Washington State Health Care Authority

Report to the Legislature

Proportion of Non-Participating Providers serving low-income enrollees in state-purchased health care programs
January 1, 2012 - June 30, 2012

As Required by Chapter 9, Laws of 2011, 1st Special Session (ESSB 5927)

January 1, 2013

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EXECUTIVE SUMMARY

Chapter 9, Laws of 2011 1st sp. sess. (ESSB 5927) requires the Health Care Authority (HCA) to submit annual reports to the Legislature. The reports are intended to show the proportion of services, by county, that are provided by non-participating providers to Basic Health (BH) and Healthy Options (HO) enrollees.

To meet this requirement, the HCA directs each contracted managed care health plan to provide the following data for the calendar year under review:

1. The total cost of overall services (claims paid), per county, paid by the managed care health plan to all providers for services provided to enrollees served under the Contract.
2. The percent of overall cost of services (claims paid), per county, paid by the managed care health plan to non-participating providers, including hospital-based physician services, provided to enrollees served under the Contract.

HCA analyzes this data to look for trends that could potentially indicate a change in network adequacy that could affect enrollee access.

Effective July 1, 2012, a new consolidated contract took effect, adding new managed care health plans for both programs. Data analysis of calendar year 2012 would not provide solid comparison data due to the addition of three new managed care health plans and consolidation of historical managed care health plans; therefore, the focus of this year's report is a review for dates of service January 1, 2012 – June 30, 2012 only. July 1, 2012 – June 30, 2013 will be available in the January 2014 report.

A thorough analysis of the county information indicates HCA clients, except for those residing in counties with limited provider pools and topography challenges as outlined below, have appropriate access to health care providers within their health plan's participating provider networks.

INTRODUCTION

In the 2009-11 biennial operating budget, the Legislature directed payments to non-participating providers for contracted services provided to Medicaid managed care enrollees should be limited to the amounts paid providers under the Medicaid fee-for-service delivery system. The duration of these provisions was limited to the period during which the operating budget was in effect.

The Legislature realized a more permanent resolution was needed as continued uncertainty for all interested parties could have adverse impacts such as:

- Diminished ability for the state to negotiate cost-effective contracts with managed care health care plans;
- A potential for significant reduction in the willingness of providers to participate in managed care health plan provider networks;
- A reduction in providers participating in the managed care health plans; and
- Increased exposure for program enrollees to balance billing practices by non-participating providers.

Ultimately, fewer eligible people would get the care they need as state purchased health care programs operate with less efficiency and reduced access to cost-effective and quality health care coverage for program enrollees.

To address this important issue, Chapter 9, Laws of 2011, 1st sp. sess. is intended to ensure:

