Chapter 74.09 RCW
MEDICAL CARE

Sections

MATERNITY CARE ACCESS PROGRAM

RCW 74.09.010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Authority" means the Washington state health care authority.

(2) "Bidirectional integration" means integrating behavioral health services into primary care settings and integrating primary care services into behavioral health settings.

(3) "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.

(4) "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.

(5) "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.

(6) "County" means the board of county commissioners, county council, county executive, or tribal jurisdiction, or its designee.

(7) "Department" means the department of social and health services.

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

(9) "Director" means the director of the Washington state health care authority.

(10) "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.

(11) "Health home" or "primary care 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. The term "coordinating all medical care services" shall not be construed to require prior authorization by a primary care provider in order for a patient to receive treatment for covered services by an optometrist licensed under chapter 18.53 RCW. Primary care health home services shall include those services defined as health home services in 42

U.S.C. Sec. 1396w-4 and, in addition, may include, but are not limited to:

(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.

(12) "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.

(13) "Managed care organization" means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, health insuring organizations, or any other entity or 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.

(14) "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.

(15) "Medical care services" means the limited scope of care financed by state funds and provided to persons who are not eligible for medicaid under RCW 74.09.510 and who are eligible for the aged, blind, or disabled assistance program authorized in RCW 74.62.030 or the essential needs and housing support program pursuant to RCW 74.04.805.

(16) "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, home care and other long-term care providers, and physicians' assistants.

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

(18) "Poverty" means the federal poverty level determined annually by the United States department of health and human services, or successor agency.

(19) "Primary care behavioral health" means a health care integration model in which behavioral health care is colocated, collaborative, and integrated within a primary care setting.

(20) "Primary care provider" means a general practice physician, family practitioner, internist, pediatrician, osteopathic physician, naturopath, physician assistant, and advanced registered nurse practitioner licensed under Title 18 RCW.

(21) "Secretary" means the secretary of social and health services.

(22) "Whole-person care in behavioral health" means a health care integration model in which primary care services are integrated into a behavioral health setting either through colocation or community-based care management. [2023 c 51 § 33; 2020 c 80 § 55; 2017 c 226 § 5; 2013 2nd sp.s. c 10 § 8. Prior: 2011 1st sp.s. c 15 § 2; 2011 c 316 § 2; prior: 2010 1st sp.s. c 8 § 28; 2007 c 3 § 2; 1990 c 296 § 6; 1987 c 406 § 11; 1981 1st ex.s. c 6 § 18; 1981 c 8 § 17; 1979 c 141 § 333; 1959 c 26 § 74.09.010; prior: 1955 c 273 § 2.]

Effective date—2020 c 80 §§ 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

Sustainable solutions for the integration of behavioral and physical health—2017 c 226: See note following RCW 74.09.497.

Effective date—2013 2nd sp.s. c 10: See note following RCW 74.62.030.

Effective date—2011 1st sp.s. c 15: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 1, 2011." [2011 1st sp.s. c 15 § 130.]

Findings—Intent—2011 1st sp.s. c 15: "The legislature finds that:

(1) Washington state government must be organized to be efficient, cost-effective, and responsive to its residents;

(2) The cost of state purchased health care continues to grow at an unsustainable rate, now representing nearly one-third of the state's budget and hindering our ability to invest in other essential services such as education and public safety;

(3) Responsibility for state health care purchasing is currently spread over multiple agencies, but successful interagency collaboration on quality and cost initiatives has helped demonstrate the benefits to the state of centralized health care purchasing;

(4) Consolidating the majority of state health care purchasing into a single state agency will best position the state to work with others, including private sector purchasers, health insurance carriers, health care providers, and consumers to increase the quality and affordability of health care for all state residents;

(5) The development and implementation of uniform state policies for all state purchased health care is among the purposes for which the health care authority was originally created; and

(6) The state will be best able to take advantage of the opportunities and meet its obligations under the federal affordable care act, including establishment of a health benefit exchange and medicaid expansion, if primary responsibility for doing so rests with a single state agency.

The legislature therefore intends, where appropriate, to consolidate state health care purchasing within the health care authority, positioning the state to use its full purchasing power to get the greatest value for its money, and allowing other agencies to focus even more intently on their core missions." [2011 1st sp.s. c 15 § 1.]

Report—2011 1st sp.s. c 15: "(1) By December 10, 2011, the department of social and health services and the health care authority shall provide a preliminary report, and by December 1, 2012, provide a final implementation plan, to the governor and the legislature with recommendations regarding the role of the health care authority in the state's purchasing of mental health treatment, substance abuse treatment, and long-term care services, including services for those with developmental disabilities.

(2) The reports shall:

(a) Consider options for effectively coordinating the purchase and delivery of care for people who need long-term care, developmental disabilities, mental health, or chemical dependency services. Options considered may include, but are not limited to, transitioning purchase of these services from the department of social and health services to the health care authority, and strategies for the agencies to collaborate seamlessly while purchasing services separately; and

(b) Address the following components:

(i) Incentives to improve prevention efforts;

(ii) Service delivery approaches, including models for care management and care coordination and benefit design;

(iii) Rules to assure that those requiring long-term care services and supports receive that care in the least restrictive setting appropriate to their needs;

(iv) Systems to measure cost savings;

(v) Mechanisms to measure health outcomes and consumer satisfaction;

(vi) The designation of a single point of entry for financial and functional eligibility determinations for long-term care services; and

(vii) Process for collaboration with local governments.

(3) In developing these recommendations, the agencies shall:

(a) Consult with tribal governments and with interested stakeholders, including consumers, health care and other service providers, health insurance carriers, and local governments; and

(b) Cooperate with the joint select committee on health reform implementation established in House Concurrent Resolution No. 4404 and any of its advisory committees. The agencies shall strongly consider the guidance and input received from these forums in the development of its recommendations.

(4) The agencies shall submit a progress report to the governor and the legislature by November 15, 2013, that provides details on the agencies' progress on purchasing coordination to date." [2011 1st sp.s. c 15 § 116.]

Agency transfer—2011 1st sp.s. c 15: "(1) All powers, duties, and functions of the department of social and health services pertaining to the medical assistance program and the medicaid purchasing administration are transferred to the health care authority to the extent necessary to carry out the purposes of this act. All references to the secretary or the department of social and health

services in the Revised Code of Washington shall be construed to mean the director or the health care authority when referring to the functions transferred in this section.

(2)(a) All reports, documents, surveys, books, records, files, papers, or written material in the possession of the department of social and health services pertaining to the powers, functions, and duties transferred shall be delivered to the custody of the health care authority. All cabinets, furniture, office equipment, motor vehicles, and other tangible property employed by the department of social and health services in carrying out the powers, functions, and duties transferred shall be made available to the health care authority. All funds, credits, or other assets held in connection with the powers, functions, and duties transferred shall be assigned to the health care authority.

(b) Any appropriations made to the department of social and health services for carrying out the powers, functions, and duties transferred shall, on July 1, 2011, be transferred and credited to the health care authority.

(c) Whenever any question arises as to the transfer of any personnel, funds, books, documents, records, papers, files, equipment, or other tangible property used or held in the exercise of the powers and the performance of the duties and functions transferred, the director of financial management shall make a determination as to the proper allocation and certify the same to the state agencies concerned.

(3) All employees of the medicaid purchasing administration at the department of social and health services are transferred to the jurisdiction of the health care authority. All employees classified under chapter 41.06 RCW, the state civil service law, are assigned to the health care authority to perform their usual duties upon the same terms as formerly, without any loss of rights, subject to any action that may be appropriate thereafter in accordance with the laws and rules governing state civil service.

(4) All rules and all pending business before the department of social and health services pertaining to the powers, functions, and duties transferred shall be continued and acted upon by the health care authority. All existing contracts and obligations shall remain in full force and shall be performed by the health care authority.

(5) The transfer of the powers, duties, functions, and personnel of the department of social and health services shall not affect the validity of any act performed before July 1, 2011.

(6) If apportionments of budgeted funds are required because of the transfers directed by this section, the director of financial management shall certify the apportionments to the agencies affected, the state auditor, and the state treasurer. Each of these shall make the appropriate transfer and adjustments in funds and appropriation accounts and equipment records in accordance with the certification.

(7) A nonsupervisory medicaid purchasing unit bargaining unit is created at the health care authority. All nonsupervisory civil service employees of the medicaid purchasing administration at the department of social and health services assigned to the health care authority under this section whose positions are within the existing bargaining unit description at the department of social and health services shall become a part of the nonsupervisory medicaid purchasing unit bargaining unit at the health care authority under the provisions of chapter 41.80 RCW. The exclusive bargaining representative of the existing bargaining unit at the department of social and health

services is certified as the exclusive bargaining representative of the nonsupervisory medicaid purchasing unit bargaining unit at the health care authority without the necessity of an election.

(8) A supervisory medicaid purchasing unit bargaining unit is created at the health care authority. All supervisory civil service employees of the medicaid purchasing administration at the department of social and health services assigned to the health care authority under this section whose positions are within the existing bargaining unit description at the department of social and health services shall become a part of the supervisory medicaid purchasing unit bargaining unit at the health care authority under the provisions of chapter 41.80 RCW. The exclusive bargaining representative of the existing bargaining unit at the department of social and health services is certified as the exclusive bargaining representative of the supervisory medicaid purchasing unit bargaining unit at the health care authority without the necessity of an election.

(9) The bargaining units of employees created under this section are appropriate units under the provisions of chapter 41.80 RCW. However, nothing contained in this section shall be construed to alter the authority of the public employment relations commission under the provisions of chapter 41.80 RCW to amend or modify the bargaining units.

(10) Positions from the department of social and health services central administration are transferred to the jurisdiction of the health care authority. Employees classified under chapter 41.06 RCW, the state civil service law, are assigned to the health care authority to perform their usual duties upon the same terms as formerly, without any loss of rights, subject to any action that may be appropriate thereafter in accordance with the laws and rules governing state civil service.

(11) All classified employees of the department of social and health services central administration assigned to the health care authority under subsection (10) of this section whose positions are within an existing bargaining unit description at the health care authority shall become a part of the existing bargaining unit at the health care authority and shall be considered an appropriate inclusion or modification of the existing bargaining unit under the provisions of chapter 41.80 RCW." [2011 1st sp.s. c 15 § 124.]

References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: "The code reviser shall note wherever "administrator" is used or referred to in the Revised Code of Washington as the head of the health care authority that the title of the agency head has been changed to "director." The code reviser shall prepare legislation for the 2012 regular session that changes all statutory references to "administrator" of the health care authority to "director" of the health care authority." [2011 1st sp.s. c 15 § 125.]

Findings—Intent—Short title—Effective date—2010 1st sp.s. c 8: See notes following RCW 74.04.225.

Effective date—1990 c 296: "This act shall take effect July 1, 1990." [1990 c 296 § 9.]

Effective date—Severability—1981 1st ex.s. c 6: See notes following RCW 74.04.005.

RCW 74.09.015 Nurse hotline, when funded. To the extent that sufficient funding is provided specifically for this purpose, the authority shall provide all persons receiving services under this chapter with access to a twenty-four hour, seven day a week nurse hotline. The authority shall determine the most appropriate way to provide the nurse hotline under RCW 41.05.037 and this section, which may include use of the 211 system established in chapter 43.211 RCW. [2011 1st sp.s. c 15 § 122; 2007 c 259 § 16.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Subheadings not law—2007 c 259: See note following RCW 7.70.060.

RCW 74.09.035 Medical care services—Eligibility, standards—Limits. (1) To the extent of available funds, medical care services may be provided to:

(a) Victims of human trafficking, as defined in RCW 74.04.005, who are not eligible for medicaid under RCW 74.09.510, section 1902(a)(10)(A)(i)(VIII) of the social security act, or apple health for kids under RCW 74.09.470, who otherwise qualify for state family assistance programs under RCW 74.04.820;

(b) Persons eligible for the aged, blind, or disabled assistance program authorized in RCW 74.62.030 and who are not eligible for medicaid under RCW 74.09.510; and

(c) Persons eligible for essential needs and housing support under RCW 74.04.805 and who are not eligible for medicaid under RCW 74.09.510.

(2) Enrollment in medical care services may not result in expenditures that exceed the amount that has been appropriated in the operating budget. If it appears that continued enrollment will result in expenditures exceeding the appropriated level for a particular fiscal year, the department may freeze new enrollment and establish a waiting list of persons who may receive benefits only when sufficient funds are available.

(3) Determination of the amount, scope, and duration of medical care services shall be limited to coverage as defined by the authority, except that adult dental, and routine foot care shall not be included unless there is a specific appropriation for these services.

(4) The authority shall enter into performance-based contracts with one or more managed health care systems for the provision of medical care services under this section. The contract must provide for integrated delivery of medical and mental health services.

(5) The authority shall establish standards of assistance and resource and income exemptions, which may include deductibles and coinsurance provisions. In addition, the authority may include a prohibition against the voluntary assignment of property or cash for the purpose of qualifying for assistance.

(6) Eligibility for medical care services shall commence with the date of eligibility for the aged, blind, or disabled assistance program provided under RCW 74.62.030 or the date of eligibility for the essential needs and housing support program under RCW 74.04.805.

(7) To the extent possible, the authority must coordinate with the department of social and health services, food assistance programs for legal immigrants, state family assistance programs, and refugee cash assistance programs. [2020 c 136 § 4; 2013 2nd sp.s. c 10 § 7. Prior: 2011 1st sp.s. c 36 § 6; 2011 1st sp.s. c 15 § 3; 2011 c 284 § 3; prior: 2010 1st sp.s. c 8 § 29; 2010 c 94 § 22; 1987 c 406 § 12; 1985 c 5 § 1; 1983 1st ex.s. c 43 § 2; 1982 1st ex.s. c 19 § 3; 1981 1st ex.s. c 6 § 19.]

Effective date—2020 c 136: See note following RCW 74.04.005.

Effective date—2013 2nd sp.s. c 10: See note following RCW 74.62.030.

Effective date—2011 1st sp.s. c 36 § 6: "Section 6 of this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 22, 2011." [2011 1st sp.s. c 36 § 39.]

Findings—Intent—2011 1st sp.s. c 36: See RCW 74.62.005.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Implementation—2010 1st sp.s. c 8 §§ 1-10 and 29: See note following RCW 74.04.225.

Findings—Intent—Short title—Effective date—2010 1st sp.s. c 8: See notes following RCW 74.04.225.

Purpose—2010 c 94: See note following RCW 44.04.280.

Effective date—1983 1st ex.s. c 43: See note following RCW 74.09.700.

Effective date—1982 1st ex.s. c 19: "This act is necessary for the immediate preservation of the public peace, health, and safety, the support of the state government and its existing public institutions, and shall take effect April 1, 1982 [April 3, 1982]." [1982 1st ex.s. c 19 § 6.]

Effective date—Severability—1981 1st ex.s. c 6: See notes following RCW 74.04.005.

