SUBSTITUTE SENATE BILL 5394

State of Washington 62nd Legislature 2011 Regular Session

By Senate Health & Long-Term Care (originally sponsored by Senators Keiser, Becker, Pflug, Conway, Kline, and Parlette)

READ FIRST TIME 02/15/11.

1 AN ACT Relating to primary care health homes and chronic care
2 management; amending RCW 43.70.533, 70.47.100, and 41.05.021;
3 reenacting and amending RCW 74.09.010 and 74.09.522; adding a new
4 section to chapter 74.09 RCW; adding a new section to chapter 41.05
5 RCW; and adding a new section to chapter 48.43 RCW.

6 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

7 <u>NEW SECTION.</u> **Sec. 1.** A new section is added to chapter 74.09 RCW
8 to read as follows:
9 The legislature finds that:
10 (1) Health care costs are growing rapidly, exceeding the consumer
11 price index year after year. Consequently, state health programs are
12 capturing a growing share of the state budget, even as state revenues
13 have declined. Sustaining these critical health programs will require
14 actions to effectively contain health care cost increases in the
15 future; and
16 (2) The primary care health home model has been demonstrated to
17 successfully constrain costs, while improving quality of care. Chronic
18 care management, occurring within a primary care health home, has been
19 shown to be especially effective at reducing costs and improving

quality. However, broad adoption of these models has been impeded by a fee-for-service system that reimburses volume of services and does not adequately support important primary care health home services, such as case management and patient outreach. Furthermore, successful implementation will require a broad adoption effort by private and public payers, in coordination with providers.

Therefore the legislature intends to promote the adoption of primary care health homes for children and adults and, within them, advance the practice of chronic care management to improve health outcomes and reduce unnecessary costs. To facilitate the best coordination and patient care, primary care health homes are encouraged to collaborate with other providers currently outside the medical insurance model, such as dental providers and senior service providers like the area agencies on aging. The legislature also intends for the methods and approach of the primary care health home to become part of basic primary care medical education.

Sec. 2. RCW 74.09.010 and 2010 1st sp.s. c 8 s 28 are each reenacted and amended to read as follows:

((~~As used in this chapter:~~)) The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Children's health program" means the health care services program provided to children under eighteen years of age and in households with incomes at or below the federal poverty level as annually defined by the federal department of health and human services as adjusted for family size, and who are not otherwise eligible for medical assistance or the limited casualty program for the medically needy.

(2) ((~~"Committee" means the children's health services committee created in section 3 of this act.~~

~~(3)~~)) "Chronic care management" means the health care management within a health home of persons identified with, or at high risk for, one or more chronic conditions. Effective chronic care management:

(a) Actively assists patients to acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability;

(b) Employs evidence-based clinical practices;

(c) Coordinates care across health care settings and providers, including tracking referrals;

(d) Provides ready access to behavioral health services that are, to the extent possible, integrated with primary care; and

(e) Uses appropriate community resources to support individual patients and families in managing chronic conditions.

(3) "Chronic condition" means a prolonged condition and includes, but is not limited to:

(a) A mental health condition;

(b) A substance use disorder;

(c) Asthma;

(d) Diabetes;

(e) Heart disease; and

(f) Being overweight, as evidenced by a body mass index over twenty-five.

(4) "County" means the board of county commissioners, county council, county executive, or tribal jurisdiction, or its designee. A combination of two or more county authorities or tribal jurisdictions may enter into joint agreements ((~~to fulfill the requirements of RCW 74.09.415 through 74.09.435~~)).

((~~(4)~~)) (5) "Department" means the department of social and health services.

((~~(5)~~)) (6) "Department of health" means the Washington state department of health created pursuant to RCW 43.70.020.

((~~(6)~~)) (7) "Full benefit dual eligible beneficiary" means an individual who, for any month: Has coverage for the month under a medicare prescription drug plan or medicare advantage plan with part D coverage; and is determined eligible by the state for full medicaid benefits for the month under any eligibility category in the state's medicaid plan or a section 1115 demonstration waiver that provides pharmacy benefits.