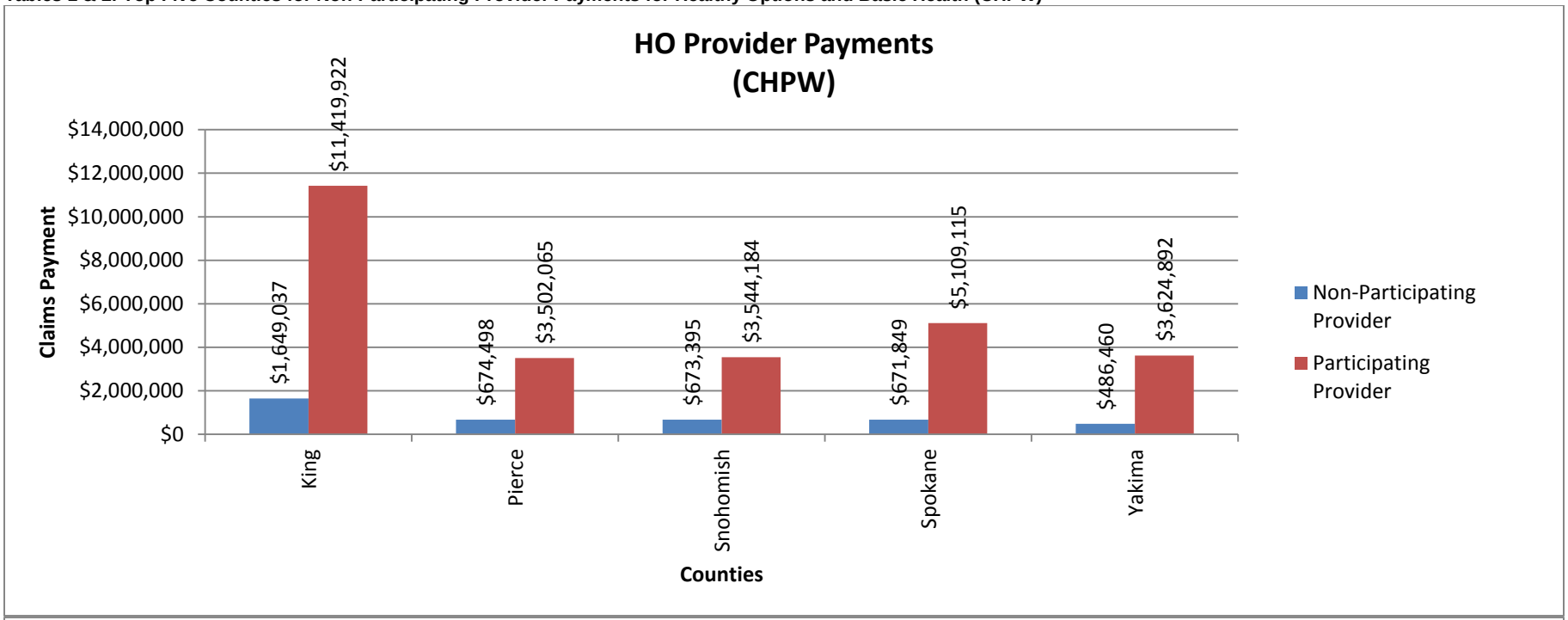
- Non-participating providers are reimbursed only up to managed care health plan's lowest amount paid for that service under its contracts with similar providers in the state.
- Non-participating providers consider the amount paid for covered services by managed care health plans as payment in full for services provided to managed care enrollees.
- Enrollees are not liable to any non-participating provider for covered services, except for amounts due for any deductible, coinsurance, or copayment, as applicable.
- The HCA conducts monitoring and periodic reporting to identify the proportion of services provided by contracted providers and non-participating providers, by county, to ensure managed care health plans meet network adequacy requirements as required under contract and federal law.