RCW 74.09.037 Identification card—Social security number restriction. Any card issued by the authority or a managed health care system to a person receiving services under this chapter, that must be presented to providers for purposes of claims processing, may not display an identification number that includes more than a four-

digit portion of the person's complete social security number. [2011 1st sp.s. c 15 § 4; 2004 c 115 § 3.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.050 Director's powers and duties—Personnel—Medical screeners—Medical director. (1) The director shall appoint such professional personnel and other assistants and employees, including professional medical screeners, as may be reasonably necessary to carry out the provisions of this chapter or other applicable law. The medical screeners shall be supervised by one or more physicians who shall be appointed by the director or his or her designee. The director shall appoint a medical director who is licensed under chapter 18.57 or 18.71 RCW.

(2) Whenever the director's authority is not specifically limited by law, he or she has complete charge and supervisory powers over the authority. The director is authorized to create such administrative structures as deemed appropriate, except as otherwise specified by law. The director has the power to employ such assistants and personnel as may be necessary for the general administration of the authority. Except as elsewhere specified, such employment must be in accordance with the rules of the state civil service law, chapter 41.06 RCW. [2018 c 201 § 7004; 2011 1st sp.s. c 15 § 5; 2000 c 5 § 15; 1979 c 141 § 335; 1959 c 26 § 74.09.050. Prior: 1955 c 273 § 6.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Intent—Purpose—2000 c 5: See RCW 48.43.500.

Application—Short title—Captions not law—Construction—Severability—Application to contracts—Effective dates—2000 c 5: See notes following RCW 48.43.500.

RCW 74.09.053 Annual reporting requirement. (1) Beginning in November 2012, the department of social and health services, in coordination with the health care authority, shall by November 15th of each year report to the legislature:

(a) The number of medical assistance recipients who: (i) Upon enrollment or recertification had reported being employed, and beginning with the 2008 report, the month and year they reported being hired; or (ii) upon enrollment or recertification had reported being the dependent of someone who was employed, and beginning with the 2008 report, the month and year they reported the employed person was hired. For recipients identified under (a)(i) and (ii) of this subsection, the department shall report the basis for their medical assistance eligibility, including but not limited to family medical coverage, transitional medical assistance, children's medical

coverage, aged coverage, or coverage for individuals with disabilities; member months; and the total cost to the state for these recipients, expressed as general fund-state and general fund-federal dollars. The information shall be reported by employer size for employers having more than fifty employees as recipients or with dependents as recipients. This information shall be provided for the preceding January and June of that year.

(b) The following aggregated information: (i) The number of employees who are recipients or with dependents as recipients by private and governmental employers; (ii) the number of employees who are recipients or with dependents as recipients by employer size for employers with fifty or fewer employees, fifty-one to one hundred employees, one hundred one to one thousand employees, one thousand one to five thousand employees and more than five thousand employees; and (iii) the number of employees who are recipients or with dependents as recipients by industry type.

(2) For each aggregated classification, the report will include the number of hours worked, the number of department of social and health services covered lives, and the total cost to the state for these recipients. This information shall be for each quarter of the preceding year. [2023 c 51 § 34. Prior: 2009 c 568 § 6; 2009 c 479 § 62; 2006 c 264 § 2.]

Effective date—2009 c 479: See note following RCW 2.56.030.

RCW 74.09.055 Copayment, deductible, coinsurance, other cost-sharing requirements authorized. The authority is authorized to establish copayment, deductible, or coinsurance, or other cost-sharing requirements for recipients of any medical programs defined in RCW 74.09.010 or other applicable law, except that premiums shall not be imposed on children in households at or below two hundred percent of the federal poverty level. [2018 c 201 § 7005; 2011 1st sp.s. c 15 § 6; 2006 c 24 § 1; 2003 1st sp.s. c 14 § 1; 1993 c 492 § 231; 1982 c 201 § 19.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Effective date—2003 1st sp.s. c 14: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 1, 2003." [2003 1st sp.s. c 14 § 2.]

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

RCW 74.09.075 Employability and disability evaluation—Medical condition—Medical reports—Medical consultations and assistance. The

department or authority, as appropriate, shall provide (1) for evaluation of employability when a person is applying for public assistance representing a medical condition as a basis for need, and (2) for medical reports to be used in the evaluation of total and permanent disability. It shall further provide for medical consultation and assistance in determining the need for special diets, housekeeper and attendant services, and other requirements as found necessary because of the medical condition under the rules promulgated by the secretary or director. [2011 1st sp.s. c 15 § 7; 1979 c 141 § 337; 1967 ex.s. c 30 § 2.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.080 Methods of performing administrative responsibilities. In carrying out the administrative responsibility of this chapter or other applicable law, the department or authority, as appropriate:

(1) May contract with an individual or a group, may utilize existing local state public assistance offices, or establish separate welfare medical care offices on a county or multicounty unit basis as found necessary; and

(2) Shall determine both financial and functional eligibility for persons applying for long-term care services under chapter 74.39 or 74.39A RCW as a unified process in a single long-term care organizational unit. [2018 c 201 § 7006; 2011 1st sp.s. c 15 § 8; 1979 c 141 § 338; 1959 c 26 § 74.09.080. Prior: 1955 c 273 § 9.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.120 Purchases of services, care, supplies—Nursing homes—Veterans' homes—Institutions for persons with intellectual disabilities—Institutions for mental diseases. (1) The department shall purchase nursing home care by contract and payment for the care shall be in accordance with the provisions of chapter 74.46 RCW and rules adopted by the department. No payment shall be made to a nursing home which does not permit inspection by the authority and the department of every part of its premises and an examination of all records, including financial records, methods of administration, general and special dietary programs, the disbursement of drugs and methods of supply, and any other records the authority or the department deems relevant to the regulation of nursing home operations, enforcement of standards for resident care, and payment for nursing home services.

(2) The department may purchase nursing home care by contract in veterans' homes operated by the state department of veterans affairs and payment for the care shall be in accordance with the provisions of

chapter 74.46 RCW and rules adopted by the department under the authority of RCW 74.46.800.

(3) The department may purchase care in institutions for persons with intellectual disabilities, also known as intermediate care facilities for persons with intellectual disabilities. The department shall establish rules for reasonable accounting and reimbursement systems for such care. Institutions for persons with intellectual disabilities include licensed nursing homes, public institutions, licensed assisted living facilities with fifteen beds or less, and hospital facilities certified as intermediate care facilities for persons with intellectual disabilities under the federal medicaid program to provide health, habilitative, or rehabilitative services and twenty-four hour supervision for persons with intellectual disabilities or related conditions and includes in the program "active treatment" as federally defined.

(4) The department may purchase care in institutions for mental diseases by contract. The department shall establish rules for reasonable accounting and reimbursement systems for such care. Institutions for mental diseases are certified under the federal medicaid program and primarily engaged in providing diagnosis, treatment, or care to persons with mental diseases, including medical attention, nursing care, and related services.

(5) Both the department and the authority may each purchase all other services provided under this chapter or other applicable law by contract or at rates established by the department or the authority respectively. [2018 c 201 § 7007; 2012 c 10 § 60; 2011 1st sp.s. c 15 § 9; 2010 c 94 § 23; 1998 c 322 § 45; 1993 sp.s. c 3 § 8; 1992 c 8 § 1; 1989 c 372 § 15; 1983 1st ex.s. c 67 § 44; 1981 2nd ex.s. c 11 § 6; 1981 1st ex.s. c 2 § 11; (1980 c 177 § 84 repealed by 1983 1st ex.s. c 67 § 48); 1975 1st ex.s. c 213 § 1; 1967 ex.s. c 30 § 1; 1959 c 26 § 74.09.120. Prior: 1955 c 273 § 13.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Application—2012 c 10: See note following RCW 18.20.010.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Purpose—2010 c 94: See note following RCW 44.04.280.

Effective date—1993 sp.s. c 3: See note following RCW 72.36.140.

Findings—1993 sp.s. c 3: See RCW 72.36.1601.

Effective dates—1983 1st ex.s. c 67: See note following RCW 74.46.475.

Severability—Effective dates—1981 1st ex.s. c 2: See notes following RCW 18.51.010.

Conflict with federal requirements and this section: RCW 74.46.840.

RCW 74.09.150 Personnel to be under existing merit system. All personnel employed in the administration of the medical care program shall be covered by the existing merit system under the Washington personnel resources board. [1993 c 281 § 66; 1959 c 26 § 74.09.150. Prior: 1955 c 273 § 16.]

Effective date—1993 c 281: See note following RCW 41.06.022.

RCW 74.09.160 Presentment of charges by contractors. Each vendor or group who has a contract and is rendering service to eligible persons as defined in this chapter or other applicable law shall submit such charges as agreed upon between the department or authority, as appropriate, and the individual or group no later than twelve months from the date of service. If the final charges are not presented within the twelve-month period, they shall not be a charge against the state. Said twelve-month period may also be extended by regulation, but only if required by applicable federal law or regulation, and to no more than the extension of time so required. [2018 c 201 § 7008; 2011 1st sp.s. c 15 § 10; 1991 c 103 § 1; 1980 c 32 § 11; 1979 ex.s. c 81 § 1; 1973 1st ex.s. c 48 § 1; 1959 c 26 § 74.09.160. Prior: 1955 c 273 § 17.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.171 Contracts for medicaid services—Border communities. (1) The legislature finds that the authority and the department purchase or contract for the delivery of medicaid programs through contracts with providers and managed care organizations under this chapter, contractors providing behavioral health services under chapters 71.24 and 71.34 RCW, and contractors providing long-term care services under chapter 74.39A RCW.

(2) The authority and department must collaborate and seek opportunities to expand access to care for enrollees in the medicaid programs identified in subsection (1) of this section living in border communities that may require contractual agreements with providers across the state border when care is appropriate, available, and cost-effective.

(3) All authority and department contracts for medicaid services issued or renewed after July 1, 2014, must include provisions that allow for care to be accessed cross-border ensuring timely access to necessary care, including inpatient and outpatient services. The contracts must include reciprocal arrangements that allow Washington, Oregon, and Idaho border residents to access care when care is appropriate, available, and cost-effective. [2023 c 51 § 35; 2014 c 39 § 1.]

RCW 74.09.180 Chapter does not apply if another party is liable—Exception—Subrogation—Lien—Reimbursement—Delegation of lien and

subrogation rights. (1) The provisions of this chapter shall not apply to recipients whose personal injuries are occasioned by negligence or wrong of another: PROVIDED, HOWEVER, That the director may furnish assistance, under the provisions of this chapter, for the results of injuries to or illness of a recipient, and the authority shall thereby be subrogated to the recipient's rights against the recovery had from any tort feasor or the tort feasor's insurer, or both, and shall have a lien thereupon to the extent of the value of the assistance furnished by the authority. To secure reimbursement for assistance provided under this section, the authority may pursue its remedies under RCW 41.05A.070.

(2) The rights and remedies provided to the authority in this section to secure reimbursement for assistance, including the authority's lien and subrogation rights, may be delegated to a *managed health care system by contract entered into pursuant to RCW 74.09.522. A *managed health care system may enforce all rights and remedies delegated to it by the authority to secure and recover assistance provided under a *managed health care system consistent with its agreement with the authority. [2011 1st sp.s. c 15 § 11; 1997 c 236 § 1; 1990 c 100 § 2; 1987 c 283 § 14; 1979 ex.s. c 171 § 14; 1971 ex.s. c 306 § 1; 1969 ex.s. c 173 § 8; 1959 c 26 § 74.09.180. Prior: 1955 c 273 § 19.]

***Reviser's note:** RCW 74.09.522 was amended by 2023 c 51 § 43, removing the definition of "managed health care system" and changing "managed health care system" to "managed care organization."

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Application—1990 c 100 §§ 2, 4, 7(1), 8(2): See note following RCW 43.20B.060.

Severability—Savings—1987 c 283: See notes following RCW 43.20A.020.

Severability—1979 ex.s. c 171: See note following RCW 74.20.300.

RCW 74.09.185 Third party has legal liability to make payments—State acquires rights—Lien—Equitable subrogation does not apply. To the extent that payment for covered expenses has been made under medical assistance for health care items or services furnished to an individual, in any case where a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services. Recovery pursuant to the subrogation rights, assignment, or enforcement of the lien granted to the authority by this section shall not be reduced, prorated, or applied to only a portion of a judgment, award, or settlement, except as provided in RCW 41.05A.060 and 41.05A.070. The doctrine of equitable subrogation shall not apply to defeat, reduce, or prorate recovery by the authority as to its assignment, lien, or subrogation rights. [2011 1st sp.s. c 15 § 12; 1995 c 34 § 6.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.190 Religious beliefs—Construction of chapter. Nothing in this chapter shall be construed as empowering the secretary or director to compel any recipient of public assistance and a medical indigent person to undergo any physical examination, surgical operation, or accept any form of medical treatment contrary to the wishes of said person who relies on or is treated by prayer or spiritual means in accordance with the creed and tenets of any well recognized church or religious denomination. [2011 1st sp.s. c 15 § 13; 1979 c 141 § 342; 1959 c 26 § 74.09.190. Prior: 1955 c 273 § 23.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.195 Audits of health care providers by the authority—Requirements—Procedure. (1) Audits of the records of health care providers performed under this chapter are subject to the following:

(a) The authority must provide at least thirty calendar days' notice before scheduling any on-site audit, unless there is evidence of danger to public health and safety or fraudulent activities;

(b) The authority must make a good faith effort to establish a mutually agreed upon time and date for the on-site audit;

(c) The authority must allow providers, at their request, to submit records requested as a result of an audit in electronic format, including compact disc, digital versatile disc, or other electronic formats deemed appropriate by the authority, or by facsimile transmission;

(d) The authority shall make reasonable efforts to avoid reviewing claims that are currently being audited by the authority, that have already been audited by the authority, or that are currently being audited by another governmental entity;

(e) A finding of overpayment to a provider in a program operated or administered by the authority may not be based on extrapolation unless there is a determination of sustained high level of payment error involving the provider or when documented educational intervention has failed to correct the level of payment error. Any finding that is based upon extrapolation, and the related sampling, must be established to be statistically fair and reasonable in order to be valid. The sampling methodology used must be validated by a statistician or person with equivalent experience as having a confidence level of ninety-five percent or greater;

(f) The authority must provide a detailed explanation in writing to a provider for any adverse determination that would result in partial or full recoupment of a payment to the provider. The written notification shall, at a minimum, include the following: (i) The reason for the adverse determination; (ii) the specific criteria on which the adverse determination was based; (iii) an explanation of the provider's appeal rights; and (iv) if applicable, the appropriate procedure to submit a claims adjustment in accordance with subsection (3) of this section;

(g) The authority may not recoup overpayments until all informal and formal appeals processes have been completed;

(h) The authority must offer a provider with an adverse determination the option of repaying the amount owed according to a negotiated repayment plan of up to twelve months;

(i) The authority must produce a preliminary report or draft audit findings within one hundred twenty days from the receipt of all requested information as identified in writing by the authority; and

(j) In the event that the authority seeks to recoup funds from a provider who is no longer a contractor with the medical assistance program, the authority must provide a description of the claim, including the patient name, date of service, and procedure. A provider is not required to obtain a court order to receive such information.

