependent Care Assistance Program
  - Health Savings Account
  - Voluntary Employees' Benefit Association Medical Expense Plan (VEBA MEP)

* The state and SEBB Organizations pays a significant portion of the premium for medical, and the entire premium for dental, vision, basic life and AD&D, and employer-paid LTD insurance.

PEBB & SEBB differences

Topic	PEBB Program	SEBB Program
Risk Pool(s)	2 risk pools, all retirees (including K-12)	1 risk pool, only K-12 employees
Funding of medical by employer	State index rate (tiered weighted average)	Employer medical contribution (calculated with a benchmark plan)
Employee medical plan offerings	10 plans (3 carriers)	17 plans (5 carriers)
Vision hardware benefit structure	Embedded in medical plans	Standalone plan coverage
Major eligibility distinctions	Maintenance eligibility rule	Eligibility evaluated each school year
HCA can contract access to benefits	Yes	No

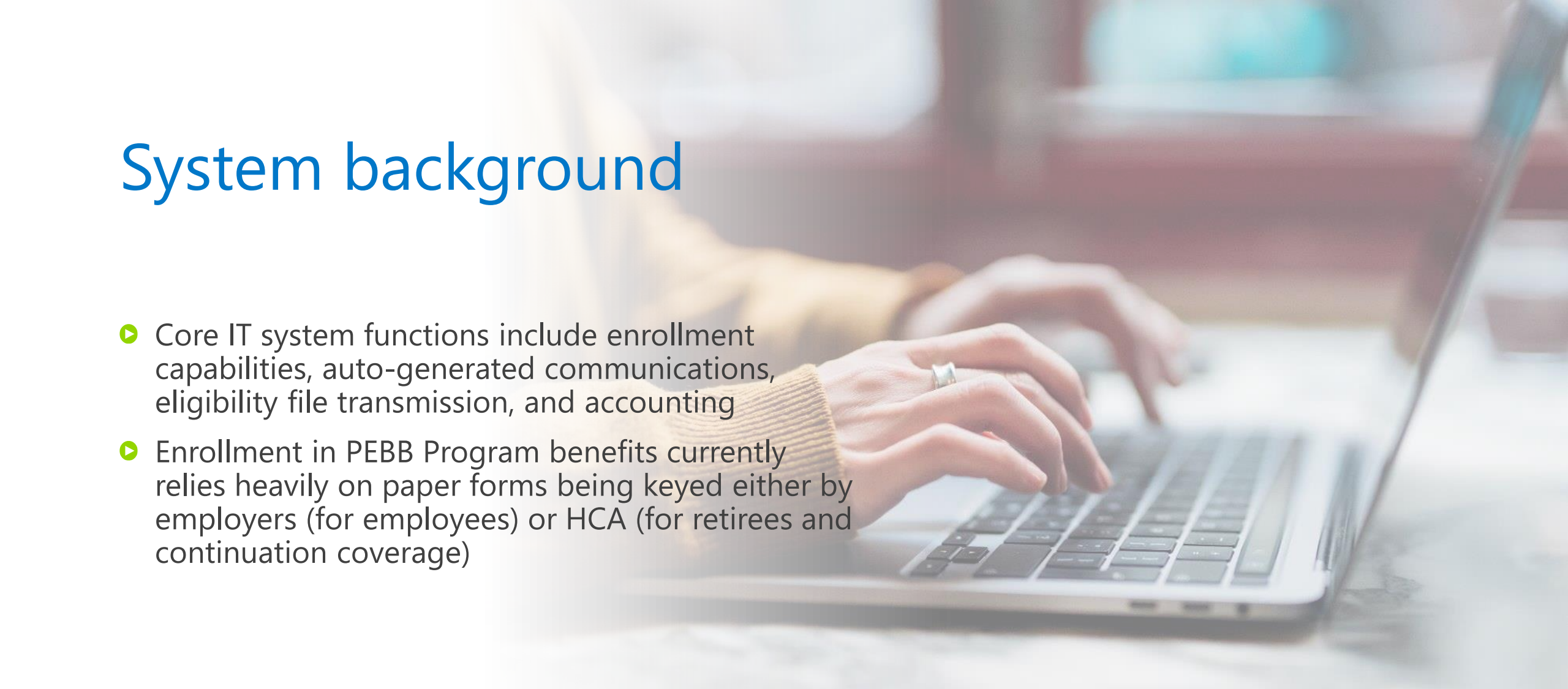
Potential consolidation of programs

- 2020 legislative report with roadmap (November 15, 2020)
- Key aspects that would require legislative decisions
  - Risk pool arrangements
  - Board composition
  - Collective bargaining structure
  - Any refinements to align/change foundational eligibility standards