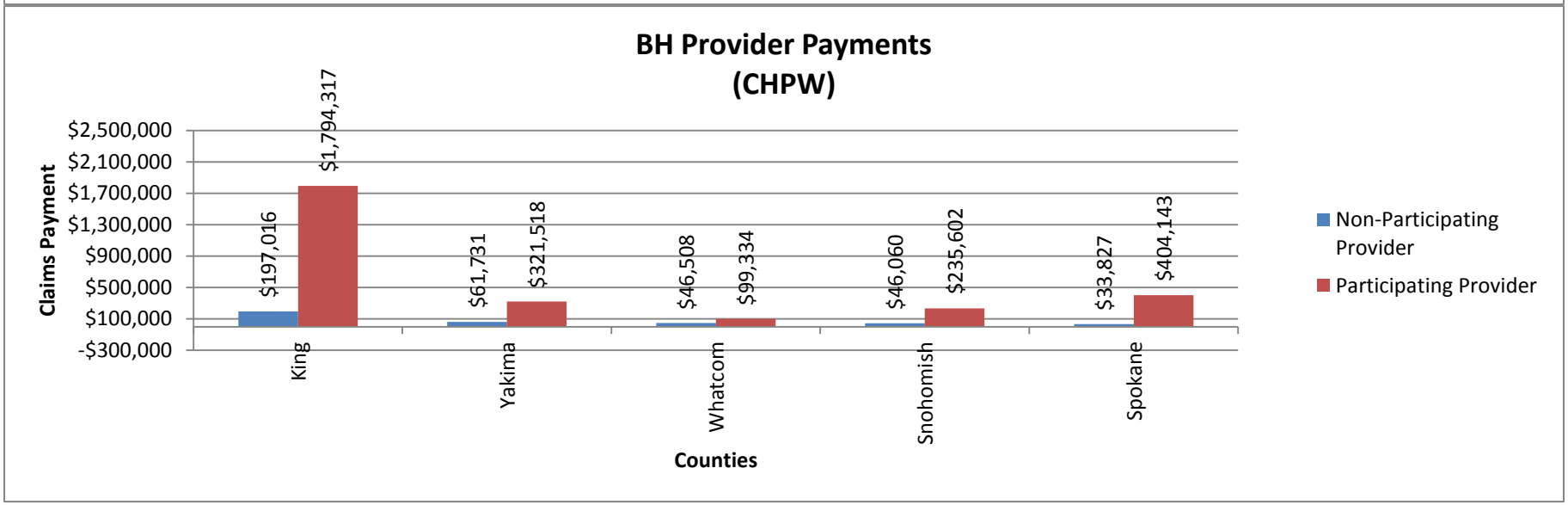
RESULTS

The following tables provide analysis outcomes for managed care health plans serving HO and BH enrollees reporting for January 1, 2012 through June 30, 2012:

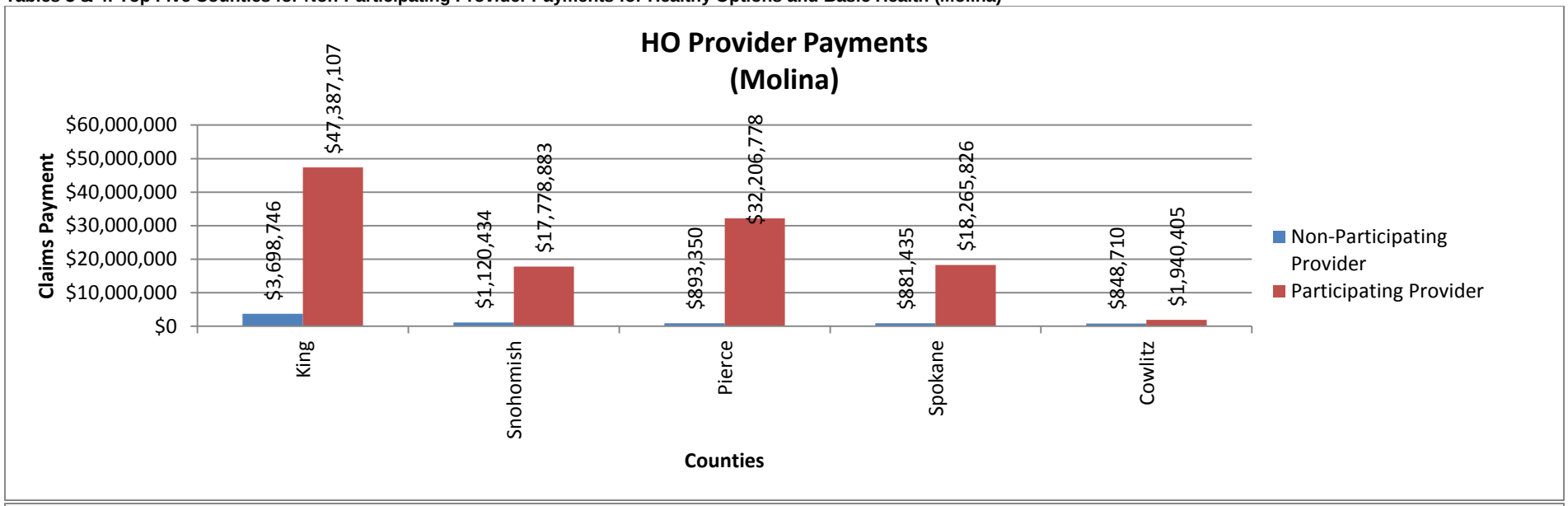
- Community Health Plan of Washington (CHPW)
- Molina Healthcare, Inc.
- Columbia United Providers (CUP)
- Group Health Cooperative (GH)