((~~(7)~~)) (8) "Health home" means coordinated health care provided by a licensed primary care provider coordinating all medical care services, and a multidisciplinary health care team comprised of clinical and nonclinical staff. At a minimum, primary care health home services include:

(a) Comprehensive care management including, but not limited to, chronic care treatment and management;

(b) Extended hours of service;

(c) Multiple ways for patients to communicate with the team, including electronically and by phone;

(d) Education of patients on self-care, prevention, and health promotion, including the use of patient decision aids;

(e) Coordinating and assuring smooth transitions and follow-up from inpatient to other settings;

(f) Individual and family support including authorized representatives;

(g) The use of information technology to link services, track tests, generate patient registries, and provide clinical data; and

(h) Ongoing performance reporting and quality improvement.

(9) "Internal management" means the administration of medical assistance, medical care services, the children's health program, and the limited casualty program.

((~~(8)~~)) (10) "Limited casualty program" means the medical care program provided to medically needy persons as defined under Title XIX of the federal social security act, and to medically indigent persons who are without income or resources sufficient to secure necessary medical services.

((~~(9)~~)) (11) "Medical assistance" means the federal aid medical care program provided to categorically needy persons as defined under Title XIX of the federal social security act.

((~~(10)~~)) (12) "Medical care services" means the limited scope of care financed by state funds and provided to disability lifeline benefits recipients, and recipients of alcohol and drug addiction services provided under chapter 74.50 RCW.

((~~(11)~~)) (13) "Multidisciplinary health care team" means an interdisciplinary team of health professionals which may include, but is not limited to, medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers including substance use disorder prevention and treatment providers, doctors of chiropractic, physical therapists, licensed complementary and alternative medicine practitioners, and physicians' assistants.

(14) "Nursing home" means nursing home as defined in RCW 18.51.010.

((~~(12)~~)) (15) "Poverty" means the federal poverty level determined

1 annually by the United States department of health and human services,
2 or successor agency.

3 ((~~(13)~~)) <u>(16) "Primary care provider" means a general practice</u>
4 <u>physician, family practitioner, internist, pediatrician, osteopath,</u>
5 <u>naturopathic physician, and advanced registered nurse practitioner</u>
6 <u>licensed under Title 18 RCW.</u>

7 <u>(17)</u> "Secretary" means the secretary of social and health services.

8 **Sec. 3.** RCW 43.70.533 and 2007 c 259 s 5 are each amended to read
9 as follows:

10 (1) The department shall conduct a program of training and
11 technical assistance regarding care of people with chronic conditions
12 for providers of primary care. The program shall emphasize evidence-
13 based high quality preventive and chronic disease care <u>and shall</u>
14 <u>collaborate with the health care authority to promote the adoption of</u>
15 <u>primary care health homes established under this act</u>. The department
16 may designate one or more chronic conditions to be the subject of the
17 program.

18 (2) The training and technical assistance program shall include the
19 following elements:

20 (a) Clinical information systems and sharing and organization of
21 patient data;

22 (b) Decision support to promote evidence-based care;

23 (c) Clinical delivery system design;

24 (d) Support for patients managing their own conditions; and

25 (e) Identification and use of community resources that are
26 available in the community for patients and their families.

27 (3) In selecting primary care providers to participate in the
28 program, the department shall consider the number and type of patients
29 with chronic conditions the provider serves, and the provider's
30 participation in the medicaid program, the basic health plan, and
31 health plans offered through the public employees' benefits board.

32 <u>(4) For the purposes of this section, "health home" and "primary</u>
33 <u>care provider" have the same meaning as in RCW 74.09.010.</u>

34 **Sec. 4.** RCW 74.09.522 and 1997 c 59 s 15 and 1997 c 34 s 1 are
35 each reenacted and amended to read as follows:

36 (1) For the purposes of this section, "managed health care system"

means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, health insuring organizations, or any combination thereof, that provides directly or by contract health care services covered under RCW 74.09.520 and rendered by licensed providers, on a prepaid capitated basis and that meets the requirements of section 1903(m)(1)(A) of Title XIX of the federal social security act or federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act.