(2) Any contractor that conducts audits of the medical assistance program on behalf of the authority must comply with the requirements in this subsection and must:

(a) In any appeal by a health care provider, employ or contract with a medical or dental professional who practices within the same specialty, is board certified, and experienced in the treatment, billing, and coding procedures used by the provider being audited to make findings and determinations;

(b) Compile, on an annual basis, metrics specified by the authority. The authority shall publish the metrics on its website. The metrics must, at a minimum, include:

(i) The number and type of claims reviewed;

(ii) The number of records requested;

(iii) The number of overpayments and underpayments identified by the contractor;

(iv) The aggregate dollar amount associated with identified overpayments and underpayments;

(v) The duration of audits from initiation until time of completion;

(vi) The number of adverse determinations and the overturn rates of those determinations at each stage of the informal and formal appeal process;

(vii) The number of informal and formal appeals filed by providers categorized by disposition status;

(viii) The contractor's compensation structure and dollar amount of compensation; and

(ix) A copy of the authority's contract with the contractor.

(3) The authority shall develop and implement a procedure by which an improper payment identified by an audit may be resubmitted as a claims adjustment.

(4) The authority shall provide educational and training programs annually for providers. The training topics must include a summary of audit results, a description of common issues, problems and mistakes identified through audits and reviews, and opportunities for improvement. [2017 c 242 § 1.]

RCW 74.09.200 Audits and investigations—Legislative declaration—State authority. The legislature finds and declares it to be in the public interest and for the protection of the health and welfare of the residents of the state of Washington that a proper regulatory and inspection program be instituted in connection with the providing of medical, dental, and other health services to recipients of public

assistance and medically indigent persons. In order to effectively accomplish such purpose and to assure that the recipient of such services receives such services as are paid for by the state of Washington, the acceptance by the recipient of such services, and by practitioners of reimbursement for performing such services, shall authorize the secretary or director, to inspect and audit all records in connection with the providing of such services. [2011 1st sp.s. c 15 § 14; 1979 ex.s. c 152 § 1.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.210 Fraudulent practices—Penalties. (1) No person, firm, corporation, partnership, association, agency, institution, or other legal entity, but not including an individual public assistance recipient of health care, shall, on behalf of himself or herself or others, obtain or attempt to obtain benefits or payments under this chapter or other applicable law in a greater amount than that to which entitled by means of:

(a) A willful false statement;

(b) By willful misrepresentation, or by concealment of any material facts; or

(c) By other fraudulent scheme or device, including, but not limited to:

(i) Billing for services, drugs, supplies, or equipment that were unfurnished, of lower quality, or a substitution or misrepresentation of items billed; or

(ii) Repeated billing for purportedly covered items, which were not in fact so covered.

(2) Any person or entity knowingly violating any of the provisions of subsection (1) of this section shall be liable for repayment of any excess benefits or payments received, plus interest at the rate and in the manner provided in RCW 43.20B.695. Such person or other entity shall further, in addition to any other penalties provided by law, be subject to civil penalties. The director or the attorney general may assess civil penalties in an amount not to exceed three times the amount of such excess benefits or payments: PROVIDED, That these civil penalties shall not apply to any acts or omissions occurring prior to September 1, 1979. RCW 43.20A.215 governs notice of a civil fine assessed by the director and provides the right to an adjudicative proceeding.

(3) A criminal action need not be brought against a person for that person to be civilly liable under this section.

(4) In all administrative proceedings under this section, service, adjudicative proceedings, and judicial review of such determinations shall be in accordance with chapter 34.05 RCW, the administrative procedure act.

(5) Civil penalties shall be deposited upon their receipt into the medicaid fraud penalty account established in RCW 74.09.215.

(6) The attorney general may contract with private attorneys and local governments in bringing actions under this section as necessary. [2018 c 201 § 7009; 2013 c 23 § 202; 2012 c 241 § 102; 2011 1st sp.s. c 15 § 15; 1989 c 175 § 146; 1987 c 283 § 7; 1979 ex.s. c 152 § 2.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Intent—Finding—2012 c 241: See note following RCW 74.66.010.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Effective date—1989 c 175: See note following RCW 34.05.010.

Severability—Savings—1987 c 283: See notes following RCW 43.20A.020.

RCW 74.09.215 Medicaid fraud penalty account. The medicaid fraud penalty account is created in the state treasury. All receipts from civil penalties collected under RCW 74.09.210, all receipts received under judgments or settlements that originated under a filing under the federal false claims act, all receipts from fines received pursuant to RCW 43.71C.090, and all receipts received under judgments or settlements that originated under the state medicaid fraud false claims act, chapter 74.66 RCW, must be deposited into the account. Moneys in the account may be spent only after appropriation and must be used only for medicaid services, fraud detection and prevention activities, recovery of improper payments, for other medicaid fraud enforcement activities, and the prescription monitoring program established in chapter 70.225 RCW. [2023 c 51 § 36; 2019 c 334 § 14. Prior: 2013 2nd sp.s. c 4 § 1902; 2013 2nd sp.s. c 4 § 997; 2013 2nd sp.s. c 4 § 995; 2013 c 36 § 3; 2012 c 241 § 103.]

Effective dates—2013 2nd sp.s. c 4: See note following RCW 2.68.020.

Findings—2013 c 36: See note following RCW 70.225.020.

Intent—Finding—2012 c 241: See note following RCW 74.66.010.

RCW 74.09.220 Liability for receipt of excess payments. Any person, firm, corporation, partnership, association, agency, institution or other legal entity, but not including an individual public assistance recipient of health care, that, without intent to violate this chapter or other applicable law, obtains benefits or payments under this code to which such person or entity is not entitled, or in a greater amount than that to which entitled, shall be liable for (1) any excess benefits or payments received, and (2) interest calculated at the rate and in the manner provided in RCW 43.20B.695 or 41.05A.220. Whenever a penalty is due under RCW 74.09.210 or interest is due under RCW 43.20B.695 or 41.05A.220, such penalty or interest shall not be reimbursable by the state as an allowable cost under any of the provisions of this chapter or other applicable law. [2023 c 51 § 37; 2018 c 201 § 7010; 1987 c 283 § 8; 1979 ex.s. c 152 § 3.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Severability—Savings—1987 c 283: See notes following RCW 43.20A.020.

RCW 74.09.230 False statements, fraud—Penalties. Any person, including any corporation, that

(1) knowingly makes or causes to be made any false statement or representation of a material fact in any application for any payment under any medical care program authorized under this chapter or other applicable law, or

(2) at any time knowingly makes or causes to be made any false statement or representation of a material fact for use in determining rights to such payment, or knowingly falsifies, conceals, or covers up by any trick, scheme, or device a material fact in connection with such application or payment, or

(3) having knowledge of the occurrence of any event affecting (a) the initial or continued right to any payment, or (b) the initial or continued right to any such payment of any other individual in whose behalf he or she has applied for or is receiving such payment, conceals or fails to disclose such event with an intent fraudulently to secure such payment either in a greater amount or quantity than is due or when no such payment is authorized,

shall be guilty of a class C felony: PROVIDED, That the fine, if imposed, shall not be in an amount more than twenty-five thousand dollars, except as authorized by RCW 9A.20.030. [2018 c 201 § 7011; 2013 c 23 § 203; 1979 ex.s. c 152 § 4.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

RCW 74.09.240 Bribes, kickbacks, rebates—Self-referrals—Penalties. (1) Any person, including any corporation, that solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind

(a) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this chapter or other applicable law, or

(b) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made in whole or in part under this chapter or other applicable law,

shall be guilty of a class C felony; however, the fine, if imposed, shall not be in an amount more than twenty-five thousand dollars, except as authorized by RCW 9A.20.030.

(2) Any person, including any corporation, that offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person

(a) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment

may be made, in whole or in part, under this chapter or other applicable law, or

(b) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made in whole or in part under this chapter or other applicable law,

shall be guilty of a class C felony; however, the fine, if imposed, shall not be in an amount more than twenty-five thousand dollars, except as authorized by RCW 9A.20.030.

(3)(a) Except as provided in 42 U.S.C. 1395 nn, physicians are prohibited from self-referring any client eligible under this chapter for the following designated health services to a facility in which the physician or an immediate family member has a financial relationship:

(i) Clinical laboratory services;

(ii) Physical therapy services;

(iii) Occupational therapy services;

(iv) Radiology including magnetic resonance imaging, computerized axial tomography, and ultrasound services;

(v) Durable medical equipment and supplies;

(vi) Parenteral and enteral nutrients equipment and supplies;

(vii) Prosthetics, orthotics, and prosthetic devices;

(viii) Home health services;

(ix) Outpatient prescription drugs;

(x) Inpatient and outpatient hospital services;

(xi) Radiation therapy services and supplies.

(b) For purposes of this subsection, "financial relationship" means the relationship between a physician and an entity that includes either:

(i) An ownership or investment interest; or

(ii) A compensation arrangement.

For purposes of this subsection, "compensation arrangement" means an arrangement involving remuneration between a physician, or an immediate family member of a physician, and an entity.

(c) The department or authority, as appropriate, is authorized to adopt by rule amendments to 42 U.S.C. 1395 nn enacted after July 23, 1995.

(d) This section shall not apply in any case covered by a general exception specified in 42 U.S.C. Sec. 1395 nn.

(4) Subsections (1) and (2) of this section shall not apply to:

(a) A discount or other reduction in price obtained by a provider of services or other entity under this chapter or other applicable law if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this chapter or other applicable law; and

(b) Any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(5) Subsections (1) and (2) of this section, if applicable to the conduct involved, shall supersede the criminal provisions of chapter 19.68 RCW, but shall not preclude administrative proceedings authorized by chapter 19.68 RCW. [2018 c 201 § 7012; 2011 1st sp.s. c 15 § 16; 1995 c 319 § 1; 1979 ex.s. c 152 § 5.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.250 False statements regarding institutions, facilities—Penalties. Any person, including any corporation, that knowingly makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operations of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, nursing facility, or home health agency, shall be guilty of a class C felony: PROVIDED, That the fine, if imposed, shall not be in an amount more than five thousand dollars. [1991 sp.s. c 8 § 6; 1979 ex.s. c 152 § 6.]

Effective date—1991 sp.s. c 8: See note following RCW 18.51.050.

RCW 74.09.260 Excessive charges, payments—Penalties. Any person, including any corporation, that knowingly:

(1) Charges, for any service provided to a patient under any medical care plan authorized under this chapter or other applicable law, money or other consideration at a rate in excess of the rates established by the department or authority, as appropriate; or

(2) Charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under such plan, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient):

(a) As a precondition of admitting a patient to a hospital or nursing facility; or

(b) As a requirement for the patient's continued stay in such facility,

when the cost of the services provided therein to the patient is paid for, in whole or in part, under such plan, shall be guilty of a class C felony: PROVIDED, That the fine, if imposed, shall not be in an amount more than twenty-five thousand dollars, except as authorized by RCW 9A.20.030. [2018 c 201 § 7013; 2011 1st sp.s. c 15 § 17; 1991 sp.s. c 8 § 7; 1979 ex.s. c 152 § 7.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Effective date—1991 sp.s. c 8: See note following RCW 18.51.050.

RCW 74.09.270 Failure to maintain trust funds in separate account—Penalties. (1) Any person having any patient trust funds in his or her possession, custody, or control, who, knowing that he or she is violating any statute, regulation, or agreement, deliberately

fails to deposit, transfer, or maintain said funds in a separate, designated, trust bank account as required by such statute, regulation, or agreement shall be guilty of a gross misdemeanor and shall be punished by imprisonment for up to three hundred sixty-four days in the county jail, or by a fine of not more than ten thousand dollars or as authorized by RCW 9A.20.030, or by both such fine and imprisonment.

(2) "Patient trust funds" are funds received by any health care facility which belong to patients and are required by any state or federal statute, regulation, or by agreement to be kept in a separate trust bank account for the benefit of such patients.

(3) This section shall not be construed to prevent a prosecution for theft. [2011 c 96 § 54; 1979 ex.s. c 152 § 8.]

Findings—Intent—2011 c 96: See note following RCW 9A.20.021.

RCW 74.09.280 False verification of written statements—Penalties. The secretary or director may by rule require that any application, statement, or form filled out by suppliers of medical care under this chapter or other applicable law shall contain or be verified by a written statement that it is made under the penalties of perjury and such declaration shall be in lieu of any oath otherwise required, and each such paper shall in such event so state. The making or subscribing of any such papers or forms containing any false or misleading information may be prosecuted and punished under chapter 9A.72 RCW. [2018 c 201 § 7014; 2011 1st sp.s. c 15 § 18; 1979 ex.s. c 152 § 9.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.290 Audits and investigations of providers—Patient records—Penalties. The secretary or director shall have the authority to:

(1) Conduct audits and investigations of providers of medical and other services furnished pursuant to this chapter or other applicable law, except that the Washington medical commission shall generally serve in an advisory capacity to the secretary or director in the conduct of audits or investigations of physicians. Any overpayment discovered as a result of an audit of a provider under this authority shall be offset by any underpayments discovered in that same audit sample. In order to determine the provider's actual, usual, customary, or prevailing charges, the secretary or director may examine such random representative records as necessary to show accounts billed and accounts received except that in the conduct of such examinations, patient names, other than public assistance applicants or recipients, shall not be noted, copied, or otherwise made available to the department or authority. In order to verify costs incurred by the department or authority for treatment of public assistance applicants or recipients, the secretary or director may examine patient records

or portions thereof in connection with services to such applicants or recipients rendered by a health care provider, notwithstanding the provisions of RCW 5.60.060, 18.53.200, 18.83.110, or any other statute which may make or purport to make such records privileged or confidential: PROVIDED, That no original patient records shall be removed from the premises of the health care provider, and that the disclosure of any records or information by the department or the authority is prohibited and shall be punishable as a class C felony according to chapter 9A.20 RCW, unless such disclosure is directly connected to the official purpose for which the records or information were obtained: PROVIDED FURTHER, That the disclosure of patient information as required under this section shall not subject any physician or other health services provider to any liability for breach of any confidential relationship between the provider and the patient, but no evidence resulting from such disclosure may be used in any civil, administrative, or criminal proceeding against the patient unless a waiver of the applicable evidentiary privilege is obtained: PROVIDED FURTHER, That the secretary or director shall destroy all copies of patient medical records in their possession upon completion of the audit, investigation or proceedings;

(2) Approve or deny applications to participate as a provider of services furnished pursuant to this chapter or other applicable law;

(3) Terminate or suspend eligibility to participate as a provider of services furnished pursuant to this chapter or other applicable law; and

(4) Adopt, promulgate, amend, and repeal administrative rules, in accordance with the administrative procedure act, chapter 34.05 RCW, to carry out the policies and purposes of this section and RCW 74.09.200 through 74.09.280. [2019 c 55 § 19; 2018 c 201 § 7015; 2011 1st sp.s. c 15 § 19; 1994 sp.s. c 9 § 749; 1990 c 100 § 5; 1983 1st ex.s. c 41 § 23; 1979 ex.s. c 152 § 10.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Severability—Headings and captions not law—Effective date—1994 sp.s. c 9: See RCW 18.79.900 through 18.79.902.