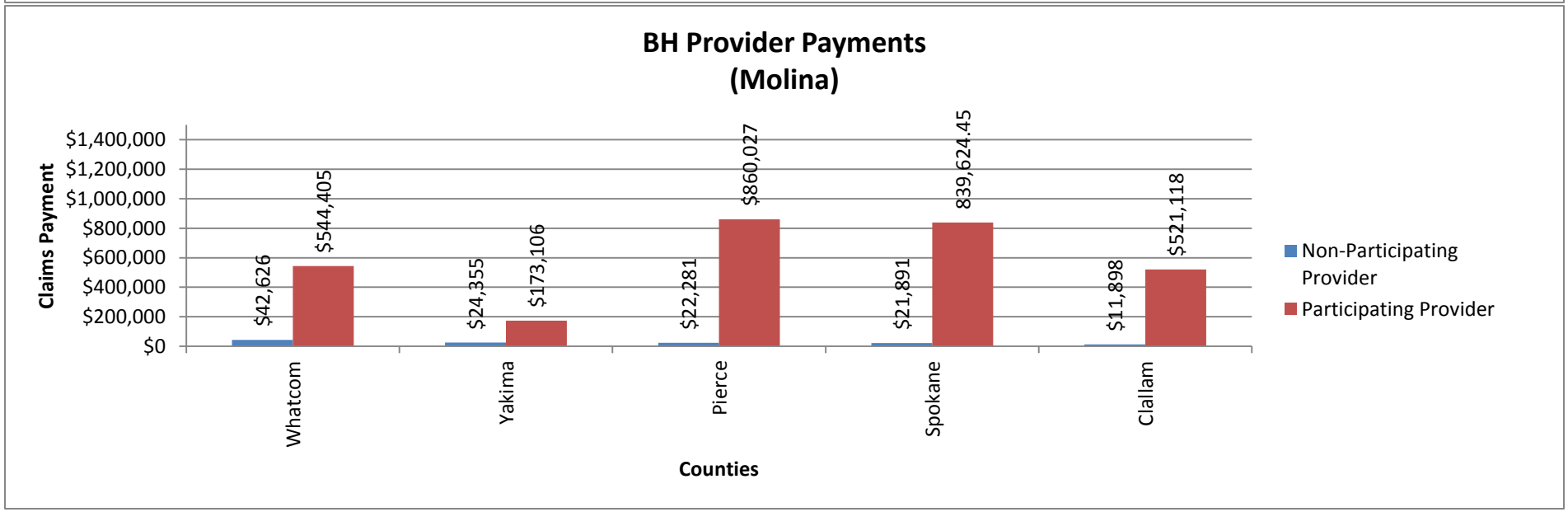
Tables 1 & 2: Top Five Counties for Non-Participating Provider Payments for Healthy Options and Basic Health (CHPW)