(2) The department of social and health services shall enter into agreements with managed health care systems to provide health care services to recipients of temporary assistance for needy families under the following conditions:

(a) Agreements shall be made for at least thirty thousand recipients statewide;

(b) Agreements in at least one county shall include enrollment of all recipients of temporary assistance for needy families;

(c) To the extent that this provision is consistent with section 1903(m) of Title XIX of the federal social security act or federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act, recipients shall have a choice of systems in which to enroll and shall have the right to terminate their enrollment in a system: PROVIDED, That the department may limit recipient termination of enrollment without cause to the first month of a period of enrollment, which period shall not exceed twelve months: AND PROVIDED FURTHER, That the department shall not restrict a recipient's right to terminate enrollment in a system for good cause as established by the department by rule;

(d) To the extent that this provision is consistent with section 1903(m) of Title XIX of the federal social security act, participating managed health care systems shall not enroll a disproportionate number of medical assistance recipients within the total numbers of persons served by the managed health care systems, except as authorized by the department under federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act;

(e) In negotiating with managed health care systems the department shall adopt a uniform procedure to ((~~negotiate and~~)) enter into

1 contractual arrangements, to be included in contracts issued or renewed
2 on or after January 1, 2012, including:
3 (i) Standards regarding the quality of services to be provided;
4 ((~~and~~))
5 (ii) The financial integrity of the responding system;
6 (iii) Provider reimbursement methods that incentivize chronic care
7 management within health homes;
8 (iv) Provider reimbursement methods that reward health homes that,
9 by using chronic care management, reduce emergency department and
10 inpatient use; and
11 (v) Promoting provider participation in the program of training and
12 technical assistance regarding care of people with chronic conditions
13 described in RCW 43.70.533, including allocation of funds to support
14 provider participation in the training, unless the managed care system
15 is an integrated health delivery system that has programs in place for
16 chronic care management.
17 Contracts that include the items in (e)(iii) through (v) of this
18 subsection must not exceed the rates that would be paid in the absence
19 of these provisions;
20 (f) The department shall seek waivers from federal requirements as
21 necessary to implement this chapter;
22 (g) The department shall, wherever possible, enter into prepaid
23 capitation contracts that include inpatient care. However, if this is
24 not possible or feasible, the department may enter into prepaid
25 capitation contracts that do not include inpatient care;
26 (h) The department shall define those circumstances under which a
27 managed health care system is responsible for out-of-plan services and
28 assure that recipients shall not be charged for such services; ((~~and~~))
29 (i) Nothing in this section prevents the department from entering
30 into similar agreements for other groups of people eligible to receive
31 services under this chapter; and
32 (j) The department must consult with the federal center for
33 medicare and medicaid innovation and seek funding opportunities to
34 support health homes.
35 (3) The department shall ensure that publicly supported community
36 health centers and providers in rural areas, who show serious intent
37 and apparent capability to participate as managed health care systems

are seriously considered as contractors. The department shall coordinate its managed care activities with activities under chapter 70.47 RCW.

(4) The department shall work jointly with the state of Oregon and other states in this geographical region in order to develop recommendations to be presented to the appropriate federal agencies and the United States congress for improving health care of the poor, while controlling related costs.

(5) The legislature finds that competition in the managed health care marketplace is enhanced, in the long term, by the existence of a large number of managed health care system options for medicaid clients. In a managed care delivery system, whose goal is to focus on prevention, primary care, and improved enrollee health status, continuity in care relationships is of substantial importance, and disruption to clients and health care providers should be minimized. To help ensure these goals are met, the following principles shall guide the department in its healthy options managed health care purchasing efforts:

(a) All managed health care systems should have an opportunity to contract with the department to the extent that minimum contracting requirements defined by the department are met, at payment rates that enable the department to operate as far below appropriated spending levels as possible, consistent with the principles established in this section.

