**Washington State**
**House of Representatives**
**Office of Program Research**

# BILL ANALYSIS

# Health Care & Wellness Committee

# HB 1713

**Brief Description:** Increasing access to health care services in rural and underserved areas of the state.

**Sponsors:** Representatives Maycumber, Chapman, Mosbrucker, Walsh, Ybarra, Tharinger, McEntire, Graham, Sandlin, Volz, Griffey, Couture, Kretz, Dent, Schmick, Barnard, Eslick and Timmons.

**Brief Summary of Bill**

- Establishes a pilot project to increase medical assistance program payments to health care providers and facilities that serve a specified number of medical assistance and Medicare enrollees in rural areas or areas with a high concentration of persons who have historically been marginalized and underserved with respect to health care access.

**Hearing Date:** 2/15/23

**Staff:** Christopher Blake (786-7392).

**Background:**

Medicaid is a federal-state partnership with programs established in the federal Social Security Act and implemented at the state level with federal matching funds. Federal law provides a framework for medical coverage of children, pregnant women, parents, elderly and disabled adults, and other adults with varying income requirements.

Payments to health care providers and facilities for providing health care services to enrollees are made in several ways. For some enrollees, their health care providers are reimbursed for health care services through direct payments from the Health Care Authority (Authority) on a fee-for-

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service basis. Alternatively, for about 85 percent of Washington's Medicaid clients, reimbursement is handled through a managed care arrangement. Managed care is a prepaid, comprehensive system of health care delivery, including preventive, primary, specialty, and ancillary health services through a network of providers. Under this arrangement, the Authority administers the program through contracts with managed care organizations on a capitated basis. In turn, the managed care organization negotiates contracts with individual health care providers, group practices, clinics, hospitals, pharmacies, and other entities to participate in their Medicaid plan's network.

Beyond these two health care delivery and payment systems, there are other payment structures that reimburse health care providers and facilities to account for unique circumstances faced by some providers and facilities or to promote certain health system initiatives. Examples of this include cost-based reimbursement for critical access hospitals and federally qualified health centers as well as incorporating value-based purchasing strategies into payment systems.

**Summary of Bill:**

The Health Care Authority (Authority) must conduct a pilot project in which medical assistance payments are increased for health care providers and facilities that meet certain criteria. A health care provider or facility is eligible for the increased payment if:

- it is authorized to provide covered services to medical assistance program enrollees;
- it is located in either a rural area of the state or an area of the state with a high concentration of persons who have historically been marginalized and underserved with respect to health care access;
- at least 50 percent of its patient encounters during the payment period were enrolled in medical assistance programs or Medicare; and
- it submits the necessary information to determine eligibility for the additional payment and the amount of the payment.

The increased payment, referred to as a rebalancing payment, is available for the duration of the pilot project from July 1, 2024, until July 1, 2027. The rebalancing payment is equal to the difference between the health care provider's or facility's reimbursement attributable to health care services provided to patients enrolled in medical assistance programs during the relevant time period and what the health care provider or facility would have been reimbursed had those services been reimbursed at 100 percent of reasonable costs based on Medicare reimbursement standards. The relevant payment periods must be established on a quarterly basis.

The Authority must establish the criteria and methodologies for determining eligibility, calculate the appropriate rebalancing payment, establish a methodology for determining 100 percent of reasonable costs based on Medicare reimbursement standards, and disburse payments to health care providers and facilities on a quarterly basis.

The Authority must submit a report to the Governor and the Legislature on the results of the pilot project by December 1, 2027. The report must include:

- the number of health care providers and facilities that received the rebalancing payment and the average amounts received by category of health care providers or facility;
- an analysis of access to health care services and overall health impacts from changes in aspects in communities receiving rebalancing payments;
- a comparison of the status of health care providers and facilities in communities receiving rebalancing payments before and after the pilot project with respect to payment rates, the numbers of health care providers and facilities, and the number of services provided to members of the community; and
- recommendations for ways to more equitably reimburse health care providers and facilities in medical assistance programs so that private insurance programs are not compelled to pay higher rates to offset low medical assistance rates.

**Appropriation:** None.

**Fiscal Note:** Available.

**Effective Date:** The bill takes effect 90 days after adjournment of the session in which the bill is passed.