

WASHINGTON STATE MEDICAL ASSOCIATION

State Legislative Agenda – 2011 Session

May 30, 2011 update

The 105 day session began on Monday, January 10. The regular session ended early, on April 23rd. A special session was called immediately, and concluded on May 25. As expected, the state's budget crisis dominated.

Overall, given the circumstances, the WSMA had a good session.

The WSMA legislative agenda included a number of policy issues important to the profession in addition to budget issues relative to access to care.

Support

2011-2013 Biennial Budget

On the 29th day of the 30-day Special Session the House and Senate resolved their budget differences and presented a compromise proposal, which was passed on the closing day of the Session. The final budget reduced state spending on critical services by \$4.6 billion (which is more than 12 percent of the overall budget). The total operating budget is now \$32.2 billion. A reserve of \$723 million has been left. The budget assumes fund transfers into the General Fund of \$459 million.

No new taxes were raised (largely because of the conditions of I-1053, which mandated a 2/3 majority vote to raise any taxes or eliminate any tax exemptions) but a number of fees were increased or added in various sectors. Despite the numerous proposals introduced, there were no fee or tax increases imposed on the medical community.

Regarding the WSMA's health care priorities:

- The Basic Health Program (BHP) was reduced by \$129 million. It will be limited to people who are eligible for services under the Medicaid waiver for the BHP beginning March 1, 2011. New admissions to the BHP will continue to be frozen throughout the 2011-13 biennium. An average of approximately 37,000 persons per month is expected to be covered by the program during FY 2012, and an average of 33,000 per month during FY 2013. (There are currently approximately 42,000 covered.) During 2011-13, a portion of the BHP is funded using Tobacco Master Settlement Agreement revenues that otherwise would have been available for the Life Sciences Discovery Fund. Under the federal Patient Protection and Affordable Care Act, current BHP clients will become eligible for Medicaid coverage with full federal funding in 2014.
- The DSHS Medical Assistance Administration will become part of the Health Care Authority, effective July 1, 2011.
- Interpreter services: No later than January 2012, the medical assistance program will develop a new system for delivery of spoken-language interpreter services. Under the new system, the medical assistance program will develop guidelines for the appropriate use of telephonic, video-remote and in-person interpreting. The medical assistance program will contract with delivery organizations that employ or contract with language access providers or interpreters. Medical practitioners will use a

secure web-based tool to schedule appointments for interpreter services, that identifies the most appropriate and cost-effective method of service delivery. (\$6.164 million GFS and federal match funding)

- The Children's Health Program was partially preserved (suffering a \$1.5 million loss) but children in the CHP will now pay premiums equal to the average state-only per capita cost of the coverage for children with family incomes at or below 200 percent of the federal poverty level.
- There are no direct reimbursement cuts for physicians for the biennium.
- Emergency room visits in the Medicaid program will be limited to three non-emergent visits per year. The WSMA and the WSHA will be included in developing the criteria for defining non-emergent. (Savings of \$33.0 million GF-State and \$38.8 million other funds)
- Hospital inpatient and outpatient rates for Prospective Payment System hospitals are reduced by 8% and 7%, respectively, by reducing the rate increases provided under the Hospital Safety Net Assessment Program. These reductions will not apply to payments for psychiatric inpatient services. (Savings of \$110.5 million GF-State and \$110.6 million other funds)
- Revenue to the Hospital Safety Net Assessment Fund is forecasted to exceed projected expenditures. The excess fund balance is used to fund hospital services that would otherwise be funded from the state general fund. (\$40 million)
- Federally-qualified rural health clinics (RHCs) will be paid their standard cost-related encounter rate for prenatal and well-child services provided to women and children enrolled in the Medicaid and State Children's Health Insurance programs. Additionally, such visits will be considered eligible for the standard encounter rate for purposes of reconciling managed care enhancement payments for 2009 and 2010. (Appropriates \$5.720 million all funds)
- Medicaid will reduce cesarean section births for savings of \$1.588 million all funds. This will be accomplished by promoting evidence-based practices through outreach, metrics and feedback reports.
- There will be prior authorizations for advanced imaging and surgical procedures for surgical procedures for orthopedic procedures, spinal procedures and interventions, and nerve procedures (\$7.225 million savings all funds).
- MAA will not pay for eyeglasses for adults, but recipients will be able to purchase eyeglasses from optical providers at the discounted correctional industries production rate. (\$6.16 million savings all funds)
- The medical assistance program will not pay for adult hearing aids and devices, except for cochlear implants and bone anchored hearing aids. (Savings \$2.898 million all funds)
- Currently there are separate limits for physical, occupational, or speech therapy. These services will be combined into one rehabilitation benefit and the number of visits or units available will be limited for adults. Patients with spinal, knee, hip or traumatic brain injuries will receive up to 12 non-physician visits per year. All other patients will receive a maximum of 6 visits per year. (Savings \$8.196 million all funds)