Severability—1983 1st ex.s. c 41: See note following RCW 26.09.060.

RCW 74.09.295 Disclosure of involuntary commitment information. It is permissible to provide to a correctional institution, as defined in RCW 9.94.049, with the fact, place, and date of an involuntary commitment and the fact and date of discharge or release of a person who has been involuntarily committed under chapter 71.05 or 71.34 RCW, without a person's consent, in the course of the implementation and use of the department's postinstitutional medical assistance system supporting the expedited medical determinations and medical suspensions as provided in RCW 74.09.555. Disclosure under this

section is mandatory for the purposes of the health insurance portability and accountability act. [2011 c 305 § 2.]

Findings—2011 c 305: "The legislature finds that effective collaboration and communication between mental health and chemical dependency treatment providers and service delivery systems and law enforcement and criminal justice agencies is important to both the care of persons with mental disorders and chemical dependency and public safety. The legislature also finds that many state and local efforts in recent years have worked to address improved treatment of persons with mental disorders, chemical dependency disorders, or co-occurring mental and substance abuse disorders who are confined in a correctional institution and to improve communication and collaboration among the agencies, institutions, and professionals who are responsible for the care or custody of those persons. While numerous laws have been enacted to clarify the appropriate sharing of information between those agencies, institutions, and professionals, the legislature finds further clarification will continue to aide [aid] and improve the care of those persons and augment public safety." [2011 c 305 § 1.]

RCW 74.09.300 Department to report penalties to appropriate licensing agency or disciplinary board. Whenever the secretary or director imposes a civil penalty under RCW 74.09.210, or terminates or suspends a provider's eligibility under RCW 74.09.290, he or she shall, if the provider is licensed pursuant to Titles 18, 70, or 71 RCW, give written notice of such imposition, termination, or suspension to the appropriate licensing agency or disciplinary board. [2011 1st sp.s. c 15 § 20; 1979 ex.s. c 152 § 11.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.315 Whistleblowers—Workplace reprisal or retaliatory action. (1) For the purposes of this section:

(a) "Employer" means any person, firm, corporation, partnership, association, agency, institution, or other legal entity.

(b) "Whistleblower" means an employee of an employer that obtains or attempts to obtain benefits or payments under this chapter or other applicable law in violation of RCW 74.09.210, who in good faith reports a violation of RCW 74.09.210 to the authority.

(c) "Workplace reprisal or retaliatory action" includes, but is not limited to: Denial of adequate staff to fulfill duties; frequent staff changes; frequent and undesirable office changes; refusal to assign meaningful work; unwarranted and unsubstantiated report of misconduct under Title 18 RCW; unwarranted and unsubstantiated letters of reprimand or unsatisfactory performance evaluations; demotion; reduction in pay; denial of promotion; suspension; dismissal; denial of employment; a supervisor or superior behaving in or encouraging coworkers to behave in a hostile manner toward the whistleblower; or a change in the physical location of the employee's workplace or a change in the basic nature of the employee's job, if either are in opposition to the employee's expressed wish.

(2) A whistleblower who has been subjected to workplace reprisal or retaliatory action has the remedies provided under chapter 49.60 RCW. RCW 4.24.500 through 4.24.520, providing certain protection to persons who communicate to government agencies, apply to complaints made under this section. The identity of a whistleblower who complains, in good faith, to the authority about a suspected violation of RCW 74.09.210 may remain confidential if requested. The identity of the whistleblower must subsequently remain confidential unless the authority determines that the complaint was not made in good faith.

(3) This section does not prohibit an employer from exercising its authority to terminate, suspend, or discipline an employee who engages in workplace reprisal or retaliatory action against a whistleblower. The protections provided to whistleblowers under this chapter do not prevent an employer from: (a) Terminating, suspending, or disciplining a whistleblower for other lawful purposes; or (b) reducing the hours of employment or terminating employment as a result of the demonstrated inability to meet payroll requirements. The authority shall determine if the employer cannot meet payroll in cases where a whistleblower has been terminated or had hours of employment reduced due to the inability of a facility to meet payroll.

(4) The authority shall adopt rules to implement procedures for filing, investigation, and resolution of whistleblower complaints that are integrated with complaint procedures under this chapter. The authority shall adopt rules designed to discourage whistleblower complaints made in bad faith or for retaliatory purposes. [2018 c 201 § 7016; 2012 c 241 § 104.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Intent—Finding—2012 c 241: See note following RCW 74.66.010.

RCW 74.09.325 Reimbursement of a health care service provided through telemedicine or store and forward technology—Audio-only telemedicine. (1)(a) All managed care organizations contracted with the authority for the medicaid program shall reimburse a provider for a health care service provided to a covered person through telemedicine or store and forward technology if:

(i) The managed care organization in which the covered person is enrolled provides coverage of the health care service when provided in person by the provider;

(ii) The health care service is medically necessary;

(iii) The health care service is a service recognized as an essential health benefit under section 1302(b) of the federal patient protection and affordable care act in effect on January 1, 2015;

(iv) The health care service is determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards, and the technology used to provide the health care service meets the standards required by state and federal laws governing the privacy and security of protected health information; and

(v) Beginning January 1, 2023, for audio-only telemedicine, the covered person has an established relationship with the provider.

(b)(i) Except as provided in (b)(ii) of this subsection, a managed care organization shall reimburse a provider for a health care

service provided to a covered person through telemedicine the same amount of compensation the managed care organization would pay the provider if the health care service was provided in person by the provider.

(ii) Hospitals, hospital systems, telemedicine companies, and provider groups consisting of eleven or more providers may elect to negotiate an amount of compensation for telemedicine services that differs from the amount of compensation for in-person services.

(iii) For purposes of this subsection (1)(b), the number of providers in a provider group refers to all providers within the group, regardless of a provider's location.

(iv) A rural health clinic shall be reimbursed for audio-only telemedicine at the rural health clinic encounter rate.

(2) For purposes of this section, reimbursement of store and forward technology is available only for those services specified in the negotiated agreement between the managed care organization and health care provider.

(3) An originating site for a telemedicine health care service subject to subsection (1) of this section includes a:

(a) Hospital;

(b) Rural health clinic;

(c) Federally qualified health center;

(d) Physician's or other health care provider's office;

(e) Licensed or certified behavioral health agency;

(f) Skilled nursing facility;

(g) Home or any location determined by the individual receiving the service; or

(h) Renal dialysis center, except an independent renal dialysis center.

(4) Except for subsection (3)(g) of this section, any originating site under subsection (3) of this section may charge a facility fee for infrastructure and preparation of the patient. Reimbursement for a facility fee must be subject to a negotiated agreement between the originating site and the managed care organization. A distant site, a hospital that is an originating site for audio-only telemedicine, or any other site not identified in subsection (3) of this section may not charge a facility fee.

(5) A managed care organization may not distinguish between originating sites that are rural and urban in providing the coverage required in subsection (1) of this section.

(6) A managed care organization may subject coverage of a telemedicine or store and forward technology health service under subsection (1) of this section to all terms and conditions of the plan in which the covered person is enrolled including, but not limited to, utilization review, prior authorization, deductible, copayment, or coinsurance requirements that are applicable to coverage of a comparable health care service provided in person.

(7) This section does not require a managed care organization to reimburse:

(a) An originating site for professional fees;

(b) A provider for a health care service that is not a covered benefit under the plan; or

(c) An originating site or health care provider when the site or provider is not a contracted provider under the plan.

(8)(a) If a provider intends to bill a patient or a managed care organization for an audio-only telemedicine service, the provider must obtain patient consent for the billing in advance of the service being

delivered and comply with all rules created by the authority related to restrictions on billing medicaid recipients. The authority may submit information on any potential violations of this subsection to the appropriate disciplining authority, as defined in RCW 18.130.020, or take contractual actions against the provider's agreement for participation in the medicaid program, or both.

(b) If the health care authority has cause to believe that a provider has engaged in a pattern of unresolved violations of this subsection (8), the health care authority may submit information to the appropriate disciplining authority for action. Prior to submitting information to the appropriate disciplining authority, the health care authority may provide the provider with an opportunity to cure the alleged violations or explain why the actions in question did not violate this subsection (8).

(c) If the provider has engaged in a pattern of unresolved violations of this subsection (8), the appropriate disciplining authority may levy a fine or cost recovery upon the provider in an amount not to exceed the applicable statutory amount per violation and take other action as permitted under the authority of the disciplining authority. Upon completion of its review of any potential violation submitted by the health care authority or initiated directly by an enrollee, the disciplining authority shall notify the health care authority of the results of the review, including whether the violation was substantiated and any enforcement action taken as a result of a finding of a substantiated violation.

(9) For purposes of this section:

(a)(i) "Audio-only telemedicine" means the delivery of health care services through the use of audio-only technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment.

(ii) For purposes of this section only, "audio-only telemedicine" does not include:

(A) The use of facsimile or email; or

(B) The delivery of health care services that are customarily delivered by audio-only technology and customarily not billed as separate services by the provider, such as the sharing of laboratory results;

(b) "Disciplining authority" has the same meaning as in RCW 18.130.020;

(c) "Distant site" means the site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine;

(d) "Established relationship" means the provider providing audio-only telemedicine has access to sufficient health records to ensure safe, effective, and appropriate care services and:

(i) For health care services included in the essential health benefits category of mental health and substance use disorder services, including behavioral health treatment:

(A) The covered person has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the provider providing audio-only telemedicine or with a provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or

(B) The covered person was referred to the provider providing audio-only telemedicine by another provider who has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the covered person and has provided relevant medical information to the provider providing audio-only telemedicine;

(ii) For any other health care service:

(A) The covered person has had, within the past two years, at least one in-person appointment, or, until July 1, 2024, at least one real-time interactive appointment using both audio and video technology, with the provider providing audio-only telemedicine or with a provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or

(B) The covered person was referred to the provider providing audio-only telemedicine by another provider who has had, within the past two years, at least one in-person appointment, or, until July 1, 2024, at least one real-time interactive appointment using both audio and video technology, with the covered person and has provided relevant medical information to the provider providing audio-only telemedicine;

(e) "Health care service" has the same meaning as in RCW 48.43.005;

(f) "Hospital" means a facility licensed under chapter 70.41, 71.12, or 72.23 RCW;

(g) "Originating site" means the physical location of a patient receiving health care services through telemedicine;

(h) "Provider" has the same meaning as in RCW 48.43.005;

(i) "Store and forward technology" means use of an asynchronous transmission of a covered person's medical information from an originating site to the health care provider at a distant site which results in medical diagnosis and management of the covered person, and does not include the use of audio-only telephone, facsimile, or email; and

(j) "Telemedicine" means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this section only, "telemedicine" includes audio-only telemedicine, but does not include facsimile or email. [2023 c 51 § 38; 2023 c 8 § 3; 2022 c 213 § 4; 2021 c 157 § 5; 2020 c 92 § 3; 2017 c 219 § 3; 2016 c 68 § 5; 2015 c 23 § 4.]

Reviser's note: This section was amended by 2023 c 8 § 3 and by 2023 c 51 § 38, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Conflict with federal requirements—2022 c 213: See note following RCW 41.05.700.

Conflict with federal requirements—2021 c 157: See note following RCW 74.09.327.

Effective date—2020 c 92: See note following RCW 48.43.735.

Effective date—2017 c 219: See note following RCW 48.43.735.

Effective date—Intent—2016 c 68: See notes following RCW 48.43.735.

Effective date—Adoption of sections—2015 c 23 §§ 2-4: See notes following RCW 41.05.700.

Intent—2015 c 23: See note following RCW 41.05.700.

RCW 74.09.327 Audio-only telemedicine—Fee-for-service reimbursement. (1) The authority shall adopt rules regarding medicaid fee-for-service reimbursement for services delivered through audio-only telemedicine. Except as provided in subsection (2) of this section, the rules must establish a manner of reimbursement for audio-only telemedicine that is consistent with RCW 74.09.325.

(2) The rules shall require rural health clinics to be reimbursed for audio-only telemedicine at the rural health clinic encounter rate.

(3)(a) For purposes of this section, "audio-only telemedicine" means the delivery of health care services through the use of audio-only technology, permitting real-time communication between a patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment.

(b) For purposes of this section only, "audio-only telemedicine" does not include:

(i) The use of facsimile or email; or

(ii) The delivery of health care services that are customarily delivered by audio-only technology and customarily not billed as separate services by the provider, such as the sharing of laboratory results. [2021 c 157 § 6.]

Conflict with federal requirements—2021 c 157: "If any part of this act is found to be in conflict with federal requirements that are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this act is inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and this finding does not affect the operation of the remainder of this act in its application to the agencies concerned. Rules adopted under this act must meet federal requirements that are a necessary condition to the receipt of federal funds by the state. Nothing in this act alters the requirement for the health care authority to report potential fraud to the medicaid fraud control division of the Washington attorney general's office under 42 C.F.R. 455.21." [2021 c 157 § 10.]

RCW 74.09.328 Use of substitute providers—When permitted—Reimbursement requirements. (1) In order to protect patients and ensure that they benefit from seamless quality care when contracted providers are absent from their practices or when there is a temporary vacancy in a position while a hospital, rural health clinic, or rural provider is recruiting to meet patient demand, hospitals, rural health clinics, and rural providers may use substitute providers to provide services. Medicaid managed care organizations must allow for the use

of substitute providers and provide payment consistent with the provisions in this section.

(2) Hospitals, rural health clinics, and rural providers that are contracted with a medicaid managed care organization may use substitute providers that are not contracted with a managed care organization when:

(a) A contracted provider is absent for a limited period of time due to vacation, illness, disability, continuing medical education, or other short-term absence; or

(b) A contracted hospital, rural health clinic, or rural provider is recruiting to fill an open position.

(3) For a substitute provider providing services under subsection (2)(a) of this section, a contracted hospital, rural health clinic, or rural provider may bill and receive payment for services at the contracted rate under its contract with the managed care organization for up to sixty days.

(4) To be eligible for reimbursement under this section for services provided on behalf of a contracted provider for greater than sixty days, a substitute provider must enroll in a medicaid managed care organization. Enrollment of a substitute provider in a medicaid managed care organization is effective on the later of:

(a) The date the substitute provider filed an enrollment application that was subsequently approved; or

(b) The date the substitute provider first began providing services at the hospital, rural health clinic, or rural provider.

(5) A substitute provider who enrolls with a medicaid managed care organization may not bill under subsection (4) of this section for any services billed to the medicaid managed care organization pursuant to subsection (3) of this section.

(6) Nothing in this section obligates a managed care organization to enroll any substitute provider who requests enrollment if they do not meet the organizations enrollment criteria.