(b) Managed health care systems should compete for the award of contracts and assignment of medicaid beneficiaries who do not voluntarily select a contracting system, based upon:

(i) Demonstrated commitment to or experience in serving low-income populations;

(ii) Quality of services provided to enrollees;

(iii) Accessibility, including appropriate utilization, of services offered to enrollees;

(iv) Demonstrated capability to perform contracted services, including ability to supply an adequate provider network;

(v) Payment rates; and

(vi) The ability to meet other specifically defined contract requirements established by the department, including consideration of

past and current performance and participation in other state or federal health programs as a contractor.

(c) Consideration should be given to using multiple year contracting periods.

(d) Quality, accessibility, and demonstrated commitment to serving low-income populations shall be given significant weight in the contracting, evaluation, and assignment process.

(e) All contractors that are regulated health carriers must meet state minimum net worth requirements as defined in applicable state laws. The department shall adopt rules establishing the minimum net worth requirements for contractors that are not regulated health carriers. This subsection does not limit the authority of the department to take action under a contract upon finding that a contractor's financial status seriously jeopardizes the contractor's ability to meet its contract obligations.

(f) Procedures for resolution of disputes between the department and contract bidders or the department and contracting carriers related to the award of, or failure to award, a managed care contract must be clearly set out in the procurement document. In designing such procedures, the department shall give strong consideration to the negotiation and dispute resolution processes used by the Washington state health care authority in its managed health care contracting activities.

(6) The department may apply the principles set forth in subsection (5) of this section to its managed health care purchasing efforts on behalf of clients receiving supplemental security income benefits to the extent appropriate.

Sec. 5. RCW 70.47.100 and 2009 c 568 s 5 are each amended to read as follows:

(1) A managed health care system participating in the plan shall do so by contract with the administrator and shall provide, directly or by contract with other health care providers, covered basic health care services to each enrollee covered by its contract with the administrator as long as payments from the administrator on behalf of the enrollee are current. A participating managed health care system may offer, without additional cost, health care benefits or services not included in the schedule of covered services under the plan. A

participating managed health care system shall not give preference in enrollment to enrollees who accept such additional health care benefits or services. Managed health care systems participating in the plan shall not discriminate against any potential or current enrollee based upon health status, sex, race, ethnicity, or religion. The administrator may receive and act upon complaints from enrollees regarding failure to provide covered services or efforts to obtain payment, other than authorized copayments, for covered services directly from enrollees, but nothing in this chapter empowers the administrator to impose any sanctions under Title 18 RCW or any other professional or facility licensing statute.

(2) The plan shall allow, at least annually, an opportunity for enrollees to transfer their enrollments among participating managed health care systems serving their respective areas. The administrator shall establish a period of at least twenty days in a given year when this opportunity is afforded enrollees, and in those areas served by more than one participating managed health care system the administrator shall endeavor to establish a uniform period for such opportunity. The plan shall allow enrollees to transfer their enrollment to another participating managed health care system at any time upon a showing of good cause for the transfer.

(3) Prior to negotiating with any managed health care system, the administrator shall determine, on an actuarially sound basis, the reasonable cost of providing the schedule of basic health care services, expressed in terms of upper and lower limits, and recognizing variations in the cost of providing the services through the various systems and in different areas of the state.

(4) In negotiating with managed health care systems for participation in the plan, the administrator shall adopt a uniform procedure that includes at least the following:

(a) The administrator shall issue a request for proposals, including standards regarding the quality of services to be provided; financial integrity of the responding systems; and responsiveness to the unmet health care needs of the local communities or populations that may be served;

(b) The administrator shall then review responsive proposals and may negotiate with respondents to the extent necessary to refine any proposals;

(c) The administrator may then select one or more systems to provide the covered services within a local area; and

(d) The administrator may adopt a policy that gives preference to respondents, such as nonprofit community health clinics, that have a history of providing quality health care services to low-income persons.

