Washington State Health Care Authority

Successes and Challenges

How the Health Care Authority Dealt with Issues, 2004 – 2012

HCA 65-050 (12/12)

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Tough decisions and close calls in an era of recession at the Health Care Authority

As our country emerges from the Great Recession and faces the challenges of implementing national health care reform, state government and the people of the state of Washington must recommit themselves to maintaining high quality health care standards in the future. Old structures and ways of doing business no longer serve the best interests of taxpayers and the beneficiaries of state health care programs. "The way it's always been" has proven to be unworkable and unsustainable. Recent experiences by the Health Care Authority provide policy makers with successful examples of health care purchasing that works and provides value.

Belt cinching necessitated by the Great Recession reinforced the need to develop and support a sustainable health care delivery system, one that can endure in bad times as well as good.

Fortunately, cost controls, quality improvement, better outcomes and efficient administration of health care were priorities at the Health Care Authority long before the Great Recession. In 2005, HCA took the lead in state government to set a framework and foundation for reforming health care through five principles developed with the Governor.

Those five principles are:

1) Emphasize evidence-based health care programs and policies that rely on scientific research to verify therapies that work.
2) Promote prevention, healthy lifestyles, and healthy communities.
3) Institute better chronic care management, targeting those individuals who would benefit the most for prompt, effective care.
4) Increase transparency for both clients and providers, since informed shoppers are smart shoppers.
5) Make better use of information technology, developing a faster exchange of health information.

These principles were strengthened and supported by effective and continuing review of policy initiatives, including the Blue Ribbon Commission on Health Care, which established a high priority on health care planning. In the case of Health Information Technology, HCA took a lead role in upgrading systems for eligibility and insurance accounting as well as helping smaller medical practices access health records technology through grants programs and the development of Electronic Medical Record Banks.

Evidence-based care in particular received a high priority early in Governor Gregoire's tenure. At the Health Care Authority, staff focused on developing and strengthening prescription drug programs, partnering with other agencies like the Department of Social and Health Services, the Department of Health and Labor and Industries. Innovative programs like the Preferred Drug List crossed agency boundaries.

Further, HCA worked with Oregon to share a single Pharmacy Benefit Manager and provided a Drug Purchasing card to any Washington resident (the Washington Drug Card). To this day, the card saves millions of dollars a year for more than 200,000 individuals across the state.

HCA also started up and developed the Health Technology Assessment program. Working the same agencies mentioned above, a process was set up to review treatments and technologies for safety and effectiveness.

These evidence-based programs are sometimes controversial and require courage in forging ahead despite the push-back by those seeking to increase their profit margins at the expense of the sick.

Other first-term HCA accomplishments:

- The Public Employees Benefits program was restructured with more variety of offerings, and the agency upgrading the administration of the Uniform Medical Plan—the most popular coverage among state workers and retirees.
- HCA preserved the popular Basic Health plan despite the threat of increasingly tight budgets. The plan was humanely slimmed by attrition, avoiding budget cuts that would have been a severe hardship on subscribers and families.
- An alternative to the Basic Health plan—a non-subsidized version called Washington Health—was developed as an option for higher income subscribers and others seeking a more affordable coverage than they could find in private markets. A model Health Insurance Program, or HIP, targeted small businesses and their employees. It was entirely federally funded, providing a laboratory that spared Washington taxpayers. Although Congress later cut its funding, that early experience gave HCA staff a head start in developing strategies that would later apply to the insurance exchanges included in the Affordable Care Act.
- HCA took the lead in organizing communities, improving quality, outcomes and cost, among them the Puget Sound Health Alliance, the Dr. Robert Bree Collaborative, and the multi-payer medical home pilot.
- The fiscal crisis of 2009-2012, with high unemployment and reduced state revenues, had a profound impact on all Washingtonians. Despite a dramatic increase in Medicaid's caseload, the impact of the recession was initially muted by the increased federal match rate granted as part of the federal stimulus package in 2008. But the enhanced funding ended in December 2010, and Governor Gregoire, the Legislature, and cabinet agencies were challenged to re-engineer health care spending and to stretch the dollars available.

When times are hard, economic conditions force people to turn to the public safety net for help. The need for medical care does not stop, nor does the need for prescription medications, surgeries, or equipment like wheelchairs or walkers. Emergency room visits continue in times of crisis, and babies continue to be born.

But through a combination of selective contracting, prudent purchasing, and improved health care outcomes by promoting best practices in medical and pharmaceutical management, the Health Care Authority was able to reduce spending by over $1 billion during the two recession biennia while largely maintaining the quality of care required by our most vulnerable citizens and the Public Employees Benefits system.

The most significant adjustment in the recession came in 2010 when the Governor announced a vision of bringing together the state's top two health purchasers—the Public Employees Benefits system and the Medicaid program. Together, the two would be able to design more effective purchasing strategies and work with other agencies across state government to improve the state's bottom line and quality outcomes at the same time. That merger was accomplished with legislative help the following summer, leading to expanded improvements in coverage, tighter focus on quality and more intensive financial planning.

The landscape is still a grim one. During a decade of hard fiscal times from 2001 to 2011, Washington state's medical assistance caseload increased 46 percent. We anticipate another nine percent increase by 2013, before federal reforms are fully implemented in 2014. Hundreds of thousands of newly eligible enrollees are expected over the first few years of the Medicaid expansion, raising the possibility that as many as one in four Washington residents will depend on Medicaid or Public Employees Benefits for health coverage by 2015.

But despite the challenges of a major reorganization and a continuing recession that has squeezed the agency's budget and services, the Health Care Authority retained its focus on customer service, quality improvements, and cost containment—keeping the key pieces of the safety net in place and poised to rebound when the economy improved.

Reacting to Reality

Two key themes emerged in health care during the governor's first term, which began on the final leg of one recession and nearly on the cusp of another. In retrospect, however, they could not have been better timed.

The first came in the opening days of her first term when, in her first official act, she issued an executive order that ended a requirement for biannual income verifications for Medicaid children. The "hassle factor" of unnecessary paperwork on poor families was driving children out of medical assistance, and the governor took quick, effective action to end the practice. It was the opening move in an eight-year effort to put children first, protecting them from the recession, and making sure that children's health care remained at the top of state priorities.

The second theme emerged in the wake of a field trip the governor took with HCA's Chief Medical Officer, Jeff Thompson, to the University of Washington, where the pair were teamed up on a sophisticated resuscitation simulator—a highly technical but realistic puppet that could track and analyze the effects of treatment. She and Dr. Thompson were assigned the job of resuscitating a difficult cardiac patient—a demanding assignment and one with a lesson even in bitter outcomes.

Dr. Thompson remembers the experience was profound, leaving both him and Governor Gregoire with a new insight and appreciation for the power of scientific research and evidence-based medicine.