- Funding is reduced for preventive and restorative dental care for adult recipients of MAA. Preventive and restorative dental care will continue to be available for Medicaid recipients who are pregnant, reside in a nursing home or intermediate care facility, or receive long-term care services. Only emergency dental care will be covered for adult medical assistance recipients. (\$57.539 million savings all funds)
- During FY 2013 the medical assistance program plans to transition all elderly and disabled supplemental security income recipients into managed care. This is expected to result in reduced expenditures through more cost-effective care management, coordination, and delivery. (Savings \$16.203 million all funds)
- Coverage of co-payments for prescription drug purchases made by qualifying dually-eligible Medicare and Medicaid clients in the Medicare Part D program is eliminated. (Savings \$14.003 million all funds)
- Maternity Support Services will be reduced by approximately 30%. The HCA will target the remaining funding to the highest risk pregnancies, prioritize evidence-based practices, and attempt to develop a mechanism to increase federal funding for MSS by using local funds to match federal funds for MSS services. (\$21.9 million savings all funds)
- Public health grants originally funded in 2008 as a result of the Blue Ribbon Commission are reduced by 50 percent. (\$10 million savings GF-S)
- Funds are provided to the Medical Quality Assurance Commission to collect demographic data on physicians at the time of license renewal. (\$336,000)
- The Economic Services Administration will reduce the average Disability Lifeline monthly grant for all DL clients by 42.11 percent. This grant reduction includes clients in the Unemployable, Aged, Blind, Disabled and Expedited programs. (Savings \$115.8 million GF-S) A new program is established (HB 2082) – an Aged, Blind, or Disabled Assistance Program – for persons who meet the income and resource eligibility requirements and are either over 65, blind, or likely to meet the federal social security income disability standards. An Essential Needs and Housing Support Program is established in the Department of Commerce. This is funded at \$64 million.
- Federal law requires that federally-qualified health centers (FQHCs) and rural health clinics (RHCs) be paid a cost-related per visit rate for services to persons covered by the Medicaid and State Children’s Health Insurance programs. In 2009 the medical assistance program replaced the federal Prospective Payment System (PPS) that was based on 2001 costs adjusted by a national measure of medical inflation with an alternative payment methodology (APM) using a higher Washington-specific inflation measure. The medical assistance program will adopt a new payment methodology on July 1, 2011 that will revert to the lower national measure of medical inflation. As a result, payment rates will be an average of approximately 10.6 percent lower than projected under the 2009 APM. (Savings \$86.321 million all funds)
- The medical assistance program will emphasize price in the 2012 competitive procurement for health insurers delivering services under the existing Healthy Options managed care program for non-disabled children and adults. This is expected to result in lower rates than the rates developed under the current systems of negotiated rate-setting. (Savings \$57.427 million all funds)

- Funding is provided to implement provider incentive payments and other initiatives related to the plan for increased use of electronic billings and medical records in the state Medicaid program. (\$2.152 million)
- The medical assistance program will seek a federal Medicaid waiver to allow implementation of enforceable co-payments for prescription drugs in FY 2013. The co-payments are expected to apply to all medical assistance enrollees, and are expected to include a tiered strategy under which there would be no co-payment for most generic drugs; a \$15 co-payment for preferred brand-name drugs; and 50 percent co-insurance for non-preferred drugs. (\$20.648 million savings, all funds)
- Funding levels for the Low-Income, Non-Rural Indigent Assistance, and Small Rural Indigent Assistance Disproportionate Share Hospital (DSH) grant programs are each reduced by 40 percent. (Savings \$28.882 million all funds)
- Funding is provided for information system modifications that will enable medical providers to access the ProviderOne payment system through OneHealthPort, which is a secure web portal that allows providers to use a single digital credential and password to access other major health insurance sites. This is expected to increase the number of providers who can bill electronically rather than through paper claims. (\$645,000)
- The medical assistance program will use federally-matched DSHS funds to reimburse hospitals for non-emergency inpatient and outpatient care for children who are not eligible for federal Title XIX or Title XXI matching funds due to their citizenship status. (Savings \$1.430 million General Fund-State)
- The medical assistance program has contracted with a private firm on a contingency basis to identify additional recipients who may have private or other public insurance coverage that can pay for their medical care. This is expected to result in an approximately 10% increase in the number of recipients for whom such coverage is identified, for a net state savings of approximately \$24 million. Funding is also provided for additional audit and benefit coordination staff who will support the medical assistance program's efforts to recover and avoid approximately \$14 million of state medical expenditures. (Savings \$79.397 million all funds)
- The medical assistance program will partner with community mental health centers, other prescribers of adult and anti-psychotic medications, and public schools of medicine and pharmacy to improve prescriptive practice and adherence with regard to the safe and effective use of antipsychotic and other medications used in the treatment of serious and persistent mental illness. The effort will include development and delivery of standard protocols and practices regarding best and promising practices; development of metrics and production of peer-comparison feedback reports for prescribers and mental health centers regarding medication adherence, poly-pharmacy, excessive dosing, and off-label use; and establishment of an access line through which community practitioners can obtain second opinion consultations regarding cases flagged for additional utilization review. These efforts, the non-federal share of which will be funded with \$300,000 obtained through settlement of lawsuits involving the drug Seroquel, are expected to result in an approximately 6% reduction in state expenditures for adult mental health medications over the course of the biennium. (Savings \$4.159 million all funds)
- The medical assistance program will increase efforts to promote more cost-effective drug utilization. Efforts will focus on drugs where there is evidence of over-utilization, off-label use, excessive dosing, duplicative therapy, or opportunities to shift utilization to less expensive, equally effective formulations. (Savings \$4.692 million all funds)