(5)(a) The administrator may contract with a managed health care system to provide covered basic health care services to subsidized enrollees, nonsubsidized enrollees, health coverage tax credit eligible enrollees, or any combination thereof. At a minimum, such contracts issued on or after January 1, 2012, must include:

(i) Provider reimbursement methods that incentivize chronic care management within health homes;

(ii) Provider reimbursement methods that reward health homes that, by using chronic care management, reduce emergency department and inpatient use; and

(iii) Promoting provider participation in the program of training and technical assistance regarding care of people with chronic conditions described in RCW 43.70.533, including allocation of funds to support provider participation in the training unless the managed care system is an integrated health delivery system that has programs in place for chronic care management.

(b) For the purposes of this subsection, "chronic care management," "chronic condition," and "health home" have the same meaning as in RCW 74.09.010.

(c) Contracts that include the items in (a)(i) through (iii) of this subsection must not exceed the rates that would be paid in the absence of these provisions.

(6) The administrator may establish procedures and policies to further negotiate and contract with managed health care systems following completion of the request for proposal process in subsection (4) of this section, upon a determination by the administrator that it is necessary to provide access, as defined in the request for proposal documents, to covered basic health care services for enrollees.

(7) The administrator may implement a self-funded or self-insured method of providing insurance coverage to subsidized enrollees, as provided under RCW 41.05.140. Prior to implementing a self-funded or self-insured method, the administrator shall ensure that funding

available in the basic health plan self-insurance reserve account is sufficient for the self-funded or self-insured risk assumed, or expected to be assumed, by the administrator. If implementing a self-funded or self-insured method, the administrator may request funds to be moved from the basic health plan trust account or the basic health plan subscription account to the basic health plan self-insurance reserve account established in RCW 41.05.140.

Sec. 6. RCW 41.05.021 and 2009 c 537 s 4 are each amended to read as follows:

(1) The Washington state health care authority is created within the executive branch. The authority shall have an administrator appointed by the governor, with the consent of the senate. The administrator shall serve at the pleasure of the governor. The administrator may employ up to seven staff members, who shall be exempt from chapter 41.06 RCW, and any additional staff members as are necessary to administer this chapter. The administrator may delegate any power or duty vested in him or her by this chapter, including authority to make final decisions and enter final orders in hearings conducted under chapter 34.05 RCW. The primary duties of the authority shall be to: Administer state employees' insurance benefits and retired or disabled school employees' insurance benefits; administer the basic health plan pursuant to chapter 70.47 RCW; study state-purchased health care programs in order to maximize cost containment in these programs while ensuring access to quality health care; implement state initiatives, joint purchasing strategies, and techniques for efficient administration that have potential application to all state-purchased health services; and administer grants that further the mission and goals of the authority. The authority's duties include, but are not limited to, the following:

(a) To administer health care benefit programs for employees and retired or disabled school employees as specifically authorized in RCW 41.05.065 and in accordance with the methods described in RCW 41.05.075, 41.05.140, and other provisions of this chapter;

(b) To analyze state-purchased health care programs and to explore options for cost containment and delivery alternatives for those programs that are consistent with the purposes of those programs, including, but not limited to:

(i) Creation of economic incentives for the persons for whom the state purchases health care to appropriately utilize and purchase health care services, including the development of flexible benefit plans to offset increases in individual financial responsibility;

(ii) Utilization of provider arrangements that encourage cost containment, including but not limited to prepaid delivery systems, utilization review, and prospective payment methods, and that ensure access to quality care, including assuring reasonable access to local providers, especially for employees residing in rural areas;

(iii) Coordination of state agency efforts to purchase drugs effectively as provided in RCW 70.14.050;

(iv) Development of recommendations and methods for purchasing medical equipment and supporting services on a volume discount basis;