(7) For purposes of this section:

(a) "Circumstances precluded enrollment" means that the provider has met all program requirements including state licensure during the thirty-day period before an application was submitted and no final adverse determination precluded enrollment. If a final adverse determination precluded enrollment during this thirty-day period, the contractor shall only establish an effective billing date the day after the date that the final adverse action was resolved, as long as it is not more than thirty days prior to the date on which the application was submitted.

(b) "Contracted provider" means a provider who is contracted with a medicaid managed care organization.

(c) "Hospital" means a facility licensed under chapter 70.41 or 71.12 RCW.

(d) "Rural health clinic" means a federally designated rural health clinic.

(e) "Rural provider" means physicians licensed under chapter 18.71 RCW, osteopathic physicians and surgeons licensed under chapter 18.57 RCW, podiatric physicians and surgeons licensed under chapter 18.22 RCW, physician assistants licensed under chapter 18.71A RCW, osteopathic physician assistants licensed under chapter 18.71A RCW, and advanced registered nurse practitioners licensed under chapter 18.79 RCW, who are located in a rural county as defined in RCW 82.14.370.

(f) "Substitute provider" includes physicians licensed under chapter 18.71 RCW, osteopathic physicians and surgeons licensed under chapter 18.57 RCW, podiatric physicians and surgeons licensed under chapter 18.22 RCW, physician assistants licensed under chapter 18.71A RCW, osteopathic physician assistants licensed under chapter 18.71A RCW, and advanced registered nurse practitioners licensed under chapter 18.79 RCW. [2023 c 51 § 39; 2020 c 4 § 3.]

Effective date—2020 c 4 § 3: "Section 3 of this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [March 17, 2020]." [2020 c 4 § 4.]

RCW 74.09.330 Reimbursement methodology for ambulance services—Transport of a medical assistance enrollee to a mental health facility or chemical dependency program. The authority shall develop a reimbursement methodology for ambulance services when transporting a medical assistance enrollee to a mental health facility or chemical dependency program in accordance with the applicable alternative facility procedures adopted under RCW 70.168.100. [2015 c 157 § 6.]

RCW 74.09.335 Reimbursement of health care services provided by fire departments—Adoption of standards. The authority shall adopt standards for the reimbursement of health care services provided to eligible clients by fire departments pursuant to a community assistance referral and education services program under RCW 35.21.930. The standards must allow payment for covered health care services provided to individuals whose medical needs do not require ambulance transport to an emergency department. [2017 c 273 § 1.]

RCW 74.09.340 Personal needs allowance, adjusted. (1) Except as provided in RCW 72.36.160, beginning July 1, 2023, the personal needs allowance for clients being served in medical institutions and in residential settings is $100.

(2) Beginning January 1, 2024, and each year thereafter, the personal needs allowance for clients being served in medical institutions and in residential settings shall:

(a) Be adjusted for economic trends and conditions by increasing the allowance by the percentage cost-of-living adjustment for old-age, survivors, and disability social security benefits as published by the federal social security administration; and

(b) Not exceed the maximum personal needs allowance permissible under the federal social security act.

(3) Unless subject to a separate determination of a monthly maintenance needs allowance for a community spouse by authority rule, beginning July 1, 2022, the personal needs allowance for a client receiving home and community-based waiver services authorized by home and community services while living at home shall:

(a) Be adjusted to an amount that is no less than 300 percent of the federal benefit rate; and

(b) Not exceed the maximum personal needs allowance permissible under the federal social security act. [2023 c 201 § 1; 2022 c 164 § 1; 2018 c 137 § 1; 2017 c 270 § 2.]

Findings—Intent—2017 c 270: "(1) The legislature finds that through the medicaid program, state and federal government fund long-term care, mental health, and medical services for many elderly persons and people with disabilities, both in institutions and in community alternatives. The legislature also finds that a significant portion of these individuals' social security benefits is retained by the state to assist with the cost of their care. The legislature intends that these individuals retain for their own use a reasonable and modest personal needs allowance which may be used to purchase clothing, postage, barber services, travel, and other personal items not covered by their care setting, in order to promote their autonomy and personal dignity.

(2) It is the intent of the legislature to adjust the personal needs allowance annually to reflect cost-of-living adjustments to federal social security benefits for medicaid-eligible residents in institutions and community-based residential settings receiving long-term care, developmental disabilities, or mental health services." [2017 c 270 § 1.]

Effective date—2017 c 270: "Section 2 of this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 1, 2017." [2017 c 270 § 3.]

RCW 74.09.390 Access to baby and child dentistry program—Coverage for eligible children—Authority's duties—Report to legislature. (1) Subject to the availability of amounts appropriated for this specific purpose, the authority shall expand the access to baby and child dentistry (ABCD) program to include eligible children as clients.

(2) Once enrolled in the program, eligible children must be covered until their thirteenth birthday.

(3) Eligible children enrolled in the program shall receive all services and benefits received by program clients.

(4) The authority shall pay enhanced fees for program services provided to eligible children enrolled in the program to dentists, primary care providers, and dental hygienists certified to provide program services. To receive certification to provide program services to eligible children, a dentist, primary care provider, or dental hygienist must:

(a) Be licensed under Title 18 RCW; and

(b) Complete a course on treating eligible children as defined by the authority in rule.

(5) On or before December 15, 2020, and on or before December 15, 2021, the authority, in consultation with any organizations administering the program, shall provide a report, in compliance with RCW 43.01.036, to the health care and fiscal committees of the legislature, to include:

(a) The number of dentists, primary care providers, and dental hygienists participating in the program; and

(b) The number of eligible children who received treatment through the program.

(6) For purposes of this section:

(a) "Eligible children" means all individuals who meet clinical criteria established by the authority, who are under the age of thirteen with a disability attributable to intellectual disability, cerebral palsy, epilepsy, autism, or another neurological condition closely related to an intellectual disability or that requires treatment similar to that required for persons with intellectual disabilities, which has continued or can be expected to continue indefinitely, and which constitutes a substantial limitation to such individual, who are eligible for one of the following medical assistance programs:

(i) Categorically needy program;

(ii) Limited casualty program-medically needy program;

(iii) Children's health program; or

(iv) State children's health insurance program.

(b) "Program" means the access to baby and child dentistry program as established by WAC 182-535-1245 or successor rule. [2020 c 242 § 1; 2018 c 156 § 1.]

RCW 74.09.395 Access to baby and child dentistry program—Outreach and engagement—Stakeholder collaboration. (1) The authority, in consultation with the office of equity, created in chapter 332, Laws of 2020, shall work with the statewide managing partner of the access to baby and child dentistry program to develop a local access to baby and child dentistry program fund allocation formula, key deliverables, and target metrics for increased outreach and provider engagement and support with the goal of reducing racial and ethnic disparities.

(2) The authority, in consultation with the office of equity, created in chapter 332, Laws of 2020, shall collaborate with stakeholders to monitor progress toward the goals articulated in subsection (1) of this section and provide support to local access to baby and child dentistry programs and providers. [2020 c 293 § 2.]

Intent—2020 c 293: "The legislature recognizes that oral disease is the most common childhood chronic disease, yet is almost entirely preventable, impacting school readiness, future employability, and overall well-being and quality of life. The access to baby and child dentistry program has made Washington a leader in oral health care access across the nation, providing greater levels of access and utilization for medicaid eligible children under six years old. The legislature further recognizes that the access to baby and child dentistry program connects children to a dental home in their communities, enabling children to get off to a healthy start. While the state has made great strides, children of color continue to experience higher rates of tooth decay than their peers and children under the age of two are not accessing care at the same rate as older children. Therefore, it is the legislature's intent to expand on the program investments the state has already made to provide additional outreach and support to eligible families and providers, increase very young children's access to care, and further reduce racial and ethnic disparities in access to care and oral health outcomes." [2020 c 293 § 1.]

RCW 74.09.402 Children's health care—Findings—Intent. (1) The legislature finds that:

(a) Improving the health of children in Washington state is an investment in a productive and successful next generation. The health of children is critical to their success in school and throughout their lives;

(b) Healthy children are ready to learn. In order to provide students with the opportunity to become responsible citizens, to contribute to their own economic well-being and to that of their families and communities, and to enjoy productive and satisfying lives, the state recognizes the importance that access to appropriate health services and improved health brings to the children of Washington state. In addition, fully immunized children are themselves protected, and in turn protect others, from contracting communicable diseases;

(c) Children with health insurance coverage have better health outcomes than those who lack coverage. Children without health insurance coverage are more likely to be in poor health and more likely to delay receiving, or go without, needed health care services;

(d) Health care coverage for children in Washington state is the product of critical efforts in both the private and public sectors to help children succeed. Private health insurance coverage is complemented by public programs that meet needs of low-income children whose parents are not offered health insurance coverage through their employer or who cannot otherwise afford the costs of coverage. In 2006, thirty-five percent of children in Washington state had some form of public health coverage. Washington state is making progress in its efforts to increase the number of children with health care coverage. Yet, even with these efforts of both private and public sectors, many children in Washington state continue to lack health insurance coverage. In 2006, over seventy thousand children were uninsured. Almost two-thirds of these children are in families whose income is under two hundred fifty percent of the federal poverty level; and

(e) Improved health outcomes for the children of Washington state are the expected result of improved access to health care coverage. Linking children with a medical home that provides preventive and well child health services and referral to needed specialty services, linking children with needed behavioral health and dental services, more effectively managing childhood diseases, improving nutrition, and increasing physical activity are key to improving children's health. Care should be provided in appropriate settings by efficient providers, consistent with high quality care and at an appropriate stage, soon enough to avert the need for overly expensive treatment.

(2) It is therefore the intent of the legislature that:

(a) All children in the state of Washington have health care coverage by 2010. This should be accomplished by building upon and strengthening the successes of private health insurance coverage and publicly supported children's health insurance programs in Washington state. Access to coverage should be streamlined and efficient, with reductions in unnecessary administrative costs and mechanisms to expeditiously link children with a medical home;

(b) The state, in collaboration with parents, schools, communities, health plans, and providers, take steps to improve health outcomes for the children of Washington state by linking children with a medical home, identifying health improvement goals for children, and

linking innovative purchasing strategies to those goals. [2007 c 5 § 1; 2005 c 279 § 1.]

RCW 74.09.460 Children's affordable health coverage—Findings—Intent. (1) The legislature finds that parents have a responsibility to:

(a) Enroll their children in affordable health coverage;

(b) Ensure that their children receive appropriate well-child preventive care;

(c) Link their child with a medical home; and

(d) Understand and act upon the health benefits of good nutrition and physical activity.

(2) The legislature intends that the programs and outreach and education efforts established in RCW 74.09.470(6), as well as partnerships with the public and private sectors, provide the support and information needed by parents to meet the responsibilities set forth in this section. [2007 c 5 § 3.]

RCW 74.09.470 Children's affordable health coverage—Authority duties. (1) Consistent with the goals established in RCW 74.09.402, through the apple health for kids program authorized in this section, the authority shall provide affordable health care coverage to children under the age of nineteen who reside in Washington state and whose family income at the time of enrollment is not greater than 260 percent of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services, and effective January 1, 2009, and only to the extent that funds are specifically appropriated therefor, to children whose family income is not greater than 312 percent of the federal poverty level. In administering the program, the authority shall take such actions as may be necessary to ensure the receipt of federal financial participation under the medical assistance program, as codified at Title XIX of the federal social security act, the state children's health insurance program, as codified at Title XXI of the federal social security act, and any other federal funding sources that are now available or may become available in the future. The authority and the caseload forecast council shall estimate the anticipated caseload and costs of the program established in this section.

(2) The authority shall accept applications for enrollment for children's health care coverage; establish appropriate minimum-enrollment periods, as may be necessary; and determine eligibility based on current family income. The authority shall make eligibility determinations within the time frames for establishing eligibility for children on medical assistance, as defined by RCW 74.09.510. The application and annual renewal processes shall be designed to minimize administrative barriers for applicants and enrolled clients, and to minimize gaps in eligibility for families who are eligible for coverage. If a change in family income results in a change in the source of funding for coverage, the authority shall transfer the family members to the appropriate source of funding and notify the family with respect to any change in premium obligation, without a break in eligibility. The authority shall use the same eligibility redetermination and appeals procedures as those provided for children on medical assistance programs. The authority shall modify its

eligibility renewal procedures to lower the percentage of children failing to annually renew. The authority shall manage its outreach, application, and renewal procedures with the goals of: (a) Achieving year by year improvements in enrollment, enrollment rates, renewals, and renewal rates; (b) maximizing the use of existing program databases to obtain information related to earned and unearned income for purposes of eligibility determination and renewals, including, but not limited to, the basic food program, the child care subsidy program, federal social security administration programs, and the employment security department wage database; (c) streamlining renewal processes to rely primarily upon data matches, online submissions, and telephone interviews; and (d) implementing any other eligibility determination and renewal processes to allow the state to receive an enhanced federal matching rate and additional federal outreach funding available through the federal children's health insurance program reauthorization act of 2009 by January 2010. The department shall advise the governor and the legislature regarding the status of these efforts by September 30, 2009. The information provided should include the status of the department's efforts, the anticipated impact of those efforts on enrollment, and the costs associated with that enrollment.

(3) To ensure continuity of care and ease of understanding for families and health care providers, and to maximize the efficiency of the program, the amount, scope, and duration of health care services provided to children under this section shall be the same as that provided to children under medical assistance, as defined in RCW 74.09.520.

(4) The primary mechanism for purchasing health care coverage under this section shall be through contracts with managed health care systems as defined in RCW 74.09.522, subject to conditions, limitations, and appropriations provided in the biennial appropriations act. However, the authority shall make every effort within available resources to purchase health care coverage for uninsured children whose families have access to dependent coverage through an employer-sponsored health plan or another source when it is cost-effective for the state to do so, and the purchase is consistent with requirements of Title XIX and Title XXI of the federal social security act. To the extent allowable under federal law, the authority shall require families to enroll in available employer-sponsored coverage, as a condition of participating in the program established under this section, when it is cost-effective for the state to do so. Families who enroll in available employer- sponsored coverage under this section shall be accounted for separately in the annual report required by RCW 74.09.053.

(5)(a) To reflect appropriate parental responsibility, the authority shall develop and implement a schedule of premiums for children's health care coverage due to the authority from families with income greater than 210 percent of the federal poverty level. For families with income greater than 260 percent of the federal poverty level, the premiums shall be established in consultation with the senate majority and minority leaders and the speaker and minority leader of the house of representatives. For children eligible for coverage under the federally funded children's health insurance program, Title XXI of the federal social security act, premiums shall be set at a reasonable level that does not pose a barrier to enrollment. The amount of the premium shall be based upon family income and shall not exceed the premium limitations in Title XXI of

the federal social security act. For children who are not eligible for coverage under the federally funded children's health insurance program, premiums shall be set every two years in an amount no greater than the average state-only share of the per capita cost of coverage in the state-funded children's health program.

(b) Premiums shall not be imposed on children in households at or below 210 percent of the federal poverty level as articulated in RCW 74.09.055.