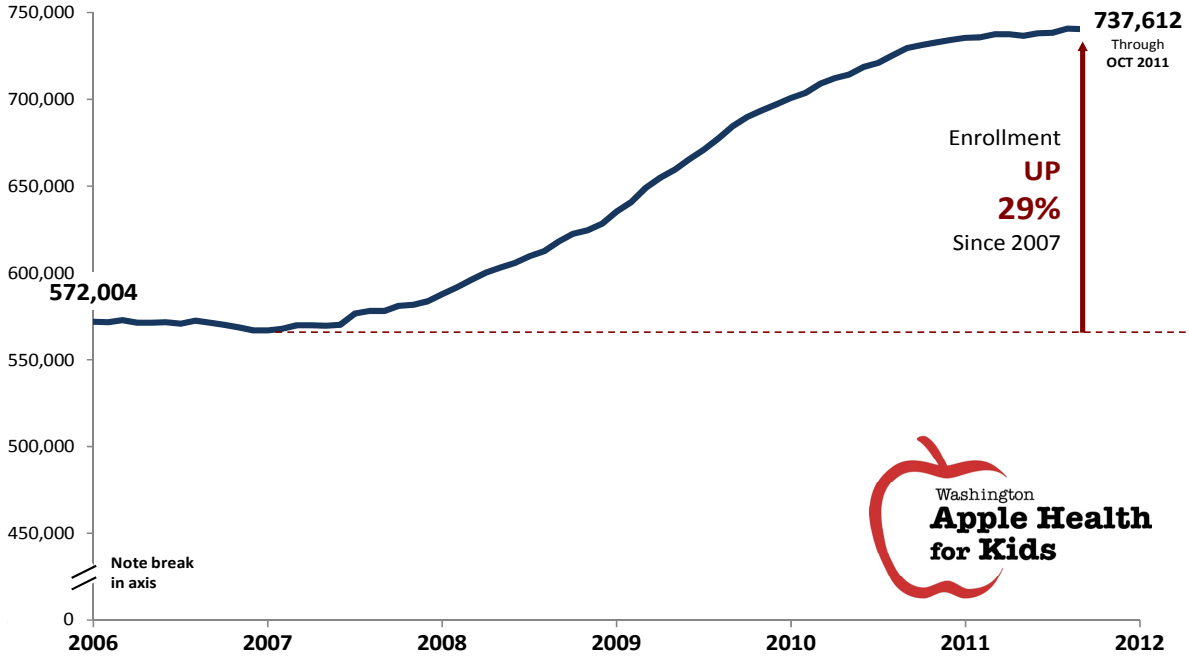
Perhaps as a result, throughout her years in office, evidence-based health care became the gold standard for the Gregoire administration, especially in health care purchasing. It would prove to be a valuable ally in a war on waste that helped her and the state avoid cuts in otherwise vulnerable programs.

The lessons learned from these challenges was that the state can purchase better health care for more of its citizens at less cost to the taxpayers through creative strategies and improved technology.

Apple Health for Kids

Washington's Apple Health for Kids is a model umbrella program, combining all children's medical (Medicaid, the Children's Health Insurance Program, and the state-funded Children's Health Program) to ensure that any child, in any family that can meet the income eligibility standards, will have access to full-scope Medicaid coverage. Despite the state's leadership, these efforts were initially not rewarded by the federal government. At first, the state was literally unable to tap into the Children's Health Insurance Program funding because it and several other states had already raised children's eligibility limits to 200 percent of the Federal Poverty Level prior to congressional approval of the Children's Health Insurance Program.

Over time, however, and with the help of Washington's congressional delegation, the state was able to win concessions that allowed the state



increased use of the Children's Health Insurance Program funds to expand children's health coverage above 200 percent of the Federal Poverty Level. That rectified earlier restrictions and allowed Washington State to continue its efforts to bring uninsured children into coverage.

Today, any child in any Washington State family can qualify for health coverage if the family's annual income does not exceed an annual limit of $57,276 (for a family of three). Coverage is free for children in families under 200 percent of the Federal Poverty Level, and the state charges only small premiums for children between 200 and 300 percent of the federal poverty standard.

Evidence-Based Health Care and Scientific Research

Washington was one of the first states to turn to scientific evidence as the basic tool in intelligent health-care purchasing decisions. New innovations in medicine, even in the last 10 years, have improved the health and lives of patients, yet they have come at a high cost in terms of health, safety, and affordability. Health care spending and costs are rising dramatically, but patients in the U.S. are not getting healthier nor using health care that is available, recommended, and proven to work.

Too often, medical products and treatments are introduced without independent, scientific evidence about whether they are safe and effective while providing benefits that are better than existing alternatives. The information age has compounded the problem—there is a flood of information, but doctors and patients don't have the tools or the time to sort through it all. In fact, some critics of the current system allege that the effort to advertise directly to consumers may be coming at the expense of the rigorous scientific standards and testing that could help assure better outcomes and safer utilization.

Health Technology Assessment: Washington State has been a pioneer in the field of assessing health care that works. The Health Technology Assessment program has been a leading voice in these issues. The primary purpose of the program is to ensure medical treatments and services paid for with state health care dollars are safe and proven to work.

The Health Technology Assessment program serves as a resource for state agencies purchasing health care. The program contracts for scientific, evidence-based reports about whether certain medical devices, procedures, and tests are safe and work as promoted. An independent clinical committee of health care practitioners then uses the reports to determine if programs should pay for the medical device, procedure, or test. Participating state agencies include the Health Care Authority, the Department of Social and Health Services, the Department of Labor & Industries, the Department of Corrections, the Department of Veterans Affairs, and the Department of Health.

State agencies using the same evidence-based reports are able to make more informed and consistent coverage decisions. Currently, decisions by the Health Technology Assessment program are estimated to be saving the state more than $31 million a year.

The Health Technology Assessment program is only one example of how Washington State is applying evidence-based tests to the broad spectrum of health care, but it provides some of the most dramatic examples of how diligent, evidence-based tests and scientific review by clinicians, not bureaucrats, help shape better outcomes. The state expects the following benefits when using information based on science to make decisions about health care coverage:

- **Better health** – Washington patients and providers have access to a centralized place to learn about proven health care.
- **Transparency** – The technology selection, evaluation, and committee decisions follow a published process and are open to public input.
- **Less bias** – Neither the state agency payer nor a company selling products makes the decision, but all can provide information.
- **Consistency** – State agencies will be relying on a single, scientifically based source to inform coverage decisions on the selected technologies.
- **Evolving and flexible** – Technical innovations occur regularly, and evidence-based reports are also reviewed regularly to ensure the latest information has been considered.

Other Evidence-Based Medicine and Decisions

Prescription Drug Programs: Medicaid and the Health Care Authority joined forces to contract with the Oregon Health Sciences University Evidence-Based Practice Center to develop a state Preferred Drug List (PDL) in more than two dozen drug classifications and compare them for effectiveness and equivalencies. The list helps prescribers select the most effective therapy as well as the least expensive.

Narcotics Utilization: The Medicaid program pioneered a provider education effort to make prescribers aware of patients' prescription histories, helping identify high utilizers who "doctor shop" to obtain narcotic painkillers. The effort also included a utilization kit on the Medicaid website and expansion of a Patient Review and Coordination program that provides closer supervision for these clients, as well as limited access to prescribers when these patterns are identified.

Generics First: Medicaid took the lead among state agencies in pushing for increases in the state's generic fill rate, which is significantly lower than private health plans. The initiative does not prohibit prescribers to use generic drugs or force clients to change existing regimens that work for them. It does require providers to start new clients on generics (try and fail) rather than more expensive brands, but allows substitution with brands when there are medically sound reasons for the change.