Program technology

Washington State Health Care Authority

System background



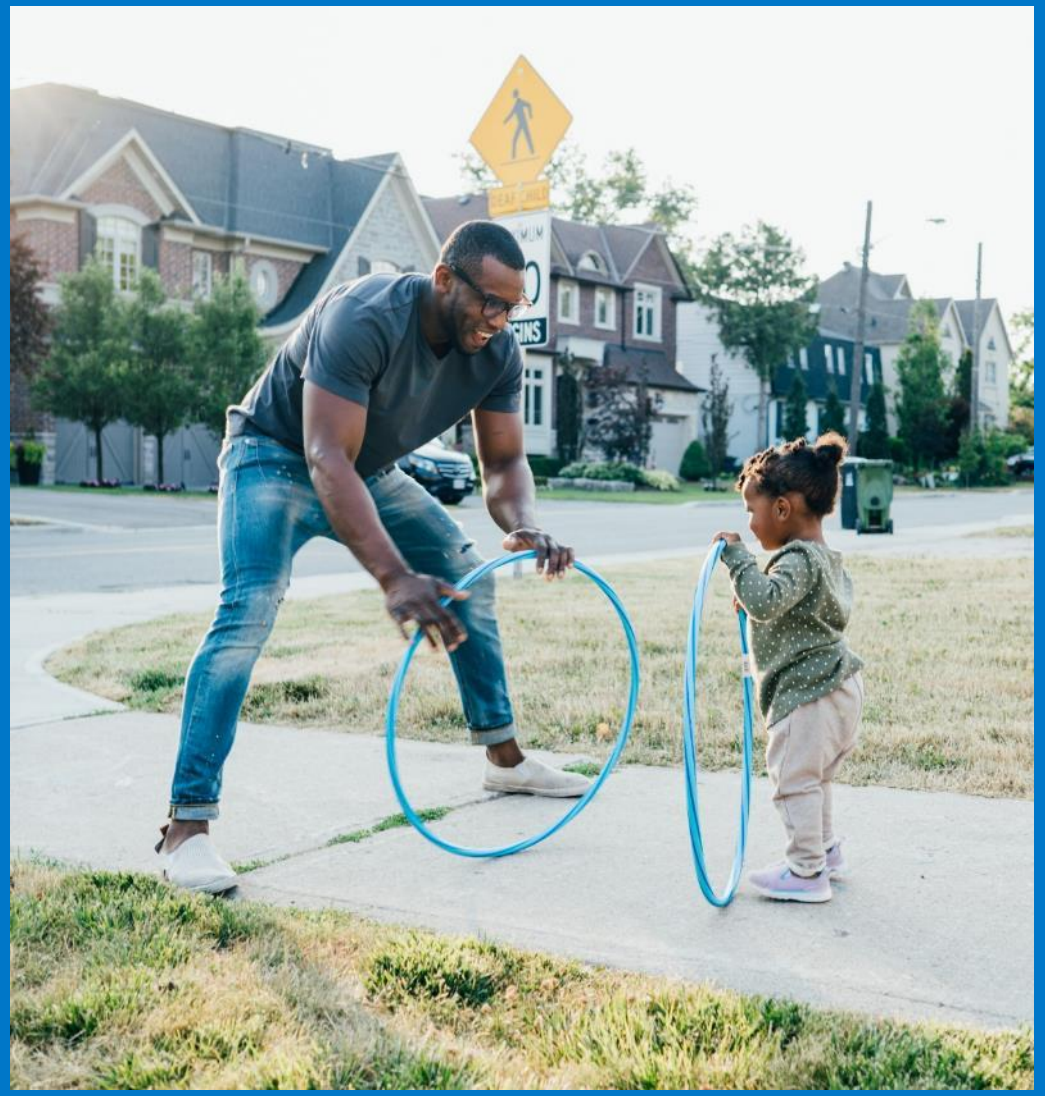
- Core IT system functions include enrollment capabilities, auto-generated communications, eligibility file transmission, and accounting
- Enrollment in PEBB Program benefits currently relies heavily on paper forms being keyed either by employers (for employees) or HCA (for retirees and continuation coverage)

Current system state

- Pay1 is COBOL-based custom-built platform created by the state in the late 1970s currently used for:
  - PEBB enrollment processes (minimal employee self-service) and has an interface with University of Washington
  - PEBB & SEBB communications, eligibility files, and accounting processes
- SEBB My Account is a custom-built enrollment platform created by HCA in 2019 with extensive self-service uses by school employees and has an interface with Seattle Public Schools

2023 system state

- HCA plans to launch the Benefits 24-7 platform, which builds on the SEBB My Account work, and will be used for
  - PEBB & SEBB enrollment processes
  - PEBB & SEBB eligibility file processes
- For now, Pay1 will continue to be used for PEBB & SEBB auto-generated communications and accounting processes



Contact us

David Iseminger, david.iseminger@hca.wa.gov

hca.wa.gov
@WAHealthCareAuthority
@WA_Health_Care

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Thank You

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