(c) The authority shall offer families whose income is greater than 312 percent of the federal poverty level the opportunity to purchase health care coverage for their children through the programs administered under this section without an explicit premium subsidy from the state. The design of the health benefit package offered to these children should provide a benefit package substantially similar to that offered in the apple health for kids program, and may differ with respect to cost-sharing, and other appropriate elements from that provided to children under subsection (3) of this section including, but not limited to, application of preexisting conditions, waiting periods, and other design changes needed to offer affordable coverage. The amount paid by the family shall be in an amount equal to the rate paid by the state to the managed health care system for coverage of the child, including any associated and administrative costs to the state of providing coverage for the child. Any pooling of the program enrollees that results in state fiscal impact must be identified and brought to the legislature for consideration.

(6) The authority shall undertake and continue a proactive, targeted outreach and education effort with the goal of enrolling children in health coverage and improving the health literacy of youth and parents. The authority shall collaborate with the department of social and health services, department of health, local public health jurisdictions, the office of the superintendent of public instruction, the department of children, youth, and families, health educators, health care providers, health carriers, community-based organizations, and parents in the design and development of this effort. The outreach and education effort shall include the following components:

(a) Broad dissemination of information about the availability of coverage, including media campaigns;

(b) Assistance with completing applications, and community-based outreach efforts to help people apply for coverage. Community-based outreach efforts should be targeted to the populations least likely to be covered;

(c) Use of existing systems, such as enrollment information from the free and reduced-price lunch program, the department of children, youth, and families child care subsidy program, the department of health's women, infants, and children program, and the early childhood education and assistance program, to identify children who may be eligible but not enrolled in coverage;

(d) Contracting with community-based organizations and government entities to support community-based outreach efforts to help families apply for coverage. These efforts should be targeted to the populations least likely to be covered. The authority shall provide informational materials for use by government entities and community-based organizations in their outreach activities, and should identify any available federal matching funds to support these efforts;

(e) Development and dissemination of materials to engage and inform parents and families statewide on issues such as: The benefits of health insurance coverage; the appropriate use of health services,

including primary care provided by health care practitioners licensed under chapters 18.71, 18.57, 18.36A, and 18.79 RCW, and emergency services; the value of a medical home, well-child services and immunization, and other preventive health services with linkages to department of health child profile efforts; identifying and managing chronic conditions such as asthma and diabetes; and the value of good nutrition and physical activity;

(f) An evaluation of the outreach and education efforts, based upon clear, cost-effective outcome measures that are included in contracts with entities that undertake components of the outreach and education effort;

(g) An implementation plan to develop online application capability that is integrated with the automated client eligibility system, and to develop data linkages with the office of the superintendent of public instruction for free and reduced-price lunch enrollment information and the department of children, youth, and families for child care subsidy program enrollment information.

(7) The authority shall take action to increase the number of primary care physicians providing dental disease preventive services including oral health screenings, risk assessment, family education, the application of fluoride varnish, and referral to a dentist as needed.

(8) The department shall monitor the rates of substitution between private-sector health care coverage and the coverage provided under this section. [2023 c 51 § 40; 2018 c 58 § 2; 2011 1st sp.s. c 33 § 2; 2011 1st sp.s. c 15 § 21; 2009 c 463 § 2; 2007 c 5 § 2.]

Reviser's note: Chapter 33, Laws of 2011 1st sp.s. took effect April 1, 2011, but amended 2011 1st sp.s. c 15, which took effect July 1, 2011.

Effective date—2018 c 58: See note following RCW 28A.655.080.

Contingent effective dates—2011 1st sp.s. c 33: "(1) Section 1 of this act takes effect if section 21, chapter 15, Laws of 2011 1st sp. sess. is not enacted into law.

(2) Section 2 of this act takes effect if section 21, chapter 15, Laws of 2011 1st sp. sess. is enacted into law." [2011 1st sp.s. c 33 § 3.]

Effective date—2011 1st sp.s. c 33: "Subject to section 3 of this act, this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect April 1, 2011." [2011 1st sp.s. c 33 § 4.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Findings—Intent—2009 c 463: "The legislature finds that substantial progress has been made toward achieving the equally important goals set in 2007 that all children in Washington state have health care coverage by 2010 and that child health outcomes improve. The legislature also finds that continued steps are necessary to reach the goals that all children in Washington state shall have access to the health services they need to be healthy and ready to learn and

that key measures of child health outcomes will show year by year improvement. The legislature further finds that reaching these goals is integral to the state's ability to weather the current economic crisis. The recent reauthorization of the federal children's health insurance program provides additional opportunities for the state to reach these goals. In view of these important objectives, the legislature intends that the apple health for kids program be managed actively across administrations in the department of social and health services, and across state and local agencies, with clear accountability for achieving the intended program outcomes. The legislature further intends that the department continue the implementation of the apple health for kids program with a commitment to fully utilizing the new program identity with appropriate materials." [2009 c 463 § 1.]

Short title—2009 c 463: "This act may be known and cited as the apple health for kids act." [2009 c 463 § 5.]

RCW 74.09.4701 Apple health for kids—Unemployment compensation. For apple health for kids, the department shall not count the twenty-five dollar increase paid as part of an individual's weekly benefit amount when determining family income, eligibility, and payment levels. [2023 c 51 § 41; 2011 c 4 § 19.]

Effective date—2011 c 4 §§ 1-6 and 16-21: See note following RCW 50.20.120.

Conflict with federal requirements—2011 c 4: See note following RCW 50.29.021.

RCW 74.09.475 Newborn delivery services to medical assistance clients—Policies and procedures—Reporting. (1) Effective January 1, 2018, the authority shall require that all health care facilities that provide newborn delivery services to medical assistance clients establish policies and procedures to provide:

(a) Skin-to-skin placement of the newborn on the mother's chest immediately following birth to promote the initiation of breastfeeding, except as otherwise indicated by authority guidelines; and

(b) Room-in practices in which a newborn and a mother share the same room for the duration of their postdelivery stay at the facility, except as otherwise indicated by authority guidelines.

(2) The authority shall provide guidelines for hospitals to use when establishing policies and procedures for services under subsection (1) of this section, including circumstances in which providing the services is not appropriate.

(3) The authority shall require managed care organizations to report on the frequency with which each facility they contract with is able to adhere to the policies and procedures and the most common reasons for nonadherence. The authority shall include a summary of this information in the biennial report required under RCW 74.09.480(3). [2017 c 294 § 2.]

Findings—2017 c 294: "(1) The legislature finds that the state has an interest in assuring that children are given the opportunity to have a healthy start in life. Because approximately half of all births in Washington state are funded by state resources, and over eight hundred thousand children in Washington state are enrolled in the apple health program, the state is in a unique position to make a difference in the health of children in Washington.

(2) The legislature also finds that there may be gaps in programs that could greatly benefit children. Where programs may benefit children in their early stages of development, the state must assure they receive these benefits. Where children are not receiving services because the public is unaware of the services, opportunities for outreach must be explored.

(3) The legislature additionally finds that several hospitals have begun adopting the best practices of the baby-friendly hospital initiative. The state can use its resources to encourage hospitals to adopt some of the most critical components by incorporating the standards into medicaid contracts.

(4) The legislature further finds that providing children with a healthy start also requires promoting healthy pregnancies. In one national survey, pregnant workers said they needed more frequent breaks while pregnant. Prenatal care is also critical for positive birth outcomes, and pregnant women have cited the need for flexibility in their work schedule for the purposes of attending doctor visits. Reasonable accommodations for pregnant women in the workplace can go a long way to promoting healthy pregnancies without producing an undue hardship on employers." [2017 c 294 § 1.]

RCW 74.09.480 Performance measures—Provider rate increases—Report. (1) The authority, in collaboration with the department of health, department of social and health services, health carriers, local public health jurisdictions, children's health care providers including pediatricians, family practitioners, advanced registered nurse practitioners, certified nurse midwives, and pediatric subspecialists, community and migrant health centers, parents, and other purchasers, shall establish a concise set of explicit performance measures that can indicate whether children enrolled in the program are receiving health care through an established and effective medical home, and whether the overall health of enrolled children is improving. Such indicators may include, but are not limited to:

(a) Childhood immunization rates;

(b) Well child care utilization rates, including the use of behavioral and oral health screening, and validated, structured developmental screens using tools, that are consistent with nationally accepted pediatric guidelines and recommended administration schedule, once funding is specifically appropriated for this purpose;

(c) Care management for children with chronic illnesses;

(d) Emergency room utilization;

(e) Visual acuity and eye health;

(f) Preventive oral health service utilization; and

(g) Children's mental health status. In defining these measures the authority shall be guided by the measures provided in RCW 71.36.025.

Performance measures and targets for each performance measure must be established and monitored each biennium, with a goal of achieving measurable, improved health outcomes for the children of Washington state each biennium.

(2) Beginning in calendar year 2009, targeted provider rate increases shall be linked to quality improvement measures established under this section. The authority, in conjunction with those groups identified in subsection (1) of this section, shall develop parameters for determining criteria for increased payment, alternative payment methodologies, or other incentives for those practices and health plans that incorporate evidence-based practice and achieve sustained improvement with respect to the measures.

(3) The department shall provide a report to the governor and the legislature related to provider performance on these measures, as well as the information collected under RCW 74.09.475, beginning in September 2010 for 2007 through 2009 and the authority shall provide the report biennially thereafter. [2023 c 51 § 42; 2017 c 294 § 4; 2011 1st sp.s. c 15 § 22; 2009 c 463 § 4; 2007 c 5 § 4.]

Findings—2017 c 294: See note following RCW 74.09.475.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Findings—Intent—Short title—2009 c 463: See notes following RCW 74.09.470.

RCW 74.09.490 Children's mental health—Improving medication management and care coordination. (1) The authority, in consultation with the evidence-based practice institute established in RCW 71.24.061, shall develop and implement policies to improve prescribing practices for treatment of emotional or behavioral disturbances in children, improve the quality of children's mental health therapy through increased use of evidence-based and research-based practices and reduced variation in practice, improve communication and care coordination between primary care and mental health providers, and prioritize care in the family home or care which integrates the family where out-of-home placement is required.

(2) The authority shall identify those children with emotional or behavioral disturbances who may be at high risk due to off-label use of prescription medication, use of multiple medications, high medication dosage, or lack of coordination among multiple prescribing providers, and establish one or more mechanisms to evaluate the appropriateness of the medication these children are using, including but not limited to obtaining second opinions from experts in child psychiatry.

(3) The authority shall review the psychotropic medications of all children under five and establish one or more mechanisms to evaluate the appropriateness of the medication these children are using, including but not limited to obtaining second opinions from experts in child psychiatry.

(4) Within existing funds, the authority shall require a second opinion review from an expert in psychiatry for all prescriptions of one or more antipsychotic medications of all children under eighteen

years of age in the foster care system. Thirty days of a prescription medication may be dispensed pending the second opinion review. The second opinion feedback must include discussion of the psychosocial interventions that have been or will be offered to the child and caretaker if appropriate in order to address the behavioral issues brought to the attention of the prescribing physician.

(5) The authority shall track prescriptive practices with respect to psychotropic medications with the goal of reducing the use of medication.

(6) The authority shall promote the appropriate use of cognitive behavioral therapies and other treatments which are empirically supported or evidence-based, in addition to or in the place of prescription medication where appropriate and such interventions are available. [2015 c 283 § 2; 2011 1st sp.s. c 15 § 23; 2007 c 359 § 5.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Captions not law—2007 c 359: See note following RCW 71.36.005.

RCW 74.09.495 Access to children's behavioral health services—Report to legislature. (1) To better assure and understand issues related to network adequacy and access to services, the authority shall report to the appropriate committees of the legislature by December 1, 2017, and annually thereafter, on the status of access to behavioral health services for children from birth through age seventeen using data collected pursuant to RCW 70.320.050.

(2) At a minimum, the report must include the following components broken down by age, gender, and race and ethnicity:

(a) The percentage of discharges for patients ages six through seventeen who had a visit to the emergency room with a primary diagnosis of mental health or alcohol or other drug dependence during the measuring year and who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within thirty days of discharge;

(b) The percentage of health plan members with an identified mental health need who received mental health services during the reporting period;

(c) The percentage of children served by behavioral health administrative services organizations and managed care organizations, including the types of services provided;

(d) The number of children's mental health providers available in the previous year, the languages spoken by those providers, and the overall percentage of children's mental health providers who were actively accepting new patients; and

(e) Data related to mental health and medical services for eating disorder treatment in children and youth by county, including the number of:

(i) Eating disorder diagnoses;

(ii) Patients treated in outpatient, residential, emergency, and inpatient care settings; and

(iii) Contracted providers specializing in eating disorder treatment and the overall percentage of those providers who were

actively accepting new patients during the reporting period. [2019 c 325 § 4002; 2018 c 175 § 3; 2017 c 226 § 6; 2017 c 202 § 3; 2016 c 96 § 3.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—2018 c 175: "The legislature finds that the children's mental health work group established in chapter 96, Laws of 2016 reported recommendations in December 2016 related to increasing access to adequate, appropriate, and culturally and linguistically relevant mental health services for children and youth. The legislature further finds that legislation implementing many of the recommendations of the children's mental health work group was enacted in 2017. Despite these gains, barriers to service remain and additional work is required to assist children with securing adequate mental health treatment. The legislature further finds that by January 1, 2020, the community behavioral health program must be fully integrated in a managed care health system that provides behavioral and physical health care services to medicaid clients. Therefore, it is the intent of the legislature to reestablish the children's mental health work group through December 2020 and to implement additional recommendations from the work group in order to improve mental health care access for children and their families." [2018 c 175 § 1.]

Sustainable solutions for the integration of behavioral and physical health—2017 c 226: See note following RCW 74.09.497.

Findings—Intent—2017 c 202: "The legislature finds that children and their families face systemic barriers to accessing necessary mental health services. These barriers include a workforce shortage of mental health providers throughout the system of care. Of particular concern are shortages of providers in underserved rural areas of our state and a shortage of providers statewide who can deliver culturally and linguistically appropriate services. The legislature further finds that greater coordination across systems, including early learning, K-12 education, and health care, is necessary to provide children and their families with coordinated care.

The legislature further finds that until mental health and physical health services are fully integrated in the year 2020, children who are eligible for medicaid services and require mental health treatment should receive coordinated mental health and physical health services to the fullest extent possible.

The legislature further finds that in 2013, the department of social and health services and the health care authority reported that only forty percent of the children on medicaid who had mental health treatment needs were receiving services and that mental health treatment needs increase with the number of adverse childhood experiences that a child has undergone.

The legislature further finds that children with mental health service needs have higher rates of emergency room use, criminal justice system involvement, and an increased risk of homelessness, and that trauma-informed care can mitigate some of these negative outcomes.

Therefore, the legislature intends to implement recommendations from the children's mental health work group, as reported in December 2016, in order to improve mental health care access for children and

their families through the early learning, K-12 education, and health care systems. The legislature further intends to encourage providers to use behavioral health therapies and other therapies that are empirically supported or evidence-based and only prescribe medications for children and youth as a last resort." [2017 c 202 § 1.]