Unnecessary C-Sections: Like many states, Washington experienced a national spike in C-section operations—a higher risk procedure and considerably more expensive than vaginal delivery. The state is looking for ways to discourage

unjustified C-sections, using provider and client education to aim for effective maternity care with the least harm for childbearing women and newborns. Those efforts are beginning to show improvements, with both C-section rates and VBAC (Vaginal Births After C-sections) showing declines.

Anti-Psychotics Use in Children: Washington is a national leader in looking at the potential overuse of anti-psychotic and ADHD (Attention Deficit Hyperactivity Disorder) medication in children. Washington's Medicaid program helped spearhead a Rutgers University study of children and mental health drugs in state Medicaid programs. That work is establishing clear standards for dosing rates and the use of second opinions not only in Washington State but nationally.

Bariatric Surgery: Four years ago the state's Medicaid program stopped automatically endorsing stomach-stapling surgeries after taking a hard look at the morbidity and mortality statistics associated with those surgeries. Today's surgery applicants now have to show that they have the corresponding conditions that predict good results, that they are good candidates for the operations, and that they have demonstrated they can live with the extreme lifestyle changes these surgeries require.

Purchasing Reforms Lead to Managed Care

Joint procurement: The Health Care Authority put together a major purchasing reform with a plan to procure Healthy Options and Basic Health together in July 2011. The contracts—won by five managed care health plans—expanded managed care coverage to most Medicaid and Basic Health clients, including the aged and blind population that resisted earlier attempts to move them into more efficient and better supervised care available.

Multiple payer/Medical home: Eight health plans (Aetna, Cigna, United, Group Health, Regence, Premera, Molina, and Community Health Plan of Washington) are committed to use of a medical home model to provide additional care management funds to practices in exchange for reductions in avoidable Emergency Room and hospital admissions. Washington's model is the first pilot to tie increased payments to accountable performance outcomes, to shift from paying for services (in a traditional fee-for-service system) to paying for outcomes.

Washington Health: This unsubsidized version of Basic Health enrolled more than 5,000 subscribers in a little more than a year of operation. The plan is a little more costly than the subsidized premiums available for lower-income Basic Health subscribers, but it also provides additional experience looking ahead for Washington Healthplanfinder—the new marketplace for individuals and small businesses that will open in 2014.

Purchasing strategies: The Health Care Authority is working with the Department of Corrections on health purchasing initiatives and exploring ways of controlling costs by improving purchasing policies and aligning strategies with major purchasers like the Public Employees Benefits program and Medicaid. The Department of Corrections has switched vendors to begin aligning itself with the consortium's consolidated purchasing strategies. We are currently looking at the previous three years of Department of Corrections drug purchasing data to identify further savings opportunities from actuarial and clinical review by the consortium vendor.

ProviderOne: From Outdated Mainframe to State of the Art

The new Washington State health care payment system called ProviderOne, known in medical assistance circles as a Medicaid Management Information System, is faster and more accurate than its predecessor. It's also able to catch billing

mistakes and fraudulent claims before payment is made, saving the state from tracking down overbillings and seeking recovery of overpayments. ProviderOne adjudication edits are implemented by a business rules engine, allowing a more robust and complex set of pre-payment edits. The system handles more than 300,000 new claims a week with more than 80 percent processed and paid the first day they are in the system.

- Enhanced eligibility and financial interfaces allow more frequent record updates with fewer errors. Eligibility interfaces now routinely include spend-down amounts and historical data.
- Transactions are fast and easy. Providers can now submit an electronic enrollment application, update their information, check client eligibility, and submit a claim or inquire about claim status via either a web portal or interactive voice recognition.
- These improvements mean better customer service, a more responsible work environment, and greater ability for providers to manage their own claims.
- The federal government paid 90 percent of the $166 million in costs for design, development, and implementation—a fraction of what some states paid to replace their Medicaid Management Information Systems.

In addition, the ProviderOne system was envisioned, designed, and developed as a state-of-the-art payment system, one that would improve decision support possibilities and lend itself to modification as the needs of the state and the payment program change. The result is a system years ahead of other states and with a modular design that makes it flexible and nimble alongside bolt-to-the-floor mainframes.

ProviderOne also may have set a record for receiving certification without a single correctional finding (flaws that a state must fix before the certification will be finalized). It's not unusual for a new Medicaid Management Information System to take years to hit its stride and win federal approval. It's also not unusual to backstop new systems by paying many providers on a lump-sum basis, estimating their payments based on their claims histories. But ProviderOne never required that kind of adjustment. The result is a state-of-the-art, nimble payer and decision-support system that can be updated when necessary to stay in tune with the needs of providers, taxpayers, and the program alike.

ProviderOne received full funding of its Phase 2 budget in the 2012 Supplemental Budget, which allows expansion of the payer system to accept billings and payments for non-medical services managed by the state Department of Social and Health Services.

An Electronic World

Improved access to electronic health information for providers and consumers will do more than save money and speed provider reimbursements. It can literally improve health care and help prevent unnecessary, duplicate, and even dangerous treatments. Washington State has taken the lead in providing more than $80 million in federal Medicaid incentives for the acquisition of Electronic Health Records (EHR) to Medicaid providers who meet the minimum Medicaid patient panel requirements. The state currently ranks sixth in the nation in electronic health care recordkeeping.

Health Information Exchange: With federal stimulus funds, Washington has established a state Health Information Exchange. The goal is to promote greater coordination of care among providers through electronic sharing of information. It also will save costs by identifying and avoiding duplicate or unnecessary services which may even be harmful. The Health Care Authority designated OneHealthPort, a private sector health care technology company, to lead development of the Health Information Exchange and foster a partnership between public and commercial

health care purchasers and providers. The Medicaid program was the first payer to join the OneHealthPort Health Information Exchange and will soon be able to share data electronically with other Health Information Exchange partners.

Program Integrity

During SFY 2011, the Health Care Authority provided health care coverage to approximately 1.6 million Washingtonians, with total annual expenditures of approximately $6 billion. The Division of Program and Payment Integrity has responsibility for ensuring the integrity and accountability of medical assistance programs administered through the agency—establishing a continuum of activities that ensure correct payments are paid to legitimate providers for appropriate and reasonable services provided to eligible clients. Program integrity is an enterprise-wide responsibility. It does not refer to the work of a discrete team, but must be stretched through the entire organization. Program integrity activities include such efforts as:

- Reviewing provider billing practices.
- Pre-enrollment screening of providers to ensure their eligibility to participate in the program.
- Monitoring the utilization and quality of care by providers and clients.
- Conducting provider post-payment reviews to detect possible weaknesses within the existing payment system and identifing overpayments.
- Using advanced technology to analyze large amounts of data to identify aberrations and billing anomalies through data mining and analysis.
- Referring possible cases of fraud to the proper authorities.

Most Medicaid programs were designed for honest providers, but the small minority of unscrupulous providers who take advantage of the Medicaid program cause millions of dollars of loss to every state. That is why it is important for states to build up our own anti-fraud and anti-waste systems. In Washington State, we overhauled our program integrity efforts over the past eight years by bringing in new technology, improving access to data, and performing sophisticated data analysis and modeling using both contracted services and state staff. Most states are bolstering their efforts in this area, but Washington State was far ahead of the pack.