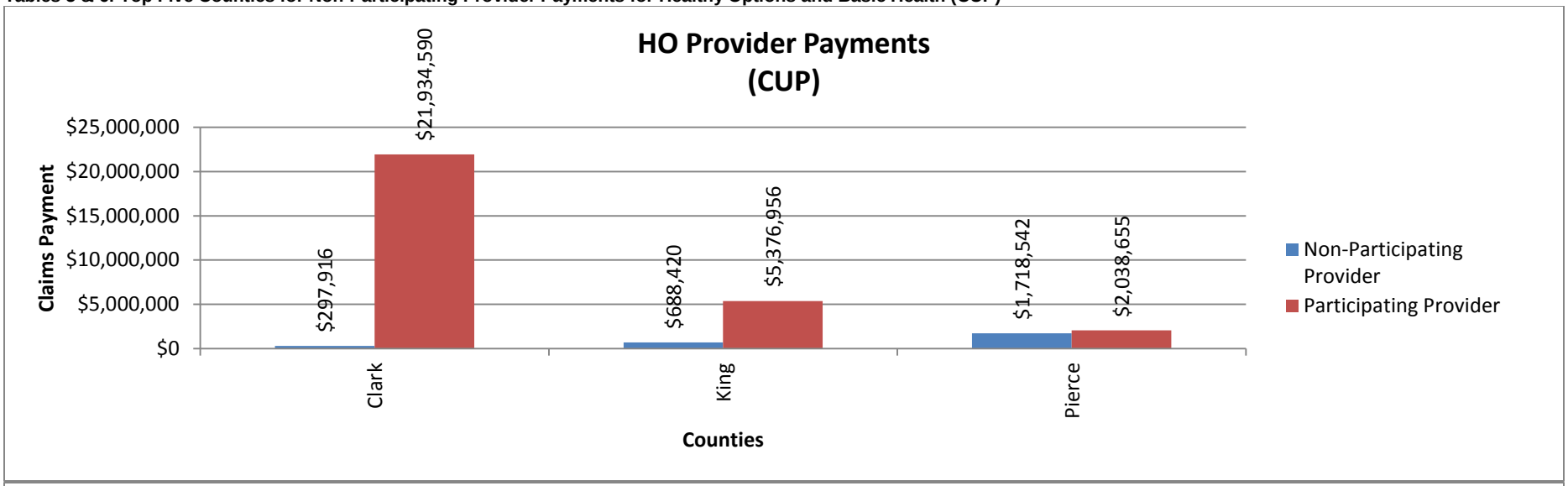


Tables 3 & 4: Top Five Counties for Non-Participating Provider Payments for Healthy Options and Basic Health (Molina)





Tables 5 & 6: Top Five Counties for Non-Participating Provider Payments for Healthy Options and Basic Health (CUP)