(v) Development of data systems to obtain utilization data from state-purchased health care programs in order to identify cost centers, utilization patterns, provider and hospital practice patterns, and procedure costs, utilizing the information obtained pursuant to RCW 41.05.031; and

(vi) In collaboration with other state agencies that administer state purchased health care programs, private health care purchasers, health care facilities, providers, and carriers:

(A) Use evidence-based medicine principles to develop common performance measures and implement financial incentives in contracts with insuring entities, health care facilities, and providers that:

(I) Reward improvements in health outcomes for individuals with chronic diseases, increased utilization of appropriate preventive health services, and reductions in medical errors; and

(II) Increase, through appropriate incentives to insuring entities, health care facilities, and providers, the adoption and use of information technology that contributes to improved health outcomes, better coordination of care, and decreased medical errors;

(B) Through state health purchasing, reimbursement, or pilot strategies, promote and increase the adoption of health information technology systems, including electronic medical records, by hospitals as defined in RCW 70.41.020(4), integrated delivery systems, and providers that:

(I) Facilitate diagnosis or treatment;

(II) Reduce unnecessary duplication of medical tests;

1 (III) Promote efficient electronic physician order entry;
2 (IV) Increase access to health information for consumers and their
3 providers; and
4 (V) Improve health outcomes;
5 (C) Coordinate a strategy for the adoption of health information
6 technology systems using the final health information technology report
7 and recommendations developed under chapter 261, Laws of 2005;
8 (c) To analyze areas of public and private health care interaction;
9 (d) To provide information and technical and administrative
10 assistance to the board;
11 (e) To review and approve or deny applications from counties,
12 municipalities, and other political subdivisions of the state to
13 provide state-sponsored insurance or self-insurance programs to their
14 employees in accordance with the provisions of RCW 41.04.205 and (g) of
15 this subsection, setting the premium contribution for approved groups
16 as outlined in RCW 41.05.050;
17 (f) To review and approve or deny the application when the
18 governing body of a tribal government applies to transfer their
19 employees to an insurance or self-insurance program administered under
20 this chapter. In the event of an employee transfer pursuant to this
21 subsection (1)(f), members of the governing body are eligible to be
22 included in such a transfer if the members are authorized by the tribal
23 government to participate in the insurance program being transferred
24 from and subject to payment by the members of all costs of insurance
25 for the members. The authority shall: (i) Establish the conditions
26 for participation; (ii) have the sole right to reject the application;
27 and (iii) set the premium contribution for approved groups as outlined
28 in RCW 41.05.050. Approval of the application by the authority
29 transfers the employees and dependents involved to the insurance,
30 self-insurance, or health care program approved by the authority;
31 (g) To ensure the continued status of the employee insurance or
32 self-insurance programs administered under this chapter as a
33 governmental plan under section 3(32) of the employee retirement income
34 security act of 1974, as amended, the authority shall limit the
35 participation of employees of a county, municipal, school district,
36 educational service district, or other political subdivision, or a
37 tribal government, including providing for the participation of those

employees whose services are substantially all in the performance of essential governmental functions, but not in the performance of commercial activities;

(h) To establish billing procedures and collect funds from school districts in a way that minimizes the administrative burden on districts;

(i) To publish and distribute to nonparticipating school districts and educational service districts by October 1st of each year a description of health care benefit plans available through the authority and the estimated cost if school districts and educational service district employees were enrolled;

(j) To apply for, receive, and accept grants, gifts, and other payments, including property and service, from any governmental or other public or private entity or person, and make arrangements as to the use of these receipts to implement initiatives and strategies developed under this section;

(k) To issue, distribute, and administer grants that further the mission and goals of the authority;

(l) To adopt rules consistent with this chapter as described in RCW 41.05.160 including, but not limited to:

(i) Setting forth the criteria established by the board under RCW 41.05.065 for determining whether an employee is eligible for benefits;

(ii) Establishing an appeal process in accordance with chapter 34.05 RCW by which an employee may appeal an eligibility determination;

(iii) Establishing a process to assure that the eligibility determinations of an employing agency comply with the criteria under this chapter, including the imposition of penalties as may be authorized by the board.