- Under ESSB 5596 (Medicaid demonstration waiver) the medical assistance program will develop and obtain federal approval for a demonstration project that will allow the state greater flexibility in management of its Medicaid program. The project will include flexibility to provide a modified benefit package modeled on the essential benefits package proposed for national health reform; to differentiate benefits based on enrollee age, disability, and medical condition; to implement reasonable and enforceable cost-sharing; to streamline and more frequently verify eligibility determination; and to adopt new payment mechanisms. (\$702,000 all funds)
- The medical assistance program will competitively contract with manufacturers and/or distributors of wheelchairs, no later than July 2012. (Savings \$1.315 million all funds)
- The medical assistance program expects to receive federal matching funds for dialysis and cancer treatment services provided to approximately 1,300 citizens that are currently funded exclusively with state funds. (Savings \$23.908 million state funds)
- Multiple reductions will be made to the administrative capacity of DOH to support public health efforts. Reductions are made to several activities, including the elimination of the Health Declarations registry; reduced expenditures in the Public Health Laboratory; reduced capacity in monitoring for health care acquired infections, reduced technical support for adverse events tracking and reduced support to the Poison Center. (Total savings \$2.542 million all funds)

WSMA Position: Reduce or eliminate health care cuts to the maximum extent possible in the 2011-13 biennial budget, beginning with retaining the BHP, interpreter services, and the Children's (Apple) Health Program. Priority: Support #1.

Additional Budget Issue - EHR Incentive Funds:

There is a large pool of federal funds (upwards of \$200-300 million) available for Medicaid payment enhancements for Washington state medical practices that meet "meaningful use" criteria for Electronic Health Records (EHR). While the actual incentive funds are 100% federal dollars, each state must fund 10% of the cost of administering the Medicaid incentive program, with the federal government picking up the remaining 90%. At stake: eligible professionals each could receive annual payments to a maximum of \$63,750. The 10% administrative expense was covered in the final budget.

WSMA Position: The WSMA sought retention of funds in the biennial budget adequate to qualify the program for the federal match for the administrative element of the program, thus releasing the incentive payments for Washington state. Support #1.

Scope of Practice/Physician-led Care Teams:

Working with the Health Care Assistant (HCA) Scope of Practice Coalition¹ the WSMA passed legislation in 2009 to clarify the scope for HCAs, including allowing them to dispense medications orally that previously they could only inject.

The WSMA has worked with a group of clinics and organizations to rewrite the Medical Assistants' scope of practice in the form of HB 2009, which establishes a clarified scope of practice for medical assistants and certified medical assistants, addressing issues currently facing medical practices' use of medical assistants (such as standing orders, supervision) and to clearly distinguish MA's from HCA's. In

¹ Comprised of several large medical groups, the MA association, MA educators and the state association of physicians assistants.

March, a “finalized” bill was submitted to Representative Cody, chair of the House health care committee and sponsor of the bill, who in turn referred it to the Department of Health for a “Sunrise Review” (the customary process).

In these reviews, the DoH investigates the legislation, listens to testimony from interested groups and then makes a recommendation to the Legislature on what to do with the bill. The process normally takes a year, so this bill is expected to return during the 2012 legislative session.

WSMA Position: Support #1.

Immunization Exemptions:

The WSMA worked with the state chapter of the Academy of Pediatrics and the Washington Academy of Family Physicians on both a Senate and a House bill to increase the number of children receiving needed immunizations. The bills required any child immunization exemption form include a statement signed by a health care practitioner stating that he or she provided the patient with information about the benefits and risk of immunizations. A final bill (SB 5005) passed and the Governor has signed. New changes added in the process grant liability protections to health care providers who sign the form, and allow a parent who rejects having their child immunized for religious purposes to not have the form signed by the physician or other health care provider.

