S-4147.3

SUBSTITUTE SENATE BILL 6107

State of Washington 62nd Legislature 2012 Regular Session

By Senate Health & Long-Term Care (originally sponsored by Senators Becker, Keiser, Conway, Swecker, Pridemore, Harper, King, Kilmer, Schoesler, Fain, Frockt, Haugen, Honeyford, Hatfield, Hill, and Parlette)

READ FIRST TIME 01/30/12.

1 AN ACT Relating to prescription review for medicaid managed care
2 enrollees; and reenacting and amending RCW 74.09.522.

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

4 **Sec. 1.** RCW 74.09.522 and 2011 1st sp.s. c 15 s 29, 2011 1st sp.s.
5 c 9 s 2, and 2011 c 316 s 4 are each reenacted and amended to read as
6 follows:
7 (1) For the purposes of this section:
8 (a) "Comprehensive medication management process" means the
9 provision of the following services utilizing the professional practice
10 of pharmaceutical care by a licensed pharmacist for patients taking
11 five or more medications for two or more chronic medical conditions:
12 (i) Assessment of the patient's health status including the
13 personal medication experience and use patterns of all prescribed and
14 over-the-counter medications;
15 (ii) Documentation of the patient's current clinical status and
16 clinical goals of therapy;
17 (iii) Assessment of each medication for appropriateness,
18 effectiveness, safety, and adherence focusing on achievement of desired
19 clinical goals;

(iv) Identification of all drug therapy problems including additions or deletions in medications or changes in dosage needed to meet desired clinical goals;

(v) Development of a comprehensive medication therapy plan for the patient in consultation with the prescribing practitioner; and

(vi) Documentation and follow up of the effects of recommended drug therapy changes on the patient's clinical status and outcomes;

(b) "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 this chapter 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;

((~~(b)~~)) (c) "Nonparticipating provider" means a person, health care provider, practitioner, facility, or entity, acting within their scope of practice, that does not have a written contract to participate in a managed health care system's provider network, but provides health care services to enrollees of programs authorized under this chapter whose health care services are provided by the managed health care system.

(2) The authority 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 authority may limit recipient termination of enrollment without cause to the first month of a period of enrollment, which period shall not exceed twelve months:

1 AND PROVIDED FURTHER, That the authority shall not restrict a
2 recipient's right to terminate enrollment in a system for good cause as
3 established by the authority by rule;

4 (d) To the extent that this provision is consistent with section
5 1903(m) of Title XIX of the federal social security act, participating
6 managed health care systems shall not enroll a disproportionate number
7 of medical assistance recipients within the total numbers of persons
8 served by the managed health care systems, except as authorized by the
9 authority under federal demonstration waivers granted under section
10 1115(a) of Title XI of the federal social security act;

11 (e)(i) In negotiating with managed health care systems the
12 authority shall adopt a uniform procedure to enter into contractual
13 arrangements, to be included in contracts issued or renewed on or after
14 January 1, 2012, including:

15 (A) Standards regarding the quality of services to be provided;

16 (B) The financial integrity of the responding system;

17 (C) Provider reimbursement methods that incentivize chronic care
18 management <u>and comprehensive medication management services</u> within
19 health homes;

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

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

29 (ii)(A) Health home services contracted for under this subsection
30 may be prioritized to enrollees with complex, high cost, or multiple
31 chronic conditions.

32 (B) Contracts that include the items in (e)(i)(C) through (E) of
33 this subsection must not exceed the rates that would be paid in the
34 absence of these provisions;

35 (f) The authority shall seek waivers from federal requirements as
36 necessary to implement this chapter;

37 (g) The authority shall, wherever possible, enter into prepaid

capitation contracts that include inpatient care. However, if this is not possible or feasible, the authority may enter into prepaid capitation contracts that do not include inpatient care;

(h) The authority shall define those circumstances under which a managed health care system is responsible for out-of-plan services and assure that recipients shall not be charged for such services;

(i) Nothing in this section prevents the authority from entering into similar agreements for other groups of people eligible to receive services under this chapter; and

(j) The department must consult with the federal center for medicare and medicaid innovation and seek funding opportunities to support health homes.

(3) The authority shall ensure that publicly supported community health centers and providers in rural areas, who show serious intent and apparent capability to participate as managed health care systems are seriously considered as contractors. The authority shall coordinate its managed care activities with activities under chapter 70.47 RCW.

(4) The authority 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 authority in its healthy options managed health care purchasing efforts:

(a) All managed health care systems should have an opportunity to contract with the authority to the extent that minimum contracting requirements defined by the authority are met, at payment rates that enable the authority 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 authority, 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 authority 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 Washington state health care authority 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 authority and contract bidders or the authority 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.

(6) The authority 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.

(7) A managed health care system shall pay a nonparticipating provider that provides a service covered under this chapter to the system's enrollee no more than the lowest amount paid for that service under the managed health care system's contracts with similar providers in the state.

(8) For services covered under this chapter to medical assistance or medical care services enrollees and provided on or after August 24, 2011, nonparticipating providers must accept as payment in full the amount paid by the managed health care system under subsection (7) of this section in addition to any deductible, coinsurance, or copayment that is due from the enrollee for the service provided. An enrollee is not liable to any nonparticipating provider for covered services, except for amounts due for any deductible, coinsurance, or copayment under the terms and conditions set forth in the managed health care system contract to provide services under this section.

(9) Pursuant to federal managed care access standards, 42 C.F.R. Sec. 438, managed health care systems must maintain a network of appropriate providers that is supported by written agreements sufficient to provide adequate access to all services covered under the contract with the department, including hospital-based physician services. The department will monitor and periodically report on the proportion of services provided by contracted providers and nonparticipating providers, by county, for each managed health care system to ensure that managed health care systems are meeting network adequacy requirements. No later than January 1st of each year, the department will review and report its findings to the appropriate policy and fiscal committees of the legislature for the preceding state fiscal year.

(10) Subsections (7) through (9) of this section expire July 1, 2016.

(11) Contracts with managed care plans must include a requirement that any patient with five or more medications for two or more chronic medical conditions be placed in a comprehensive medication management process with the primary care provider or Washington state licensed pharmacist to ensure all the prescriptions are medically appropriate and to review for drug interactions and opportunities to improve

1 clinical outcomes and reduce emergency care.

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