(2) On and after January 1, 1996, the public employees' benefits board may implement strategies to promote managed competition among employee health benefit plans. Strategies may include but are not limited to:

(a) Standardizing the benefit package;

(b) Soliciting competitive bids for the benefit package;

(c) Limiting the state's contribution to a percent of the lowest priced qualified plan within a geographical area;

(d) Monitoring the impact of the approach under this subsection with regards to: Efficiencies in health service delivery, cost shifts

to subscribers, access to and choice of managed care plans statewide, and quality of health services. The health care authority shall also advise on the value of administering a benchmark employer-managed plan to promote competition among managed care plans.

(3)(a) The authority must enter into contracts with all the managed care plans and for the self-insured plan or plans, to be implemented as soon as possible but no later than 2013, that include:

(i) Provider reimbursement methods that incentivize chronic care management within health homes;

(ii) Provider reimbursement methods that reward health homes that, by using chronic care management, reduce emergency department and inpatient use; and

(iii) Promoting provider participation in the program of training and technical assistance regarding care of people with chronic conditions described in RCW 43.70.533, including allocating funds for provider participation in the training unless the managed care system is an integrated health delivery system that has programs in place for chronic care management.

(b) For the purposes of this subsection, "chronic care management," and "health home" have the same meaning as in RCW 74.09.010.

(c) Contracts with fully insured plans that include the items in (a)(i) through (iii) of this subsection must be funded within the resources provided by employer funding rates provided for employee health benefits in the omnibus appropriations act.

(d) Funding for the items in (a)(i) through (iii) of this subsection in self-insured plans must not increase the resources provided by employer funding rates provided for employee health benefits in the omnibus appropriations act in the absence of these provisions.

NEW SECTION. **Sec. 7.** A new section is added to chapter 41.05 RCW to read as follows:

(1) The legislature finds that collaboration among public payers, private health carriers, third-party payers, and providers to identify appropriate reimbursement methods to align incentives in support of patient centered health homes is necessary to implement the requirements of this act. The legislature therefore declares its intent to exempt from state antitrust laws, and to provide immunity

from federal antitrust laws, through the state action doctrine, the collaborative and associated payment reforms designed and implemented under this section that might otherwise be constrained by such laws. The legislature does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state or federal antitrust laws including, but not limited to, agreements among competing health care providers or health carriers as to the prices of specific levels of reimbursement for health care services.

(2) The legislature recognizes that many Washingtonians are covered by health plans regulated by the federal government, including self-insured and Taft-Hartley plans. While such plans are largely outside the state's purview, they share with the state an interest in containing health care costs and promoting quality of care. The legislature recognizes that the participation of such plans in the state's efforts to promote health homes and reform payment methods would greatly increase the likelihood of success of such efforts.

(3) The administrator shall establish a collaborative work group process to encourage input from and participation by such plans to work with the state and carriers to promote health homes and to learn from the experience of the health care authority for successful implementation of health homes for employees with chronic and multiple conditions.

(4) Beginning December 1, 2012, the administrator must report to the legislature annually on the efforts of the collaborative work group to broadly implement health homes. The report must also document the efforts to integrate health homes in the publicly purchased programs administered under this chapter and chapters 74.09 and 70.47 RCW.

(5) The administrator may write rules to establish the information that insurance carriers must submit for inclusion in the annual report to the legislature.

(6) For the purposes of this section, "chronic condition" and "health home" have the same meaning as in RCW 74.09.010.

NEW SECTION. **Sec. 8.** A new section is added to chapter 48.43 RCW to read as follows:

Each carrier licensed under this title and providing a comprehensive health plan in the state shall participate in the

1 collaborative work group established in section 7 of this act and
2 submit information the health care authority requires for the annual
3 report to the legislature.

--- END ---