WSMA Position: The WSMA pushed for passage of this bill. Priority: Support #1.

Health Care Reform Implementation Bills:

Exchange – A number of bills were introduced this session to enable the state to set up its own health insurance exchange under provisions of the federal health care reform law. The governor sought action that would provide her administration with time to form a group to define the form and direction of the exchange (anticipated to be more market oriented). Several legislators pushed for more immediate implementation of a Massachusetts style exchange that effectively created a public plan option and reduced the ability of insurers to participate in the exchange and market.

A House resolution (HCR 4404) passed the Legislature and has been filed with the Secretary of State. The Joint Select Committee on Health Reform Implementation (Joint Select Committee) will continue to determine how to implement federal health care reform. The Joint Select Committee membership will consist of the chairs of the health committees of the Senate and the House and eight additional legislative members, four from the Senate and four from the House, appointed by the leadership of the two largest caucuses of the Senate and the House. The Governor will be invited to appoint a non-voting liaison member. The chairs of the Senate and House health care committees will serve as co-chairs. The co-chairs must establish an advisory committee to provide advice and recommendations to the Department of Social and Health Services and the Health Care Authority in the development of an implementation plan to coordinate the purchase and delivery of acute care, long-term care, and behavioral health services. The House exchange bill (HB 1740) reflected the governor’s desired position and was passed out of the House but died in the Senate Rules Committee. A different senate bill (SB 5545) passed the Senate and has been signed by the Governor.

Under SB 5545 the Exchange is established as a public-private partnership separate and distinct from the state, exercising functions delineated by the act. By January 1, 2014, the Exchange must be operational, consistent with federal law, and subject to statutory authorization. The powers and duties of the Exchange and the Board are limited to those necessary to apply for and administer grants, establish information technology infrastructure, and other administrative functions necessary to begin operating the Exchange

by January 1, 2014. Any actions relating to substantive policy decisions must be consistent with statutory direction.

The Exchange Board must be appointed by the Governor. By October 1, 2011, each of the four caucuses of the House and Senate must submit a list of five nominees to the Governor. Persons on the list may not be legislators or government employees. Nominations from the largest caucus in the House must include one employee benefits specialist. Nominations from the second largest caucus in the House must include one health economist or actuary. Nominations from the largest caucus in the Senate must include one representative of health consumer advocates. Nominations from the second largest caucus in the Senate must include one representative of small business. The remaining nominations from each caucus must have demonstrated and acknowledged expertise in one of the following: individual health care coverage, small employer health care coverage, health benefits plan administration, health care finance and economics, actuarial science, or administering a public or private health care delivery system.

By December 15, 2011, the Governor must appoint two members from each list submitted by the caucuses, including at least one employee benefits specialist, one health economist or actuary, one representative of small business, and one representative of health consumer advocates. The Governor must appoint an additional member to act as chair, who will serve as a nonvoting member except to break ties. The chair may not be a government employee.

The Insurance Commissioner or designee and the Administrator of the HCA or designee will serve as nonvoting members. The Board must establish an advisory committee to allow for the views of the health care industry and other stakeholders, and the Board must consult with the American Indian Health Commission.

The HCA must collaborate with the Joint Select Committee on Health Reform Implementation (JSC), and submit analysis and recommendations to the Legislature by January 1, 2012, on the broad range of policy options and design features for the Exchange.

The HCA must apply for and implement grants, and whenever possible grant applications must allow for partial funding of the JSC. The HCA and the Board must consult with the JSC, the Office of Insurance Commissioner, and interested stakeholders including: consumers; individuals and entities with experience facilitating enrollment in health insurance coverage including health insurance carriers, producers, and navigators; representatives of small businesses, employees of small business, and self-employed individuals; advocates for enrolling hard-to-reach populations and populations enrolled in publicly subsidized health care programs; facilities and providers of health care; and actuaries.

WSMA Position: The WSMA supported a more market based approach to an exchange and legislation to create a process to form such an exchange with adequate private sector input, and an exchange that: promotes the purchase of insurance, administrative simplification, ensures patients have access to local providers, provides coverage for key benefits, and promotes viability of providers and plans.² Priority: Support #1.

Primary Care Home and Chronic Care Management:

Two bills were introduced that promote the primary care home and chronic care management. HB 1739 and SB 5394 both envisioned that by the beginning of the 2012 plan year plans contracting with the state will demonstrate that they have systems in place including new reimbursement formulas to incentivize primary care and chronic care management. The bills also granted a state action exemption against

² EC action at its December 9, 2010 meeting.

antitrust so that payers and providers can talk together about rates to be paid by the plans. HB 1739 died in committee. SB 5394 passed the Senate and House and has been signed by the Governor.

WSMA Position: The WSMA supported these measures and the promotion of primary care medical homes and chronic care management. Priority: Support #1.