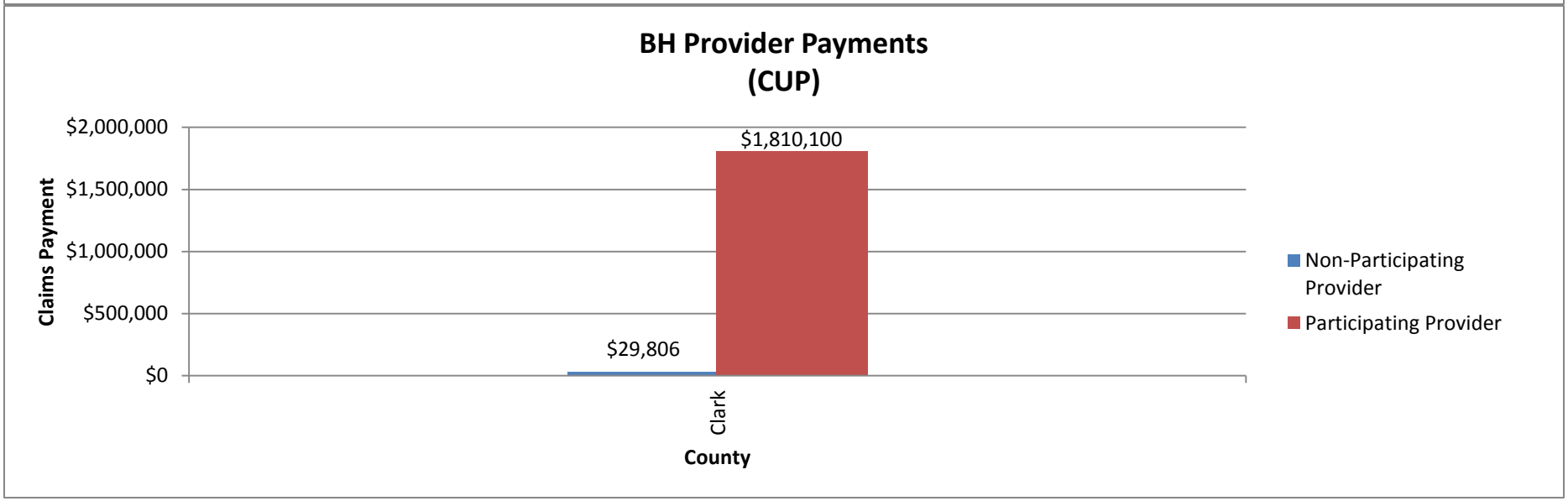
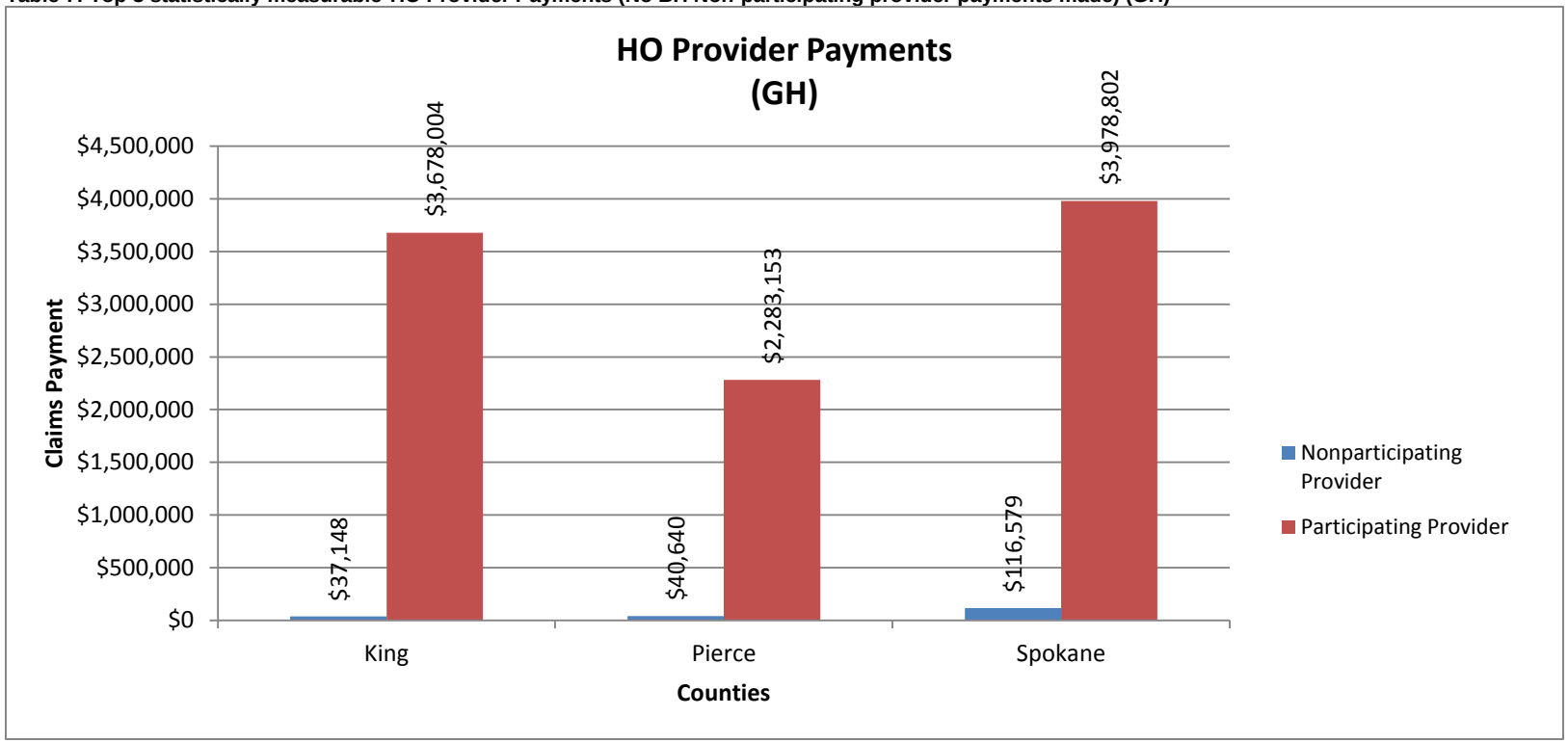


Table 7: Top 3 statistically measurable HO Provider Payments (No BH Non-participating provider payments made) (GH)



DISCUSSION

Based on the information HCA received, there continues to be a relatively small proportion of services provided to HCA enrollees by non-participating providers for all contracted managed care health plans reporting.