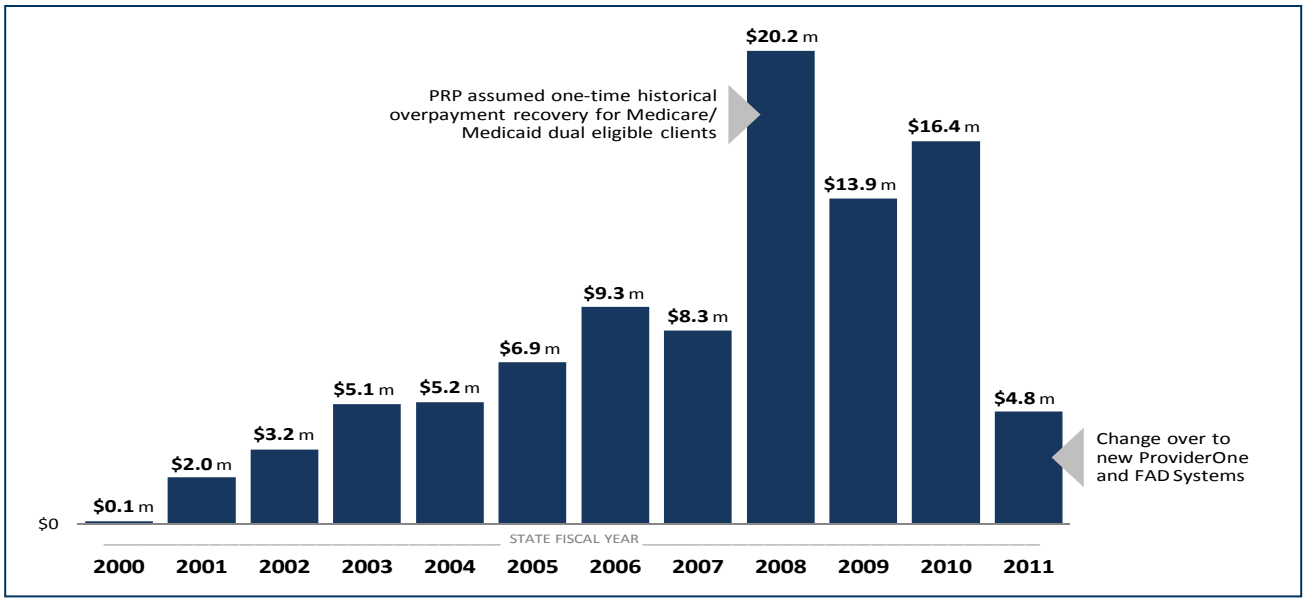
These investments have helped us turn our Medicaid data into meaningful information that fights fraud, waste, and abuse in the program, but also to better manage our Medicaid program. We also made deliberate attempts to communicate throughout our organization a sense of fiscal responsibility—that program managers must be prudent purchasers of health care services that are proven. In fact, payment integrity is everybody's business, not just the business of our auditing staff. Toward this end, we have established a series of staff "steering committees" that have been assigned different areas of our operations to review and analyze, such as durable medical equipment, inpatient hospital care, pharmacy, etc.

Washington State also recognizes states need to come to terms with the fact they need more muscle to defend programs. We should find ways to band together, even to file suit against the government as a last resort in those areas where there is a consensus that the feds are wrong. However, in most matters, parties can find common ground in the outcome, and we do not need to go to court.

Payment Review Program Savings Trend, SFY 2000-2011

Payment Review Program

The Payment Review Program is nationally recognized for its progressive and innovative approach, sophisticated technology, and data mining techniques used to ferret out Medicaid fraud, waste, and abuse, and to recover overpayments. The



program was launched in 2000 and its recoveries grew steadily through the decade. However, 2011 was a retooling year as the program switched over to the new payer system and changes in Fraud and Abuse Detection Systems.

During state fiscal years 2010 and 2011, the Payment Review Program transitioned from the legacy Fraud and Abuse Detection Systems to a new second-generation Fraud and Abuse Detection Systems. This transition was coordinated with the implementation of the new Medicaid Management Information System, called ProviderOne, which went live in May of 2010. Fraud and Abuse Detection Systems analytics required extensive re-mapping of historical algorithms, as well as learning new data structures and elements. Since implementation of the initial Fraud and Abuse Detection System in 2000, the Payment Review Program savings total more than $95 million in recoveries plus increased savings through improved audit support.

Other Key Elements of Program Integrity

Provider Audit and Review Units: Health Care Authority audit staff conducts onsite and desk audits and reviews Medicaid and medical assistance provider billings to ensure that payments comply with federal and state regulations, and that potential fraud, waste, and abuse are identified and referred for further investigation.

Medical Audits and Reviews: Medical audit staff conducts provider post-payment audits to identify providers who are out of compliance. Medical auditors also conduct pharmacy third-party-liability desk reviews to ensure that Medicaid is not paying for prescription drugs that should be covered by another insurer.

Hospital Audits and Reviews: The hospital audit team has experience in hospital billing practices and conducts post-payment audits on inpatient and outpatient hospital claims to identify abusive billing practices and noncompliance with applicable program rules and regulations.

Pre-payment and Post-payment Clinical Reviews: Licensed registered nurses and registered health information professionals/coders conduct clinical data analysis of inpatient hospital claims, pre-payment and post-payment, to identify atypical practices.

ProviderOne: This new payment system provides more robust automation and pre-payment edits

and audits. ProviderOne Phase 2 will expand the payer system's responsibilities to include billing and payment of social services. This will significantly enhance payment integrity by allowing ProviderOne to check payments across systems. For example, Phase 2 controls will help ensure that hospital and in-home care providers cannot both bill for services to the same client on the same day.

Triage and Referral: With the implementation of ProviderOne, the Surveillance and Utilization Review Section staff now are able to use new technology to monitor the claims processing system and look for patterns of potential fraud and abuse. The new tool is called "Impact Surveillance and Utilization Review." It uses Medicaid payment data to generate statistical peer group comparisons of Medicaid providers to identify abnormal behavior patterns. The Impact Surveillance and Utilization Review also responds to constituent referrals for suspected cases of fraud and waste, and it produces Provider Activity Spike detection, which alerts auditors to changes in providers' billing practices earlier than other reports.

Provider Self Review: A voluntary web-based Provider Self Review Program was implemented as part of the Second Generation Fraud and Abuse Detection Systems. It invites providers to review claims identified as potentially improper. After providers complete their online review they submit the information to the Health Care Authority to review a random sample of their documentation. The Health Care Authority then generates an overpayment notice to the provider for any improperly billed claims.

Veterans Benefits Enhancement: Veterans who are in need of medical benefits often turn to state Medicaid programs first for help, not realizing that they may qualify for more generous benefits from the U.S. Department of Veterans Affairs. Almost eight years ago, state Medicaid employees launched a partnership with the Washington State Department of Veterans Affairs to coordinate referrals of Medicaid veterans to federal programs, making sure veterans and their families were linked to available federal benefits. Typically, the veterans wind up with better benefits, and the cost is picked up by the federal government rather than the state.

Even better, while Medicaid is legally required to try to recover costs from client estates, for example, forcing survivors to sell a family home or turn over other assets—federal veteran programs have no strings attached. Veterans earned those benefits with their military service.