Other Health Care Reform Legislation:

WSMA Position: Regarding reform, the WSMA supported legislation and regulation that supported meaningful physician involvement in, and delivery of, new delivery mechanisms (ACO regulations and standards, for example), and opposed legislation or regulation that reduce this engagement or which in other ways might have lessened the ability of the delivery system in Washington state to continue its record of providing innovative care models. Priority: Support #1.

Public Health Funding:

(See budget results above)

WSMA Position: As a member of the Public Health Roundtable the WSMA supported efforts to minimize the negative impact of budget cuts on public health agencies and programs, and supported policy that may be necessary to allow agencies to redefine their mission and operations. Priority: Support #2.

Demographic Information from Physicians and Physician Assistants:

SB 5480 requires the Medical Quality Assurance Commission collect demographic data (specialty, location, practice size, etc.) from physicians and physician assistants at the time of licensing and license renewal. The bill passed the Senate and the House and has been signed by the Governor.

WSMA Position: The WSMA has long asked for this type of information, which will be helpful particularly in health care research. Priority: Support #2

Ambulatory Surgery Center Licensing:

Legislation to license ambulatory surgery centers passed four years ago. Organizations that do not use general anesthesia were exempted from the act. This has caused problems for some 60 facilities that want to be licensed but don't administer general anesthesia. The Washington Ambulatory Surgery Center Association (WASCA) worked with the WSMA this session to prevent surgical services provided in a physician's practice from requiring licensure.

HB 1575 and SB 5619 protected physician practices from licensure requirements when the practice provides surgical services in their office when those services do not constitute the purpose of the physician's office. The House bill passed the House and the Senate and was signed into law. The Senate bill died.

WSMA Position: Priority: Support: #3

Collection, Transportation and Disposal of Unwanted Medicines:

HB 1370 and SB 5234 would have established the Medicine Return Association, a nonprofit organization to finance and operate a product stewardship program for the collection, transportation, and disposal of unwanted covered drugs from residential sources. Covered drugs would include all legend and non-legend

drugs from residential sources, including brand name and generic drugs. Both bills died -- HB 1370 in its committee of origin and SB 5234 in Senate Rules.

WSMA Position: The WSMA supported both measures. Priority: Support #3.

Electronic Transactions in State Programs:

The Health Care Authority, L&I and Medicaid introduced legislation that requires providers to use electronic transactions to submit claims, authorize services and receive payments. The legislation allows the state agencies to waive the bill's requirements if:

- (a) The health care provider or vendor delivers timely access to care or services for which there is a critical need in the geographic area served by the provider or vendor;
- (b) The health care provider or vendor has service interruptions or inadequate internet service in their community and has low claim volume; or
- (c) The health care provider or vendor is a newly contracted provider or vendor and needs sufficient time to be able to comply with the requirements of this section.

Transactions that are not submitted electronically in the manner and format prescribed by the authority may be returned without processing. The authority must adopt any rules it deems necessary to implement the provisions of this section, including an administrative processing fee for any charge that is not submitted electronically in the manner and format specified by the authority.

The WSMA staff worked with agency personnel to modify the implementation language in the bill in order to allow physicians more time to comply. The bill died in the House Rules Committee.

WSMA Position: Support #3

Wound Care Management by Occupational Therapists:

Bills (HB 1076 and SB 5018) to allow Occupational Therapists to perform wound debridement were introduced in the House and Senate. The Senate bill passed the Legislature and has been signed by the Governor. The House bill died.

WSMA Position: The WSMA supported both of these measures. The bills were particularly important to hand surgeons. Priority: Support #3

Tanning Facilities:

The Legislature has weighed into the debate about the adverse outcomes of the use of tanning facilities. The WSMA worked with the Washington State Dermatology Association on HB 1363 and SB 5593, both of which would license tanning facilities. If the bills passed the facilities would be required to post a danger sign that is visible to customers, and allow the DoH to investigate the facility. No one under the age of 18 could use the facility unless they have a note from a physician and there would have to be a trained operator on staff at all times. HB 1363 died in the Rules Committee; SB 5593 died in the Senate Ways and Means Committee.

WSMA Position: The WSMA supported both pieces of legislation. Priority: Support #1.

Elimination of Non-Contracted Physicians' Ability to Balance Bill:

HB 1561, as introduced, would have banned balance billing for services provided by non-contracted physicians (non-contracted with the patient's insurer) in the hospital for care necessary to satisfy EMTALA requirements, i.e., stabilization of the patient in the ED and beyond—if necessary. The bill is similar to provisions in the federal health care reform act (and cites two of its provisions) and it proposed enacting regulations in these respects: It applies to services provided to Medicaid, Medicare beneficiaries and patients covered by private insurance, and would pay non-contracting (or in the case of Medicare and Medicaid non-participating) physicians the highest of UCR³, the median rate that health plans pay to their contracted physicians for such services, or Medicaid rates.