Further review of the county information provided by the reporting managed care health plans also indicates non-participating services provided to HCA enrollees are stable across the state, both for the Basic Health Plan and Healthy Options program, with non-participating provider services accounting for only 13% and 11% of all health care services received by HCA clients, respectively.

The tables below provide the counties with non-participating provider percentages higher than 30 percent and the specific unique challenges each county faces:

Table 8 & 9: Non-participating Provider usage greater than 30% by program

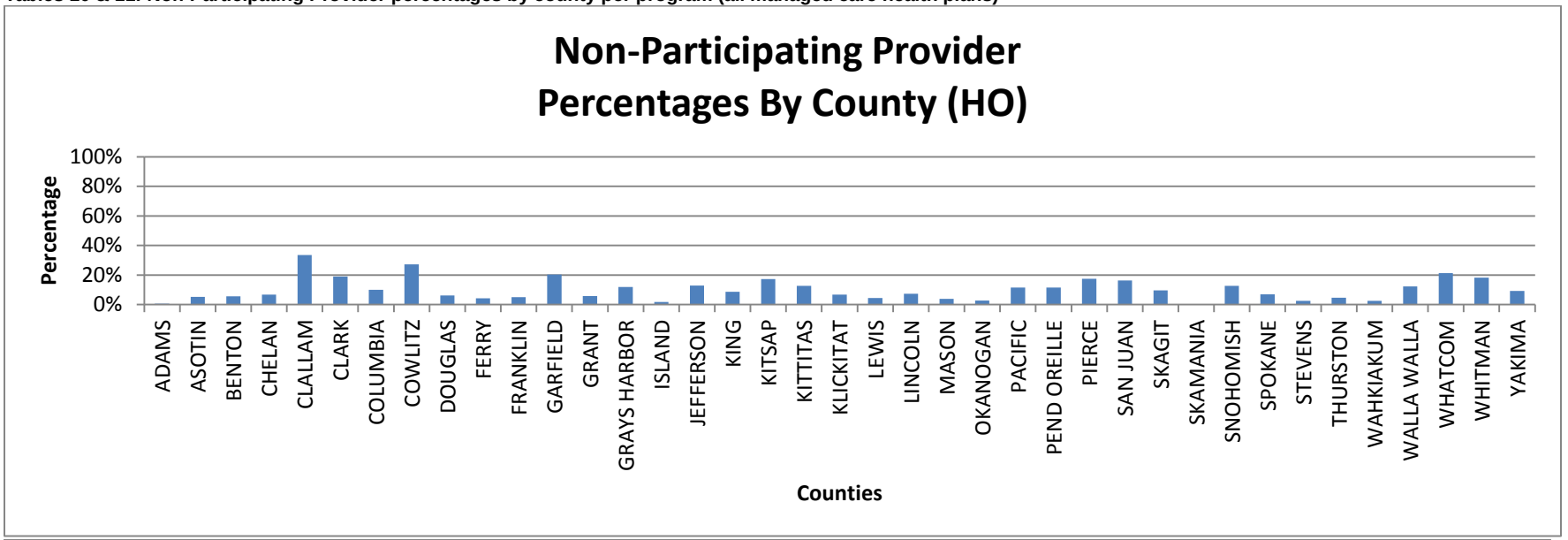
County	HO Challenges
Clallam	The population is split, with a higher concentration of enrollees and providers to the east side of the county vs. the west. Enrollees on the west side need to seek services closer to their residences which causes an increased in non-participating service cost.
Cowlitz	The hospital within this county will not contract with Molina Healthcare which forces Molina to operate on a non-participating provider agreement for hospital services.
Whitman	Demographic issues affect this county, as there are many small rural communities spread out across a wide area (agriculture community). Enrollees cross the border into Idaho or go to Spokane to receive hospital services.
County	**BH Challenges**
Lincoln	There are very limited providers in this rural county to provide care. All health care providers available do partner with the managed care health plans. For enrollees to receive specialty care they must, in most cases, seek care from non-participating providers.
Skamania	The only clinic available will not contract with any managed care health plan.
Whitman	Demographic issues affect this county, as there are many small rural communities spread out across a wide area (agriculture community).