The key to Washington State's initiative was an interstate military database called PARIS—the Public Assistance Reporting Information System.

Public Assistance Reporting Information System data includes information from the Veteran's Administration, the Department of Defense, and other participating states. The Public Assistance Reporting Information System reporting system was originally created to compare state and federal public assistance files to assure no one was double-dipping (drawing the same kind of benefits from different programs). But Medicaid staff saw an additional opportunity, and Washington was the first state to put together an initiative on veterans' behalf. Today, more than two dozen other states are establishing similar programs.

Through the efforts of the Health Care Authority and other state agencies working with the Veteran's Administration and the Department of Defense, we identified and facilitated benefits for more than 4,000 veterans since 2006. These efforts have resulted in more than $30 million of avoided state Medicaid costs.

Cracking Down on Drugs, the Fastest Growing Expense

Preferred Drug List: In 2003, the Department of Social and Health Services (then home of the Medicaid program), the Department of Labor &

Industries (which handles worker compensation), and the Health Care Authority (which operated the Basic Health program and state employee benefits) joined forces to contract with the Oregon Health Sciences University Evidence-based Practice Center to formally develop a state Preferred Drug List for more than two dozen drug classes.

That fall, after passage of legislation strengthened the project, a panel of clinicians on a new advisory group called the Pharmacy and Therapeutics Committee became stewards of the list. Research from Oregon Health Sciences University now goes to that committee for review and decisions. The Health Care Authority staff works with the committee and the list to help prescribers and pharmacists make sure Medicaid clients are receiving the most effective medications at the best price.

Today, the Preferred Drug List complements the Health Care Authority's extensive prior authorization pharmacy system, which applies to prescriptions for Medicaid's 500,000 fee-for-service clients.

Prescriptions for the other 700,000 managed-care clients in Healthy Options or the State Children's Health Insurance Program are handled through the private insurance plans administering that coverage. Those plans use their own drug formularies to control prescription access and costs.

Preferred drugs on the state Preferred Drug List are those judged to be equally or more effective —and equally or more safe—than the other drugs in the same classification. Evaluating the safety and efficacy of the drug is always the first step. However, once that determination has been made, the state may be able to select a drug that is not only equally safe and effective but much less expensive than other drugs in the class.

Under the legislation, prescribers who endorse the Preferred Drug List agree in advance to avoid prior authorization by letting pharmacists substitute the preferred drugs within classes unless they write "Dispense As Written" on the prescription. Non-endorsing prescribers still have to work through the prior authorization steps.

Pain Management: A new Washington law went into effect on January 1, 2012, putting more responsibility on providers who prescribe opioid painkillers. For several reasons, a once-relaxed attitude toward pain management drugs is changing, both nationally and in Washington State. Complex pain patients often take more time than the average practitioner has to give, making it less realistic for providers to center their practices on pain management. At the same time, the hazards of narcotic treatments puts a premium on expertise in pain management consultation and second opinions.

Currently, there are few community resources where the primary care provider can turn for assistance or to discuss treatment alternatives for chronic pain. But Washington State government is stepping into that vacuum, making expertise available under a variety of programs, including a web-based calculator of morphine equivalents and a second opinion process that links providers to the University of Washington's pain management center. Another effective option: Medicaid's "lock-in program" limits known high utilizers to a single primary care provider, single pharmacy, and single hospital (with an exception for emergencies).

That program—Patient Review and Coordination—currently serves a caseload of about 4,000. Together with an additional Narcotics Control initiative, the Health Care Authority is working effectively with providers to educate them on narcotics abusers, to integrate information about narcotic prescriptions into their care plan, and to work with local pharmacies and other prescribers to address abuse.

Over time, state government health agencies are working together to address these issues and to develop best practices on a community-wide basis, helping prevent abuse of opioids and adequately addressing chronic pain. One focus for the future is a "medical home" concept for chronic pain patients —a more integrated and coordinated approach

to care. The health agency partnership on pain management consists of the Health Care Authority, the Department of Health, the Department of Labor & Industries (workers' compensation), and the Agency Medical Directors Group, which cuts across agency boundaries. That coalition will work to develop appropriate financial and non-financial incentives for the next few years.

Prescription Drug Discount Cards, Utilization, and Savings: Enrollment in the Health Care Authority's Prescription Drug Discount Card program reached 185,000 by the middle of 2012, and cardholders have saved more than $6 million since the program was launched in 2007.

In addition, Medicaid and the Health Care Authority worked closely with the Preferred Drug List to implement other changes, including pharmacy policy, rates, and prior authorization. The result continues to show positive trends for pharmacy.

Overall, the agency achieved a generic fill rate of more than 80 percent (more than 90 percent for the discount card program). This is comparable to most commercial payers; payment rates that are competitive, stable, and designed to track savings opportunities as they arise.

The agency managed to bend the pharmacy growth curve without negative impacts to pharmacy access or adherence.

Value-based Drug Purchasing: After thorough discussions with the federal Centers for Medicare and Medicaid Services, as well as the new Center for Medicare and Medicaid Innovations, Washington State has been given approval to research and design a "formulary" that will complement the Preferred Drug List. A stricter set of evidence-based principles is envisioned for defining least costly generics and brands that are effective alternatives to expensive prescription drugs. A non-formulary justification process would make sure a client with a proven medical need for a specific drug could get coverage without undue hardship. Even so, the project would aim for a system that would mirror the outcome of private plans' formularies—offering drug coverage for "needs" instead of "wants."

Emergency Room Collaboration

After several unsuccessful attempts at a collaborative solution to the abuse of emergency rooms, on July 1, 2012, the Health Care Authority, Washington State Hospital Association, and emergency department physicians teamed up on a legislative mandate to reduce non-emergency use of hospital emergency departments as well as over-utilization of emergency services. The new plan—included in the Supplemental Budget passed April 2011 by the Legislature—replaces earlier state proposals that would have limited the annual number of non-emergency visits by a client to the emergency department and to stop reimbursing hospitals and physicians for treatments and services that are not medically necessary in an emergency department.

Instead, the new plan follows a collaborative effort with the American College of Emergency Physicians, the Washington State Medical Society, and the hospital association to better manage emergency department services and prevent over-utilization.

The plan depends on hospitals and doctors to help identify systems and procedures that will reduce emergency department usage by referring non-emergency patients to more efficient and effective levels of care and to educate all clients about appropriate use of emergency departments. Hospitals across the state are committed to implementing those changes, including electronic health information exchanges that would allow emergency department physicians and community primary care physicians to quickly share information on high emergency department users, especially patients with drug- or painkiller-seeking behaviors.

Health Homes and Dual Eligibles

Person-centered Health Homes: The integration of primary care, mental health services, and substance abuse treatment does more than re-integrate part of health care. The true vision was to see these coordinated care services from the viewpoint of the consumer, who would be placed at the center of health care as the system developed integrated, person-centered "health homes." Health homes are a step beyond the concept of "medical homes," a narrower concept. The health homes idea was to bring all three phases of health care—acute medical care, long-term care, and behavioral health care—to the same place; so that the consumer would receive an assessment and any needed treatment from any of the three areas. In short, health care providers would no longer separate mind from body—all three specialties are essential components of well being and good health.