The bill prohibited balance billing (the federal Act does not) and empowered the insurance commissioner to write regulations to change the law if necessary (to raise or lower the payment rate/methodology).

The measure was heard in the health care committee. WSMA President Dr. Dean Martz, WACEP President Dr. John Milne and Pediatrix Regional Representative Dr. Gary Twiggs along with WSMA Director of Legal Affairs Tim Layton testified against the bill.

The bill passed out of committee in a completely revised form—as a consumer transparency bill. It required health plans, hospitals and physicians to notify patients when they are not contracted with the patient's health plan.

Without explanation, Representative Cody then pulled the bill from further consideration for the year. It died in the House Rules Committee.

(A Writ of Mandamus asking the State Supreme Court to compel the OIC to apply the 1997 Act as written was filed by the WSMA in December. The Court denied an OIC petition to dismiss the case, a win for the WSMA. The Court remanded the case to the Thurston County Superior Court where the litigation is ongoing.)

Two weeks before the end of the session, on the request of the Health Care Authority and the Department of Social and Health Services, Representative Cody introduced HB 2057 and Senator Keiser introduced the same bill in the Senate as SB 5927. It was argued that both bills were “necessary to implement the budget” and thus were excused from cutoffs.

In their original form both bills stated that in the Healthy Options Program (HO) and the Basic Health Plan (BHP), a non-contracted provider (physicians and hospitals) will receive in reimbursement what is paid in the Medicaid fee-for-service program. Also, the provider will not be allowed to balance bill the patient. WSMA strongly opposed the bills because they effectively eliminate the ability for physicians to negotiate a fair rate of reimbursement with the managed care plans the state contracts with to administer these programs. The managed care plan has no incentive to contract with the physician or physician group as the amount they pay is already set-forth in statute. HB 2057 died, but SB 5927 ultimately passed the legislature in a slightly amended form.

³ Left to the insurer to define: “the same method the plan generally uses to determine payments for out-of-network services, such as usual, customary and reasonable (UCR.)”

As amended, SB 5927 requires the managed care plan to pay no more than the lowest amount (that is the managed care amount) paid for that service to similar providers. The physician may not balance bill the patient for any additional amounts.

WSMA Position: Priority: Oppose #1.

Tax Revenue – Sales Tax on Non-Emergency Plastic Surgery:

For the past several session State Labor Council and the Services Employees Union advocated for a sales tax on non-emergency plastic surgery (HB 1847 and SB 5816) The groups argue that not charging a tax is a tax loophole, oblivious to the fact no health care services provided by physicians are taxed in Washington state. HB 2002 was also introduced, which proposes a sales and use tax on elective cosmetic surgery, with the proceeds used to fund Medicare Part D co-payments for low income seniors.

The WSMA opposed all bills imposing a tax on cosmetic surgery, as it has done for the last two sessions. Taxing health care to pay for health care is bad public policy. Due to the two-thirds vote requirement to implement any new taxes, these bills ultimately died.

WSMA Position: Oppose #1.

Prescription Drug Monitoring Program:

In 2008 the WSMA introduced and passed legislation to establish the Prescription Drug Monitoring Program (PDMP) within the DoH to provide physicians and law enforcement agencies with information that would document drug seeking behavior by patients. Subsequent budget problems defunded the program. The WSMA has participated on a task force created by Attorney General Rob McKenna to explore how to make the program operational. The DoH has received a grant that will fund the program for a year, and a number of additional potential funding sources have been discussed, including a \$4-\$12 assessment on licensing fees for health care professionals.

There was no legislative action dealing with fees to fund this program, but the WSMA will continue to work with stakeholders to find a viable long-term funding solution for this very important program.

WSMA Position: The WSMA supports moving the program to operational status; it opposed any effort to add an assessment to physicians' licensing fees as any such assessment would not be consistent with the fundamental purposes to which current licensing fees are directed. Priority: Support #1 on the program / Oppose #1 on the fees.

False Claims Against the Government:

Two pieces of legislation were introduced in the Senate to give the state additional tools to fight Medicaid fraud— SB 5310, and SB 5458. As drafted, both measures would change Medicaid fraud statutes to allow private, non-government individuals to bring cases against providers, and if successful in recovering funds would share in the bounty. The WSMA testified against both bills arguing that Washington state already has a Medicaid fraud statute and these bills will do nothing more than create bounty hunters to comb through physicians' records and bring cases for profit against physicians and other providers.

Senator Randi Becker (R-Eatonville) sponsored a floor amendment during the regular session that stripped the Senate bill of the bounty hunter provisions. There were enough Democratic votes for the amendment to pass had it been considered. Both bills died in the Senate without a full Senate vote. SB 5310 died in the Ways and Means Committee and SB 5458 died on the Senate Floor Calendar. SB 5458

was considered “necessary to implement the budget,” which allowed the bill to be active during the special session.