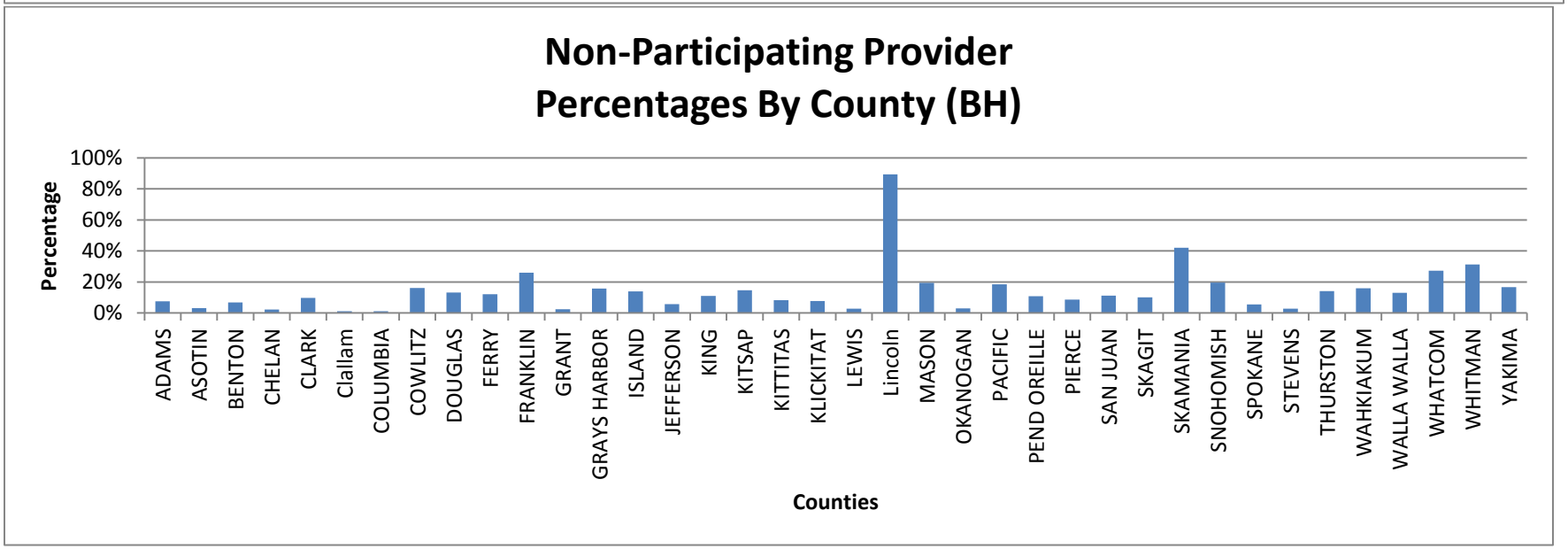
HCA continues to work with its plan partners to increase network availability in these counties by:

- Bringing in new managed care health plans through combining the Basic Health and Healthy Options enrolled population in July 2012.
- Continuing to work with provider associations.
- Meeting one-on-one with communities to discuss provider network difficulties.

The final tables outline Non-Participating Provider percentages, by county, across all managed care health plans.

Tables 10 & 11: Non-Participating Provider percentages by county per program (all managed care health plans)





Future Network Analysis

The intent of the Basic Health – Healthy Options contract was to increase enrollee access to high quality health care. To do this, the HCA developed a procurement that successfully secured three new managed care health plans, bringing the total managed care health plan choices for enrollees to five, in most counties.

In January 2014, a thorough analysis of the managed health care plans contracted for the Basic Health – Healthy Options contract will be available. This report will provide a comprehensive look at the provider network and its stability.