Health homes coordinate a variety of services, including primary care and specialty care, to ensure referrals to community supports and services are effectively managed. Health homes are also a vehicle for improving care in another area. The Health Care Authority is also working with the Department of Social and Health Services within the concept of health homes to improve care for chronically ill individuals covered by Medicaid.

The real goal of health homes is to increase the use of evidence-based screening tools for early detection and intervention and increase patient self-management skills and abilities through comprehensive care management. Achieving this goal should result in a reduction of unnecessary visits to emergency rooms, as well as fewer admissions to hospitals and nursing homes.

The health homes model is designed to stand alone or serve as one of the three options for delivering health home services to dual Medicare-Medicaid eligible, chronically ill, high-risk individuals. The Department of Health is a key partner in this effort, advising on the most appropriate approaches to serving individuals with chronic conditions.

Interpreter Program

Washington is one of a handful of states that has traditionally shared the cost of providers' communications with patients of limited English proficiency. But legislators regularly objected to the cost of the program, so Medicaid first devised a broker-assignment system that cut the costs in half. The broker system, modeled on a similar system used in Medicaid Transportation, set up a disinterested middleman to handle the process of matching interpreters to assignments. In the current biennium, legislators again asked for cuts—ordering the program to find a way to trim about a third of the $29 million the state spends on interpreters over the biennium.

This time, the program revamped the system again, contracting with a new statewide vendor to handle all interpreter assignments and tapping into the more efficient alternatives of video and telephonic interpreter services as well as developing online systems to handle interpreter appointments and billings. Like the broker system, the new changes still leave providers in the driver's seat when it comes to determining the level of interpreter services needed to meet clinical requirements.

Public Employees Benefits

In 2011, the Health Care Authority introduced major benefit changes for public employees, retirees, and their dependents. The most striking of these was the development of new consumer-directed health plans with a health savings account option for 2012.

The consumer-directed health plans, also known as high-deductible plans, give state employees and their families choices that could save them money, provide more information about health care, and put them in better control of health care decisions.

In a nutshell, consumer-directed health plans will help employers improve the way they manage their coverage by making employees more aware of health care costs and the choices they have as health care consumers.

Monthly premiums for consumer-directed health plans are lower than premiums for traditional health plans, and the health savings account option allows employees to contribute pre-tax earnings to a savings account earmarked for health care expenses. Unlike the flexible savings accounts offered by the Public Employees Benefits (PEB) program, the new savings accounts allow members to carry unused funds forward from year to year.

A second major undertaking for PEB in 2011 was a study of the state's K-12 school districts and their benefit system. The 2011 Legislature requested the Health Care Authority to review the current system and develop a proposal by year's end that could consolidate health care purchasing for the state's 295 state school districts. The requirement was written into the 2011–2013 biennial budget, which was signed by Governor Gregoire in June. The Legislature's interest was to gain a better understanding of the current system and the approximately $1 billion in public funds that make up the state's annual employer contribution to insurance benefits for employees of local school districts and nine educational service districts. Working with Health Care Policy staff, PEB completed its report despite the short deadline, but the Legislature opted not to act immediately on the study.

PEB also established an ongoing eligibility audit, following up on a 2010 initiative aimed at verifying eligibility for all dependents of non-Medicare members enrolled in PEB. From now on, eligibility verification will continue every year, making sure questions are answered for new employees and their dependents at the time they enroll.

Summary of 2012 and 2013 Open Enrollment:
The state's 2012 open enrollment period began November 1 and ended November 30, 2011. This is the one time each year when PEB members—including state agency and higher-education employees, retirees, and their dependents, as well as participating local governments and K-12 districts—review their current health coverage and make account and plan changes for the following year.

Starting in 2012, state agency and higher-education employees shouldered a larger share of health care costs. On average, PEB members paid 15 percent of the cost of their health plan premiums in 2012, up from 12 percent in previous years. As the economy continues to falter, many observers predict member cost-sharing is likely to continue to increase.

As noted above, to help lower members' costs, the Health Care Authority offered the new consumer-directed health plans and adjusted cost-sharing for certain benefits. The plans increased members' costs for more expensive, lesser-used benefits and lowered costs for many primary care office visits and low-cost generic drugs.

With these changes, the state's total cost for providing PEB medical benefits increased 4.0–4.5 percent for 2012—lower than the projected 7.2 percent increase and the lowest increase in several years.

In 2013, PEB members will see fewer changes to their benefits:

- Employees will see no premium increases for optional life or long-term disability insurance; no benefit changes for dental, life, and long-term disability insurance; and few benefit cost-sharing changes for medical coverage. Monthly premiums will decrease for three of PEB's seven medical plans (including the state's Uniform Medical Plan).
- Retirees will see no premium or benefit changes to retiree term life insurance, few benefit cost-sharing changes for medical coverage, and slight premium changes for dental plans.

While the Health Care Authority intended to implement a new wellness program that would have allowed employees to receive a lower premium in 2014 by participating in wellness activities in 2013, Labor and Management were unable to reach an agreement on the funding for the premium incentives. The Health Care Authority will work with Labor to propose an alternate wellness program for 2014.

Wellness for State Employees and Their Communities: To achieve her goal for a healthier Washington, Governor Gregoire established the state employee wellness program—Washington Wellness—with shared leadership between the Health Care Authority and the Department of Health, funded by the Legislature for demonstration projects to develop the program.

The health and wellness of state employees is closely linked to the health of the communities in which they live. Since 2006, the Public Employees Benefits (PEB) program has partnered with the Department of Health to improve the health of state employees and their families. Collaboration has included development of programs to promote serving healthy food at meetings and at home; establishing farmers markets near worksites and delivering local produce to worksites; consulting on developing smoke-free campus worksites; producing walking maps of the Olympia area; and developing and testing early identification actions for chronic illness (i.e., diabetes, heart disease, and stroke).

Tribal connections

In August 1989 the state of Washington signed the Centennial Accord with the 26 federally recognized Tribes that are the original residents of our state. The Accord commits the state to regular open consultations with each of the tribes on matters that would impact their relationship with all of the programs administered by the state, including the Medicaid program. One of our highest priorities has been to ensure that tribal programs are able to access and bill through the ProviderOne claims processing system so that Medicaid funding is available to the tribes to address the health equity issues in Indian Country. We have also maintained regular consultation with the Department of Social and Health Services Indian Policy Advisory Committee, the Tribal Chairmen, and the Tribal and Indian Health Service facilities on all program changes that require amendments to the Medicaid State Plan.

PART 2: *The Recession Strikes*

The Evolution of State Health Care Purchasing, 2004-2012

Tough decisions and close calls in an era of recession at the Health Care Authority

In late 2008 and early 2009, Washington State departments began feeling the full impact of the downturn. In response to ongoing budget pressures and revenue shortfalls, Governor Gregoire set an ambitious agenda that included innovative approaches to restructuring the financing and delivery of health care.

Federal stimulus funds appropriated in early 2009 protected many Medicaid-funded programs from immediate federal budget cuts, but the Medicaid program still faced an appropriate share of the administrative cuts assigned to all state agencies. These included layoffs of approximately 150 FTEs across the entire program between late 2008 and June 2009. In all, the Medicaid program would lose more than 200 positions during the three-year recession.