Findings—Intent—2016 c 96: "(1) The legislature understands that adverse childhood experiences, such as family mental health issues, substance abuse, serious economic hardship, and domestic violence, all increase the likelihood of developmental delays and later health and mental health problems. The legislature further understands that early intervention services for children and families at high risk for adverse childhood experience help build secure parent-child attachment and bonding, which allows young children to thrive and form strong relationships in the future. The legislature finds that early identification and intervention are critical for children exhibiting aggressive or depressive behaviors indicative of early mental health problems. The legislature intends to improve access to adequate, appropriate, and culturally responsive mental health services for children and youth. The legislature further intends to encourage the use of behavioral health therapies and other therapies that are empirically supported or evidence-based and only prescribe medications for children and youth as a last resort.

(2) The legislature finds that nearly half of Washington's children are enrolled in medicaid and have a higher incidence of serious health problems compared to children who have commercial insurance. The legislature recognizes that disparities also exist in the diagnosis and initiation of treatment services for children of color, with studies demonstrating that children of color are diagnosed and begin receiving early interventions at a later age. The legislature finds that within the current system of care, families face barriers to receiving a full range of services for children experiencing behavioral health problems. The legislature intends to identify what network adequacy requirements, if strengthened, would increase access, continuity, and coordination of behavioral health services for children and families. The legislature further intends to encourage managed care plans and behavioral health organizations to contract with the same providers that serve children so families are not required to duplicate mental health screenings, and to recommend provider rates for mental health services to children and youth which will ensure an adequate network and access to quality based care.

(3) The legislature recognizes that early and accurate recognition of behavioral health issues coupled with appropriate and timely intervention enhances health outcomes while minimizing overall expenditures. The legislature intends to assure that annual depression screenings are done consistently with the highly vulnerable medicaid population and that children and families benefit from earlier access to services." [2016 c 96 § 1.]

RCW 74.09.4951 Children and youth behavioral health work group—Advisory groups—Report to governor and legislature. ***(Expires December 30, 2026.)*** (1) The children and youth behavioral health work group is established to identify barriers to and opportunities for accessing behavioral health services for children and their families, and to

advise the legislature on statewide behavioral health services for this population.

(2) The work group shall consist of members and alternates as provided in this subsection. Members must represent the regional, racial, and cultural diversity of all children and families in the state.

(a) The president of the senate shall appoint one member and one alternate from each of the two largest caucuses in the senate.

(b) The speaker of the house of representatives shall appoint one member and one alternate from each of the two largest caucuses in the house of representatives.

(c) The governor shall appoint six members representing the following state agencies and offices: The department of children, youth, and families; the department of social and health services; the health care authority; the department of health; the office of homeless youth prevention and protection programs; and the office of the governor.

(d) The governor shall appoint the following members:

(i) One representative of behavioral health administrative services organizations;

(ii) One representative of community mental health agencies;

(iii) Two representatives of medicaid managed care organizations, one of which must provide managed care to children and youth receiving child welfare services;

(iv) One regional provider of co-occurring disorder services;

(v) One pediatrician or primary care provider;

(vi) One provider specializing in infant or early childhood mental health;

(vii) One representative who advocates for behavioral health issues on behalf of children and youth;

(viii) One representative of early learning and child care providers;

(ix) One representative of the evidence-based practice institute;

(x) Two parents or caregivers of children who have received behavioral health services, one of which must have a child under the age of six;

(xi) One representative of an education or teaching institution that provides training for mental health professionals;

(xii) One foster parent;

(xiii) One representative of providers of culturally and linguistically appropriate health services to traditionally underserved communities;

(xiv) One pediatrician located east of the crest of the Cascade mountains;

(xv) One child psychiatrist;

(xvi) One representative of an organization representing the interests of individuals with developmental disabilities;

(xvii) Two youth representatives who have received behavioral health services;

(xviii) One representative of a private insurance organization;

(xix) One representative from the statewide family youth system partner roundtable established in the *T.R. v. Strange and McDermott*, formerly the *T.R. v. Dreyfus and Porter*, settlement agreement; and

(xx) One substance use disorder professional.

(e) The governor shall request participation by a representative of tribal governments.

(f) The superintendent of public instruction shall appoint one representative from the office of the superintendent of public instruction.

(g) The insurance commissioner shall appoint one representative from the office of the insurance commissioner.

(h) The work group shall choose its cochairs, one from among its legislative members and one from among the executive branch members. The representative from the health care authority shall convene at least two, but not more than six, meetings of the work group each year.

(i) The cochairs may invite additional members of the house of representatives and the senate to participate in work group activities, including as leaders of advisory groups to the work group. These legislators are not required to be formally appointed members of the work group in order to participate in or lead advisory groups.

(3) The work group shall:

(a) Monitor the implementation of enacted legislation, programs, and policies related to children and youth behavioral health, including provider payment for mood, anxiety, and substance use disorder prevention, screening, diagnosis, and treatment for children and young mothers; consultation services for child care providers caring for children with symptoms of trauma; home visiting services; and streamlining agency rules for providers of behavioral health services;

(b) Consider system strategies to improve coordination and remove barriers between the early learning, K-12 education, and health care systems;

(c) Identify opportunities to remove barriers to treatment and strengthen behavioral health service delivery for children and youth;

(d) Determine the strategies and resources needed to:

(i) Improve inpatient and outpatient access to behavioral health services;

(ii) Support the unique needs of young children prenatally through age five, including promoting health and social and emotional development in the context of children's family, community, and culture; and

(iii) Develop and sustain system improvements to support the behavioral health needs of children and youth; and

(e) Consider issues and recommendations put forward by the statewide family youth system partner roundtable established in the *T.R. v. Strange and McDermott*, formerly the *T.R. v. Dreyfus and Porter*, settlement agreement.

(4) At the direction of the cochairs, the work group may convene advisory groups to evaluate specific issues and report related findings and recommendations to the full work group.

(5) The work group shall convene an advisory group focused on school-based behavioral health and suicide prevention. The advisory group shall advise the full work group on creating and maintaining an integrated system of care through a tiered support framework for kindergarten through twelfth grade school systems defined by the office of the superintendent of public instruction and behavioral health care systems that can rapidly identify students in need of care and effectively link these students to appropriate services, provide age-appropriate education on behavioral health and other universal supports for social-emotional wellness for all students, and improve both education and behavioral health outcomes for students. The work

group cochairs may invite nonwork group members to participate as advisory group members.

(6)(a) Subject to the availability of amounts appropriated for this specific purpose, the work group shall convene an advisory group for the purpose of developing a draft strategic plan that describes:

(i) The current landscape of behavioral health services available to families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth in Washington state, including a description of:

(A) The gaps and barriers in receiving or accessing behavioral health services, including services for co-occurring behavioral health disorders or other conditions;

(B) Access to high quality, equitable care and supports in behavioral health education and promotion, prevention, intervention, treatment, recovery, and ongoing well-being supports;

(C) The current supports and services that address emerging behavioral health issues before a diagnosis and more intensive services or clinical treatment is needed; and

(D) The current behavioral health care oversight and management of services and systems;

(ii) The vision for the behavioral health service delivery system for families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth, including:

(A) A complete continuum of services from education, promotion, prevention, early intervention through crisis response, intensive treatment, postintervention, and recovery, as well as supports that sustain wellness in the behavioral health spectrum;

(B) How access can be provided to high quality, equitable care and supports in behavioral health education, promotion, prevention, intervention, recovery, and ongoing well-being when and where needed;

(C) How the children and youth behavioral health system must successfully pair with the 988 behavioral health crisis response described under chapter 82.86 RCW;

(D) The incremental steps needed to achieve the vision for the behavioral health service delivery system based on the current gaps and barriers for accessing behavioral health services, with estimated dates for these steps; and

(E) The oversight and management needed to ensure effective behavioral health care; and

(iii) A comparison of the current behavioral health system for families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth that is primarily based on crisis response and inadequate capacity with the behavioral health system vision created by the strategic planning process through a cost-benefit analysis.

(b) The work group cochairs may invite nonwork group members to participate as advisory group members, but the strategic plan advisory group shall include, at a minimum:

(i) Community members with lived experience including those with cultural, linguistic, and ethnic diversity, as well as those having diverse experience with behavioral health care invited by the work group cochairs;

(ii) A representative from the department of children, youth, and families;

(iii) A representative from the department;

(iv) A representative from the authority;

(v) A representative from the department of health;

(vi) A representative from the office of homeless youth prevention and protection programs;

(vii) A representative from the office of the governor;

(viii) A representative from the developmental disability administration of the department of social and health services;

(ix) A representative from the office of the superintendent of public instruction;

(x) A representative from the office of the insurance commissioner;

(xi) A tribal representative;

(xii) Two legislative members or alternates from the work group; and

(xiii) Individuals invited by the work group cochairs with relevant subject matter expertise.

(c) The health care authority shall conduct competitive procurements as necessary in accordance with chapter 39.26 RCW to select a third-party facilitator to facilitate the strategic plan advisory group.

(d) To assist the strategic plan advisory group in its work, the authority, in consultation with the cochairs of the work group, shall select an entity to conduct the activities set forth in this subsection. The health care authority may contract directly with a public agency as defined under RCW 39.34.020 through an interagency agreement. If the health care authority determines, in consultation with the cochairs of the work group, that a public agency is not appropriate for conducting these analyses, the health care authority may select another entity through competitive procurements as necessary in accordance with chapter 39.26 RCW. The activities that entities selected under this subsection must complete include:

(i) Following a statewide stakeholder engagement process, a behavioral health landscape analysis for families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth outlining:

(A) The current service continuum including the cost of care, delivery service models, and state oversight for behavioral health services covered by medicaid and private insurance;

(B) Current gaps in the service continuum, areas without access to services, workforce demand, and capacity shortages;

(C) Barriers to accessing preventative services and necessary care including inequities in service access, affordability, cultural responsiveness, linguistic responsiveness, gender responsiveness, and developmentally appropriate service availability; and

(D) Incorporated information provided by the 988 crisis hotline crisis response improvement strategy committee as required under *RCW 71.24.893;

(ii) A gap analysis estimating the prevalence of needs for Washington state behavioral health services for families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth served by medicaid or private insurance, including:

(A) The estimated number of families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth who need clinical behavioral health services or could benefit from preventive or early intervention services on an annual basis;

(B) The estimated number of expectant parents and caregivers in need of behavioral health services;

(C) A collection and analysis of disaggregated data to better understand regional, economic, linguistic, gender, and racial gaps in access to behavioral health services;

(D) The estimated costs of providing services that include a range of behavioral health supports that will meet the projected needs of the population; and

(E) Recommendations on the distribution of resources to deliver needed services to families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth across multiple settings; and

(iii) An analysis of peer-reviewed publications, evidence-based practices, and other existing practices and guidelines with preferred outcomes regarding the delivery of behavioral health services to families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth across multiple settings including:

(A) Approaches to increasing access and quality of care for underserved populations;

(B) Approaches to providing developmentally appropriate care;

(C) The integration of culturally responsive care with effective clinical care practices and guidelines;

(D) Strategies to maximize federal reinvestment and resources from any alternative funding sources; and

(E) Workforce development strategies that ensure a sustained, representative, and diverse workforce.

(e) The strategic plan advisory group shall prioritize its work as follows:

(i) Hold its first meeting by September 1, 2022;

(ii) Select third-party entities described under (d) of this subsection by December 31, 2022;

(iii) Provide a progress report on the development of the strategic plan, including a timeline of future strategic plan development steps, to be included in the work group's 2022 annual report required under subsection (10) of this section;

(iv) Provide a progress report on the development of the strategic plan, including discussion of the work group recommendations that align with the strategic plan development thus far, to be included in the work group's 2023 annual report required under subsection (10) of this section;

(v) Provide a draft strategic plan, along with any materials produced by entities selected under (d) of this subsection, to the work group by October 1, 2024. The draft strategic plan must include an incremental action plan outlining the action steps needed to achieve the vision provided by the draft strategic plan, clear prioritization criteria, and a transparent evaluation plan. The action plan may include further research questions, a proposed budget to continue the strategic planning work or implementation process, and a process for reviewing and updating the strategic plan.

(f) The work group shall discuss the draft strategic plan and action plan after they are submitted and adopt a final strategic plan that must be submitted to the governor and the appropriate committees of the legislature at the same time as the work group's 2024 annual report required under subsection (10) of this section.

(7)(a) Staff support for the work group, including administration of work group meetings and preparation of full work group

recommendations and reports required under this section, must be provided by the health care authority.

(b) Additional staff support for legislative members of the work group may be provided by senate committee services and the house of representatives office of program research.

(c) Subject to the availability of amounts appropriated for this specific purpose, the office of the superintendent of public instruction must provide staff support to the school-based behavioral health and suicide prevention advisory group, including administration of advisory group meetings and the preparation and delivery of advisory group recommendations to the full work group.

(8)(a) Legislative members of the work group are reimbursed for travel expenses in accordance with RCW 44.04.120. Nonlegislative members are not entitled to be reimbursed for travel expenses if they are elected officials or are participating on behalf of an employer, governmental entity, or other organization. Except as provided under (b) of this subsection, any reimbursement for other nonlegislative members is subject to chapter 43.03 RCW.

(b) Members of the children and youth behavioral health work group or an advisory group established under this section with lived experience may receive a stipend of up to $200 per day if:

(i) The member participates in the meeting virtually or in person, even if only participating for one meeting and not on an ongoing basis; and

(ii) The member does not receive compensation, including paid leave, from the member's employer or contractor for participation in the meeting.

(9) The following definitions apply to this section:

(a) "A member with lived experience" means an individual who has received behavioral health services or whose family member has received behavioral health services; and

(b) "Families in the perinatal phase" means families during the time from pregnancy through one year after birth.

(10) Beginning November 1, 2020, and annually thereafter, the work group shall provide recommendations in alignment with subsection (3) of this section to the governor and the legislature. Beginning November 1, 2025, the work group shall include in its annual report a discussion of how the work group's recommendations align with the final strategic plan described under subsection (6) of this section.

(11) This section expires December 30, 2026. [2022 c 76 § 1; 2020 c 130 § 1; 2019 c 360 § 2; 2018 c 175 § 2.]

***Reviser's note:** RCW 71.24.893 expired July 1, 2023.

Findings—Intent—2019 c 360: "(1) The legislature finds that the children's mental health work group established in chapter 96, Laws of 2016 reported recommendations related to increasing access to mental health services for children and youth and that many of those recommendations were adopted by the 2017 and 2018 legislatures. The legislature further finds that additional work is needed to improve mental health support for children and families and that the children's mental health work group was reestablished for this purpose in chapter 175, Laws of 2018.

(2) The legislature finds that there is a workforce shortage of behavioral health professionals and that increasing medicaid rates to a level that is equal to medicare rates will increase the number of providers who will serve children and families on medicaid. Further,

the legislature finds that there is a need to increase the cultural and linguistic diversity among children's behavioral health professionals and that hiring practices, professional training, and high quality translations of accreditation and licensing exams should be implemented to incentivize this diversity in the workforce.