Early in the special session SB 5458 was considered and Senator Becker’s amendment to remove the “qui tam” provisions was successfully hung on the bill. At that time the proponents of the bill chose to put it down rather than pass it without those provisions. Ultimately the proponents, which included the chairs of the both the House and Senate health care committees, introduced a new bill SB 5960. This time, however, the votes were not there to hang Senator Becker’s amendment and the bill was ultimately passed out of the Senate with the troublesome qui tam (or whistleblower) provisions in the bill. In the House, Rep. Reuven Carlyle was instrumental at working with WSMA to find an alternative to the qui tam. Working closely with the Liability Reform Coalition we discovered that a number of states have successful Medicaid fraud recovery units without adopting the lawsuit generating qui tam provisions. The state that we focused on was Missouri which simply provides a strong financial incentive to report fraud minus the “qui tam” provisions. Under the strong leadership of Rep. Carlyle, a Missouri style amendment was hung on the bill that removed the qui tam whistleblower provisions. At that point, without the “qui tam” provisions, the proponents chose not to pass the bill and SB 5960 died on the House calendar as the special session adjourned.

WSMA Position: The WSMA aggressively fought SB 5458 and SB 5960 in the special session as nothing more than the creation of bounty hunters to pursue health care providers. Priority: Oppose #1.

OIC Imposed Reserve Caps on Non-profit Health Care Service Contractors:

Two bills to give the OIC the power to cap the level of reserves for state licensed health care service contractors (statutory minimums for reserves already exist) were introduced – HB 1301 SB 5247. Both bills limited reserves to three months of revenue. Existing reserves are in excess of \$2 billion on reports from the carriers. Both bills died in the policy committees in their respective houses.

WSMA Position: The WSMA opposed these efforts to empower the OIC to cap the reserve levels of a portion of the insurance market due to the deleterious downstream impact on medical practice revenues, and, more generally, the market.⁴ Priority: Oppose #3⁵.

Naturopathic Scope of Practice:

Bills (HB 1228 and SB 5152) were introduced in the House and Senate to remove the prohibition on Naturopaths to perform noninvasive procedures.

The bills specified that invasive procedures “that do not exceed those used as of the effective date of this section in minor office procedures or common diagnostic procedures” are permissible.

The Senate bill died, while the House bill passed and has been signed by the Governor.

WSMA Position: The WSMA was opposed to both of these bills. Naturopaths should not be able to offer invasive treatments. Priority: Oppose #2.

Use of Evidence Based Care:

⁴ EC action at its December 9, 2010 meeting.

⁵ This will be an “oppose” priority for the Washington Healthcare Forum.

HB 1311 creates a public private collaborative to identify and study health care services and decide if they meet the standards of evidence based care. The bill was very similar to the legislation that created the HCA's Health Technology Assessment Program (HTA) several sessions ago.

The proposed collaborative would identify:

- Up to three services per year to be studied.
- Analyze and identify evidence-based best practice approaches to improve quality and reduce variation in use of the services.
- Data collection and reporting necessary to develop baseline utilization rates.
- Strategies to increase the use of evidence-based best practice approaches.

The governor is to appoint twenty members of the collaborative, which must include:

- Four physicians, selected from a list of nominees submitted by the WSMA, as follows:
 - Two physicians, one of whom must be a practicing primary care physician, representing large multispecialty clinics with fifty or more physicians, selected from a list of five nominees. The primary care physician must be a family physician, an internal medicine physician, or a general pediatrician; and
 - Two physicians, one of whom must be a practicing primary care physician, representing clinics with less than fifty physicians, selected from a list of five nominees. The primary care physician must be either a family physician, an internal medicine physician, or a general pediatrician;
- Two physicians representing the largest hospital-based physician systems in the state, selected from a list of five nominees submitted jointly by the WSMA and the WSHA;
- One osteopathic physician, selected from a list of five nominees submitted by the Washington state osteopathic medical association.

Other members would include: Two members from the most fully insured and self-funded covered lives in Washington state; one member, selected from the health maintenance organization; one member representing national health carriers; three members representing hospital systems; three members, representing self-funded purchasers of health care services for employees; two members, representing state purchased health care programs; and, one member, representing the Puget Sound health alliance.

The bill passed the House and the Senate and was signed by the Governor.

There were additional good amendments to the bill adopted in the Senate Health Care Committee. The first amendment granted immunity from liability to the members of the collaborative when acting in good faith. The second amendment, requested by Physicians Insurance, states that the guidelines do not establish a new standard of care for liability purposes. An amendment on the floor of the Senate was adopted. It provided that when the collaborative was reviewing a certain health care service, two additional specialists who provide that treatment would be added to the working group.