In addition, much of the Medicaid program is federally mandated, while state employee benefits are contractually guaranteed. That left the Legislature and the Medicaid program with few real targets. In most cases, these were optional programs under federal law (adult hearing, adult vision, Medicare drug co-pays), but they also included state-only-funded programs like non-Medicaid substance abuse treatment or medical coverage for people enrolled in Disability Lifeline, Basic Health, or the Children's Health Program.

But budget cuts by themselves were not the only answer. Under the Governor's guidance, the Health Care Authority looked first at its own practices to see where belts could be tightened without gutting programs or dropping coverage.

An immediate answer was a series of steering committees set up along evidence-based lines to review every aspect of the Medicaid program's spending. Those steering committees included:

- Licensed Health Care Professionals
- Provider Enrollment
- Pharmacy
- Durable Medical Equipment
- Facilities/Hospitals
- Contracts

Together, the committees would put together more than $200 million in smart spending efficiencies by focusing on areas where program expenses did not match outcomes. These spending strategies hinged on cost avoidance, efficiencies, and better benefit design. In many cases, the "cuts" also represented both quality and safety improvements, organizational efficiencies, better targeting customer needs, and circumstances. The structural changes were significant since they moved the agency forward on the Director's and Governor's agenda and seized the opportunity of the budget crisis to make lasting improvements in the system.

Health care reform was another overriding factor in overcoming the impact of the most serious

downturn in the state's economy since the Great Depression. Health care reform will have a major impact on Medicaid programs across the nation, and Washington State is in the forefront of the states moving ahead to take early advantage of the federal changes and funding that begin in January 2014. Currently, the caseload forecast council has not pinned down the precise enrollment changes, but the state is operating under the assumption that up to 250,000 newly eligible clients—mostly childless adults—can be expected to enroll in Medicaid. Another 75,000 clients—mostly children—who already meet eligibility criteria also are expected to apply for Medicaid coverage over the first years of reform. Regardless of the better estimates from the Forecast Council, the federal government will pick up 100 percent of the costs of the newly eligible enrollees for the first three years of reform—and gradually down to 90 percent over the next three years and thereafter.

Another successful initiative that helped to mitigate the state's funding distress was the Section 1115 Bridge Waiver. This 1115 waiver was approved by the federal Centers for Medicare and Medicaid Services in January 2011 and helped save the state-funded Basic Health and Disability Lifeline programs by making their previously state-only funded costs eligible for federal matching funds under the Medicaid program. Together, the two programs serve about 50,000 low-income residents in Washington State, many of whom will be newly eligible for Medicaid under Health Reform in 2014.

But the most successful strategy was the Governor's vision of a new focus in state health care purchasing, one that brought together the state's two largest purchasers—Medicaid and Public Employees Benefits—into a single agency. The Health Care Authority that resulted from this merger was better focused, more muscular, and highly effective—the reorganization saved the state more than $1 million in the consolidation of executive salaries alone.

Centralizing health care purchasing expertise and decision-support benefits the entirety of state government. In its new role, the Health Care Authority has become consultant and confidante to all of the Cabinet agencies, especially those that deal in health care—helping them better leverage their purchasing power, seize efficiencies, and improve the quality of services they provide to their clients, customers, and employees. These partnerships were vital to preserving state health care operations during the recession. They will continue to improve those services and hold down costs as we move into more normal economic times.

Strategic Partnerships Blunt Some Effects of Downturn

Department of Social and Health Services: In development now, ProviderOne's Phase 2 will extend use of the new payer system to social services in the Department of Social and Health Services. Within the next few years, that upgrade will improve the billing and payment process for thousands of other providers—home case, disability services, and substance abuse.

In the meantime, other partnerships with ProviderOne are already paying off.

Department of Corrections: The Health Care Authority and the Department of Corrections have teamed up to start processing prison health care billings through the state's ProviderOne payment computer that also handles Medicaid claims. The first claim was received and processed several days after Labor Day. The partnership between the two state agencies has been under development for months and parallels the relationship that developed between the Health Care Authority and the Department of Health fostered by the Principles of Government exercises in health care planning.

In ordering that merger, Governor Gregoire said she anticipated that other public and private health

care systems would be able to benefit from shared expertise and innovation. "Previously, health care providers handling corrections health care outside our prisons have had to submit manual billings—a time-consuming and expensive process," Gregoire said. "Working with ProviderOne will save both money and time, and it has the long-range potential to link up easily with Medicaid, where health care costs can be shared with the federal government."

Overall, the use of ProviderOne by the prison system is proving high value in several ways, including giving prison officials access to decision-support data that will help them manage health care expenditures within the corrections area.

Department of Health: The Health Care Authority collaborates with the Department of Health in many ways, and the two agencies are currently exploring new purchasing relationships to facilitate our mutual goals.

- **ChildProfile Immunization Registry:** We have had a longstanding partnership with the Department of Health's ChildProfile Immunization Registry, promoting full immunization of children and supporting the development of educational materials for children in Washington State. After data from the Health Care Authority showed that children of Russian-speaking parents were less likely to be fully immunized, the two agencies agreed to conduct a study to better understand the root causes of this under-immunization. Study results will be used to target educational materials aimed at both parents and providers.
- Through their long-standing relationship, the Health Care Authority and the Department of Health are working together to promote healthful living habits, improve the health of state employees, and raise the quality of health care provided to Washington residents through Medicaid and other state-subsidized health programs.
- **Chronic Disease Partnership:** PEB is currently considering a proposal to collaborate with the National Council on Aging and the Physicians of Southwest Washington for the national Chronic Disease Self-Management pilot program.
- **Health Homes to Serve the Whole Person:** The Health Care Authority is also working with the Department of Social and Health Services to improve care for chronically ill individuals covered by Medicaid. The Health Care Authority and the Aging and Disability Services Administration, within the Department of Social and Health Services, submitted a funding proposal to the Centers for Medicare and Medicaid Services to coordinate and integrate care for those eligible for both Medicare and Medicaid. The plan would use managed care organizations to develop health homes for dual-eligible clients.
- **Managing Medications for Safety and Cost Control:** The Health Care Authority works with the Department of Health to monitor prescriptions for commonly abused controlled substances to ensure Medicaid clients are not taking narcotics in dangerous quantities or combinations. The Prescription Monitoring Program began in October 2011 with the Department of Health partnering with Health Information Designs to collect prescription data from pharmaceutical dispensers across Washington for all medications likely to be abused. For the first time, using the Prescription Monitoring Program, the Health Care Authority will be able to tell when Medicaid clients pay for narcotics with cash or credit cards.

Bending the Cost Curve

The success of Health Care Authority's budget management during the recession years also hinged on two additional factors.

One was the agency's continuing willingness to explore new answers, not to rely on unsustainable ideas or pilots. In improving chronic care, for

example, the Medicaid program pursued a number of options—including disease management. Many states continue to rely on variations of disease management, but Washington State saw early on that it was a dead end and was not producing the savings that were anticipated. As a result, the state moved on to other answers, including developing the pioneering PRISM system, a system of predictive modeling that lets the state target those populations that will benefit the most from increased care and case management.

The second area was the merger of the Medicaid and Public Employees Benefits programs in the same agency—consolidating the two largest health care purchasers in state government. Governor Gregoire's vision of that merger—expressed in Executive Order 10-1—was the next step in a five-point health care strategy she articulated shortly after taking office:

- **Emphasize evidence-based health care –** Governor Gregoire called for programs and policies that would use scientific research to find health care that works. Nearly one-third of what is spent on health care today has little or no effect on our health, which is close to saying that much money in the system is wasted. Governor Gregoire called for that to change.
- **Promote prevention, healthy lifestyles, and healthy communities –** To succeed in controlling costs, state-purchased health care should lead the way in encouraging the good health of citizens and applying principles of evidence-based care to families and communities. Providing preventive care and encouraging wellness activities before individuals become sick is key toward achieving healthy communities.
- **Better chronic care management –** Just as preventive health measures can lead us to a healthier population, so can management of chronic care help prevent the precipitous declines that leave 5 percent of our clients responsible for nearly half of our total costs. Together with other agencies, Medicaid has developed predictive queries using health care utilization data that are helping identify those clients who need to receive care before their conditions reach a point of no return.
- **Create more transparency for clients and providers –** Informed shoppers are smart shoppers, whether purchasing a car or making decisions about health care. Health care consumers need to be engaged and have information that will help them decide what the various options for treatment are, which treatments are most effective, which providers offer the best success rates and at what cost.
- **Make better use of information technology –** Health care payers, providers, and clients share a common need for the ready exchange of health information across systems as needed. Twenty years after personal computers became as common as telephones on every work desk, doctors were still scribbling illegible notes to pharmacists. Many medical tests are meaningless because the results are not available when providers call for them. Medical testing may be redundant because health care providers are not able to effectively share their records as patients go from doctor to doctor. We need commonly shared information among doctors and patients as well as between providers and payers in order to help improve health outcomes, increase quality and safety, and reduce medical errors and redundancies.

These same guidelines are informing the Health Care Authority and Medicaid transition. A number of medical initiatives helped contain costs, each founded on the principle of evidence-based research and a scientific demonstration that the procedures had good outcomes, represented improved care, and were cost effective.

The most striking example was drug utilization. For perhaps the first time in the history of Medicaid, Washington State's fee-for-service drug spending

actually dropped during 2010 despite increasing caseload. With legislative support, Medicaid pushed providers and clients to use generic drugs on new prescriptions, avoiding the expensive consequences of locking clients into regimens built around expensive brands. This campaign now includes anti-psychotic drugs, which make up nearly one-quarter of Medicaid's entire fee-for-service drug spending. Every 1 percent increase in Washington's generic fill rate equals a savings of $1 million.

Effective January 1, 2010, the Medicaid program stopped reimbursing providers for these services:

- **Adult Dental –** Medicaid only covers emergency medical and surgical treatment for adult clients (age 21 and older). Children, pregnant women, and disabled adult clients in state facilities continued to be covered.
- **Adult Hearing –** The state no longer covers hearing aids, cochlear implants, bone-anchored hearing aids, and repair of this equipment, parts, or batteries. Audiology exams and medical treatment of the ear are still covered.
- **Adult Podiatry –** Medicaid no longer reimburses for foot care that is not medically necessary to treat an acute condition.
- **Adult Vision –** Medicaid no longer pays for adult eyeglasses (frames and lenses), although eye exams and medical treatment of the eyes are still to be covered. Under a new program, however, doctors are able to receive prison-manufactured lenses and frames for clients at cost.
- **Medicare Part D Co-pays –** The state no longer picks up the cost of small prescription co-pays that range from $1 to $6.30 for Medicaid clients who are also Medicare subscribers.

Major 2009 Rate Changes

As the recession deepened, the Medicaid program and the Governor's Office took swift steps in early 2009 to control costs and cut spending as much as possible in a program dominated by federally mandated coverage.

- **Pediatrics:** In the 2007 legislative session, pediatric office visit rates increased by 48 percent. This rate was reduced to a 15 percent increase (effective July 1).
- **Adult Evaluation and Management Services:** In the 2007 legislative session, adult office visit rates increased by 12 percent. This rate was reduced to a 1 percent increase (effective July).
- Lab Services for the 2009-2011 biennium were reduced by approximately 4 percent (July 1).
- Rates for Healthy Option managed care health contractors were cut 1 percent (July 1).
- Rates for inpatient and outpatient hospital care were cut 4 percent (July 1).
- Pharmacy reimbursement for the purchase of drug ingredients were cut by 2 percent after a market study concluded the state was paying too much (July 1).
- 9.5 percent rate reductions for incontinence products, effective July 1, plus lower benefit limits on those products for children and adults, effective August 1. Resulted in a 25 percent savings ($6 million) on incontinence supplies overall during the biennium.

Major 2012 Rate Changes

Recovery was slow as the recession ebbed, and the Health Care Authority and its major programs continued to manage the budget carefully. Below are additional rate cuts implemented on July 1 of 2011:

- **Hospital Inpatient:** Inpatient payment rates in non-rural, non-governmental hospitals were reduced by 8 percent.
- **Hospital Outpatient:** Outpatient rates at the same hospitals were cut by 7 percent.
- **FQHCs/RHCs:** Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) are paid on a cost-related basis, not like other hospitals. The new budget required Medicaid to adopt a new payment methodology, including a new lower measure of medical inflation. As a result, payment rates were cut by about 10.6 percent.

These budget cuts were offered to the Legislature but never completed:

- **Children's Health Program –** This would have meant terminating medical coverage for 27,000 children on March 1, 2010. These families met medical income eligibility but did not qualify for Medicaid for other reasons.
- **Interpreter services –** This program, also proposed for termination on March 1, 2010, provides medically certified interpreters for English-deficient Medicaid clients. Ultimately, the Legislature ordered the Health Care Authority to cut the cost of the program by about one-third by relying more on the Internet, telephones, and video communications.
- **Medical Care for Disability Lifeline, Alcohol and Drug Addition Treatment, and Basic Health –** Medical services would have ended for the Disability Lifeline Program, previously known as General Assistance-Unemployable, and the Alcohol and Drug Addiction Treatment and Support Act, also known as ADATSA. These programs cover about 20,000 individuals with temporary disabilities. The state still subsidizes premiums of approximately 30,000 Washington residents on Basic Health's sliding scale. Another 150,000 individuals are on a waiting list. The Legislature was able to save these programs thanks to a federal waiver that allowed the state to split the cost with federal Medicaid dollars.

Here are Medicaid cuts originally discussed in 2009 but later dropped from budget plans prepared by the Governor's Office:

- **Adult pharmacy –** This cut would have eliminated coverage for outpatient prescription drugs provided by a retail pharmacy for all adult clients (age 21 and older).
- **Adult hospice –** This program provides skilled nursing care for end-of-life.

- **Adult Outpatient Physical, Occupational, Speech therapies –** These will continue for all adult clients.
- **Take Charge Family Planning –** The program is available for incomes under 200 percent of the Federal Poverty Level. Medicaid also will continue family planning services for a full year post pregnancies.
- **State Alien Medical (AEM) –** Provides cancer, dialysis and nursing home coverage for a small group of non-citizens.
- **First Steps/Maternity Support Services/Infant Case Management/Childbirth Education –** Funding to assist high-risk mothers before and after birth will continue, but funding was cut by 50 percent. The program uses remaining funds to focus on the highest risk families.

Washington State
Health Care Authority