- *WSMA Position: The WSMA was opposed to this legislation over the following points: it is duplicative of the HCA's existing Health Care Technology Assessment Program, which has grown into evaluating services, not just technologies; such a collaborative shouldn't result in an additional shift of more state and private sector non-value added preauthorization processes to medical*

practices; creating a state sanctioned “safe table” where health plans can cogitate, protected from federal anti-trust laws, creates potential problems; and who is going to pay for this project? Oppose #3.

Graduates from Foreign Medical Schools:

HB 1595, introduced by Representative Cody on the request of the Multiple Sclerosis Society, relaxes the licensing process to allow for more neurologists to care for MS patients. The bill passed out of the House and the Senate and was signed into law by the Governor.

WSMA Position: The WSMA was opposed to the bill because licensing exceptions should not be granted to a particular specialty in order to bring additional physicians from that specialty from out of the country to treat a particular disease. Priority: Oppose #3.

Monitor

ARNP Standard of Care:

Pathology Billing:

HB 1190 prevents a provider from billing for a service that the provider did not personally perform. The bill is request legislation from the Washington State Society of Pathologists. It passed the House and the Senate and was signed by the Governor.

WSMA Position: The WSMA was neutral on the bill because there are specialties that oppose the Pathologist’s efforts. (When there is a division in the House of Medicine, the WSMA takes a neutral stand). Priority: Monitor #1

Corporate Practice of Medicine:

A nursing home provider in Washington state has a business model that allows them to hire physicians to care for the patients in their nursing homes. The company has been concerned that they would be in violation of the Washington State Corporate Practice of Medicine Act should it bring its model to this state. HB 1315 and SB 5396 would allow the company to employ physicians. The House bill passed the House and the Senate and was signed by the Governor. The Senate bill died in its policy committee.

WSMA Position: The WSMA conducted considerable research on this issue and determined that the bill only applied to nursing homes in Washington state. With that understanding, the WSMA was neutral on the bill⁶. Priority: Monitor #1.

Limited Service Pregnancy Centers:

HB 1366 and SB 5274 would have required limited service pregnancy centers operating in Washington state to provide truthful information about the services they offer, and maintain the privacy of, and respect a person's right to, his or her health care information. Both bills died.

⁶ Board of Trustees action taken on January 23, 2011.

WSMA Position: The American College of Obstetricians and Gynecologists was very supportive of this legislation. The WSMA was supportive as well. Priority: Support #3.

Decriminalization of Marijuana:

The WSMA was asked to support HB 1550 and SB 5598 which would decriminalize the sale and possession of marijuana. Marijuana would be sold through the state's liquor stores and would be taxed. The proceeds of the tax, estimated at \$400 million per year, would go toward health care. Both bills died.

WSMA Position: The WSMA was neutral on the legislation. Priority: Monitor #1

Labor and Industries Networks:

The negotiated business and labor bill (SB 5801) that would established a medical provider network for Labor & Industries (L&I) has easily passed both the Senate (48-0; with 1 excused) and the House (96-1, with 1 excused). The network is for both workers enrolled in the state program and self-insured employers. The bill is now on the Governor's desk and she will sign the bill in the next few days. It was one of her top priorities this session.

Currently, the only meaningful requirement for a physician to be an L&I provider is that he or she has a medical license. Under this bill:

- Minimum network standards are established in order to participate in the L&I program. Providers apply by completing an application, which is a contract.
- It requires that workers receive care only from network providers.
- Creates two best practice tiers, above the minimum standards base network mentioned above:
 - Establishes best practice standards, and financial and nonfinancial incentives, for second tier providers.
 - Establishes best practice standards, and financial and nonfinancial incentives, for providers participating in Centers for Occupational Health and Education (COHE). A COHE is a resource to help L&I providers manage and integrate the care and recovery of injured workers focusing on the first 12 weeks of a claim.
- L&I must convene an advisory group made up of representatives from or designees of the Workers Compensation Advisory Committee, the Medical Industrial Insurance Advisory Committee (*a number of WSMA members sit on this committee*), and the Chiropractic Industrial Insurance Committee to advise L&I on the implementation, including the development of best practices treatment guidelines (second tier and COHE).

The bill leaves much of the details as to its implementation and specifics as to participation, non-participation, and dismissal rights up to L&I (with advice from the advisory group) and through rulemaking. The WSMA along with other provider groups sought greater clarification in the bill but the legislature was reluctant to adopt our clarifying amendments once both labor and business had signed-off on the bill.

WSMA Position: The general health care provider community was not a significant party to the talks between the business community and labor. Priority: Monitor #3. The WSMA will monitor this legislation closely as it moves into its implementation phase, and will coordinate with its members on the Medical Industrial Insurance Advisory Committee.

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