(3) Therefore, the legislature intends to implement the recommendations adopted by the children's mental health work group in January 2019, in order to improve mental health care access for children and their families." [2019 c 360 § 1.]

RCW 74.09.497 Authority review of payment codes available to health plans and providers related to primary care and behavioral health—Requirements—Principles considered—Matrices—Reporting. (1) By August 1, 2017, the authority must complete a review of payment codes available to health plans and providers related to primary care and behavioral health. The review must include adjustments to payment rules if needed to facilitate bidirectional integration. The review must involve stakeholders and include consideration of the following principles to the extent allowed by federal law:

(a) Payment rules must allow professionals to operate within the full scope of their practice;

(b) Payment rules should allow medically necessary behavioral health services for covered patients to be provided in any setting;

(c) Payment rules should allow medically necessary primary care services for covered patients to be provided in any setting;

(d) Payment rules and provider communications related to payment should facilitate integration of physical and behavioral health services through multifaceted models, including primary care behavioral health, whole-person care in behavioral health, collaborative care, and other models;

(e) Payment rules should be designed liberally to encourage innovation and ease future transitions to more integrated models of payment and more integrated models of care;

(f) Payment rules should allow health and behavior codes to be reimbursed for all patients in primary care settings as provided by any licensed behavioral health professional operating within their scope of practice, including but not limited to psychiatrists, psychologists, psychiatric advanced registered nurse professionals, physician assistants working with a supervising psychiatrist, psychiatric nurses, mental health counselors, social workers, chemical dependency professionals, chemical dependency professional trainees, marriage and family therapists, and mental health counselor associates under the supervision of a licensed clinician;

(g) Payment rules should allow health and behavior codes to be reimbursed for all patients in behavioral health settings as provided by any licensed health care provider within the provider's scope of practice;

(h) Payment rules which limit same-day billing for providers using the same provider number, require prior authorization for low-level or routine behavioral health care, or prohibit payment when the patient is not present should be implemented only when consistent with national coding conventions and consonant with accepted best practices in the field.

(2) Concurrent with the review described in subsection (1) of this section, the authority must create matrices listing the following

codes available for provider payment through medical assistance programs: All behavioral health-related codes; and all physical health-related codes available for payment when provided in licensed behavioral health agencies. The authority must clearly explain applicable payment rules in order to increase awareness among providers, standardize billing practices, and reduce common and avoidable billing errors. The authority must disseminate this information in a manner calculated to maximally reach all relevant plans and providers. The authority must update the provider billing guide to maintain consistency of information.

(3) The authority must inform the governor and relevant committees of the legislature by letter of the steps taken pursuant to this section and results achieved once the work has been completed. [2017 c 226 § 2.]

Contingent effective date—2017 c 226 § 2: "Section 2 of this act takes effect only if Engrossed Substitute House Bill No. 1340 (including any later amendments or substitutes) is not signed into law by the governor by July 23, 2017." [2017 c 226 § 10.] Engrossed Substitute House Bill No. 1340 was not signed into law by July 23, 2017.

Sustainable solutions for the integration of behavioral and physical health—2017 c 226: "Health transformation in Washington state requires a multifaceted approach to implement sustainable solutions for the integration of behavioral and physical health. Effective integration requires a holistic approach and cannot be limited to one strategy or model. Bidirectional integration of primary care and behavioral health is a foundational strategy to reduce health disparities and provide better care coordination for patients regardless of where they choose to receive care.

An important component to health care integration supported both by research and experience in Washington is primary care behavioral health, a model in which behavioral health providers, sometimes called behavioral health consultants, are fully integrated in primary care. The primary care behavioral health model originated more than two decades ago, has become standard practice nationally in patient centered medical homes, and has been endorsed as a viable integration strategy by Washington's Dr. Robert J. Bree Collaborative.

Primary care settings are a gateway for many individuals with behavioral health and primary care needs. An estimated one in four primary care patients have an identifiable behavioral health need and as many as seventy percent of primary care visits are impacted by a psychosocial component. A behavioral health consultant engages primary care patients and their caregivers on the same day as a medical visit, often in the same exam room. This warm hand-off approach fosters coordinated whole-person care, increases access to behavioral health services, and reduces stigma and cultural barriers in a cost-effective manner. Patients are provided evidence-based brief interventions and skills training, with more severe needs being effectively engaged, assessed, and referred to appropriate specialized care.

While the benefits of primary care behavioral health are not restricted to children, the primary care behavioral health model also provides a unique opportunity to engage children who have a strong relationship with primary care, identify problems early, and assure healthy development. Investment in primary care behavioral health

creates opportunities for prevention and early detection that pay dividends throughout the life cycle.

The legislature also recognizes that for individuals with more complex behavioral health disorders, there are tremendous barriers to accessing primary care. Whole-person care in behavioral health is an evidence-based model for integrating primary care into behavioral health settings where these patients already receive care. Health disparities among people with behavioral health disorders have been well-documented for decades. People with serious mental illness or substance use disorders continue to experience multiple chronic health conditions and dramatically reduced life expectancy while also constituting one of the highest-cost and highest-risk populations. Two-thirds of premature deaths are due to preventable or treatable medical conditions such as cardiovascular, pulmonary, and infectious diseases, and forty-four percent of all cigarettes consumed nationally are smoked by people with serious mental illness.

The whole-person care in behavioral health model allows behavioral health providers to take responsibility for managing the full array of physical health needs, providing routine basic health screening, and ensuring integrated primary care by actively coordinating with or providing on-site primary care services.

Providers in Washington need guidance on how to effectively implement bidirectional integration models in a manner that is also financially sustainable. Payment methodologies must be scrutinized to remove nonessential restrictions and limitations that restrict the scope of practice of behavioral health professionals, impede same-day billing for behavioral health and primary care services, abet billing errors, and stymie innovation that supports wellness and health integration." [2017 c 226 § 1.]

RCW 74.09.500 Medical assistance—Established. There is hereby established a new program of federal-aid assistance to be known as medical assistance to be administered by the authority. The authority is authorized to comply with the federal requirements for the medical assistance program provided in the social security act and particularly Title XIX of Public Law (89-97), as amended, in order to secure federal matching funds for such program. [2011 1st sp.s. c 15 § 24; 1979 c 141 § 343; 1967 ex.s. c 30 § 3.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.510 Medical assistance—Eligibility. Medical assistance may be provided in accordance with eligibility requirements established by the authority, as defined in the social security Title XIX state plan for mandatory categorically needy persons and:

(1) Individuals who would be eligible for cash assistance except for their institutional status;

(2) Individuals who are under twenty-one years of age, who would be eligible for medicaid, but do not qualify as dependent children and who are in (a) foster care, (b) subsidized adoption, (c) a nursing facility or an intermediate care facility for persons with intellectual disabilities, or (d) inpatient psychiatric facilities;

(3) Individuals who:

(a) Are under twenty-one years of age;

(b) On or after July 22, 2007, were in foster care under the legal responsibility of the department of social and health services, the department of children, youth, and families, or a federally recognized tribe located within the state; and

(c) On their eighteenth birthday, were in foster care under the legal responsibility of the department of children, youth, and families or a federally recognized tribe located within the state;

(4) Persons who are aged, blind, or disabled who: (a) Receive only a state supplement, or (b) would not be eligible for cash assistance if they were not institutionalized;

(5) Categorically eligible individuals who meet the income and resource requirements of the cash assistance programs;

(6) Individuals who are enrolled in managed health care systems, who have otherwise lost eligibility for medical assistance, but who have not completed a current six-month enrollment in a managed health care system, and who are eligible for federal financial participation under Title XIX of the social security act;

(7) Children and pregnant women allowed by federal statute for whom funding is appropriated;

(8) Working individuals with disabilities authorized under section 1902(a)(10)(A)(ii) of the social security act for whom funding is appropriated;

(9) Other individuals eligible for medical services under RCW 74.09.700 for whom federal financial participation is available under Title XIX of the social security act;

(10) Persons allowed by section 1931 of the social security act for whom funding is appropriated; and

(11) Women who: (a) Are under sixty-five years of age; (b) have been screened for breast and cervical cancer under the national breast and cervical cancer early detection program administered by the department of health or tribal entity and have been identified as needing treatment for breast or cervical cancer; and (c) are not otherwise covered by health insurance. Medical assistance provided under this subsection is limited to the period during which the woman requires treatment for breast or cervical cancer, and is subject to any conditions or limitations specified in the omnibus appropriations act. [2017 3rd sp.s. c 6 § 337; 2013 2nd sp.s. c 10 § 6. Prior: 2011 1st sp.s. c 36 § 9; 2011 1st sp.s. c 15 § 25; 2010 c 94 § 24; 2007 c 315 § 1; prior: 2001 2nd sp.s. c 15 § 3; 2001 1st sp.s. c 4 § 1; prior: 1997 c 59 § 14; 1997 c 58 § 201; 1991 sp.s. c 8 § 8; 1989 1st ex.s. c 10 § 8; 1989 c 87 § 2; 1985 c 5 § 2; 1981 2nd ex.s. c 3 § 5; 1981 1st ex.s. c 6 § 20; 1981 c 8 § 19; 1971 ex.s. c 169 § 4; 1970 ex.s. c 60 § 1; 1967 ex.s. c 30 § 4.]

Effective date—2017 3rd sp.s. c 6 §§ 102, 104-115, 201-227, 301-337, 401-419, 501-513, 801-803, and 805-822: See note following RCW 43.216.025.

Conflict with federal requirements—2017 3rd sp.s. c 6: See RCW 43.216.908.

Effective date—2013 2nd sp.s. c 10: See note following RCW 74.62.030.

Findings—Intent—2011 1st sp.s. c 36: See RCW 74.62.005.

Effective date—2011 1st sp.s. c 36: See note following RCW 74.62.005.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Purpose—2010 c 94: See note following RCW 44.04.280.

Conflict with federal requirements—2007 c 315: "If any part of this act is found to be in conflict with federal requirements that are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this act is inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and this finding does not affect the operation of the remainder of this act in its application to the agencies concerned. Rules adopted under this act must meet federal requirements that are a necessary condition to the receipt of federal funds by the state." [2007 c 315 § 3.]

Findings—Intent—2001 2nd sp.s. c 15: See note following RCW 74.09.540.

Effective date—2001 1st sp.s. c 4: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 1, 2001." [2001 1st sp.s. c 4 § 2.]

Short title—Part headings, captions, table of contents not law—Exemptions and waivers from federal law—Conflict with federal requirements—Severability—1997 c 58: See RCW 74.08A.900 through 74.08A.904.

Effective date—1991 sp.s. c 8: See note following RCW 18.51.050.

Effective dates—1989 c 87: "(1) Sections 7 and 8 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect July 1, 1989.

(2) Sections 1 through 5 of this act shall take effect October 1, 1989." [1989 c 87 § 9.]

Severability—1981 2nd ex.s. c 3: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [1981 2nd ex.s. c 3 § 8.]

Effective date—Severability—1981 1st ex.s. c 6: See notes following RCW 74.04.005.

RCW 74.09.515 Medical assistance—Coverage for youth released from confinement. (1) The authority shall adopt rules and policies

providing that when youth who were enrolled in a medical assistance program immediately prior to confinement are released from confinement, their medical assistance coverage will be fully reinstated on the day of their release, subject to any expedited review of their continued eligibility for medical assistance coverage that is required under federal or state law.

(2) The authority, in collaboration with the department, county juvenile court administrators, managed care organizations, the department of children, youth, and families, and behavioral health administrative services organizations, shall establish procedures for coordination among field offices, juvenile rehabilitation institutions, and county juvenile courts that result in prompt reinstatement of eligibility and speedy eligibility determinations for youth who are likely to be eligible for medical assistance services upon release from confinement. Procedures developed under this subsection must address:

(a) Mechanisms for receiving medical assistance services' applications on behalf of confined youth in anticipation of their release from confinement;

(b) Expeditious review of applications filed by or on behalf of confined youth and, to the extent practicable, completion of the review before the youth is released; and

(c) Mechanisms for providing medical assistance services' identity cards to youth eligible for medical assistance services immediately upon their release from confinement.

(3) For purposes of this section, "confined" or "confinement" means detained in a juvenile rehabilitation facility operated by or under contract with the department of children, youth, and families, or detained in a juvenile detention facility operated under chapter 13.04 RCW.

(4) The authority shall adopt standardized statewide screening and application practices and forms designed to facilitate the application of a confined youth who is likely to be eligible for a medical assistance program. [2019 c 325 § 4003; 2014 c 225 § 100; 2011 1st sp.s. c 15 § 26; 2007 c 359 § 8.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Effective date—2014 c 225: See note following RCW 71.24.016.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Captions not law—2007 c 359: See note following RCW 71.36.005.

RCW 74.09.520 Medical assistance—Care and services included—Funding limitations. (1) The term "medical assistance" may include the following care and services subject to rules adopted by the authority or department: (a) Inpatient hospital services; (b) outpatient hospital services; (c) other laboratory and X-ray services; (d) nursing facility services; (e) physicians' services, which shall include prescribed medication and instruction on birth control devices; (f) medical care, or any other type of remedial care as may be established by the secretary or director; (g) home health care

services; (h) private duty nursing services; (i) dental services; (j) physical and occupational therapy and related services; (k) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select; (l) personal care services, as provided in this section; (m) hospice services; (n) other diagnostic, screening, preventive, and rehabilitative services; and (o) like services when furnished to a child by a school district in a manner consistent with the requirements of this chapter. For the purposes of this section, neither the authority nor the department may cut off any prescription medications, oxygen supplies, respiratory services, or other life-sustaining medical services or supplies.

"Medical assistance," notwithstanding any other provision of law, shall not include routine foot care, or dental services delivered by any health care provider, that are not mandated by Title XIX of the social security act unless there is a specific appropriation for these services.

(2) The department shall adopt, amend, or rescind such administrative rules as are necessary to ensure that Title XIX personal care services are provided to eligible persons in conformance with federal regulations.

(a) These administrative rules shall include financial eligibility indexed according to the requirements of the social security act providing for medicaid eligibility.

(b) The rules shall require clients be assessed as having a medical condition requiring assistance with personal care tasks. Plans of care for clients requiring health-related consultation for assessment and service planning may be reviewed by a nurse.

(c) The department shall determine by rule which clients have a health-related assessment or service planning need requiring registered nurse consultation or review. This definition may include clients that meet indicators or protocols for review, consultation, or visit.

(3) The department shall design and implement a means to assess the level of functional disability of persons eligible for personal care services under this section. The personal care services benefit shall be provided to the extent funding is available according to the assessed level of functional disability. Any reductions in services made necessary for funding reasons should be accomplished in a manner that assures that priority for maintaining services is given to persons with the greatest need as determined by the assessment of functional disability.

(4) Effective July 1, 1989, the authority shall offer hospice services in accordance with available funds.

(5) For Title XIX personal care services administered by the department, the department shall contract with area agencies on aging or may contract with a federally recognized Indian tribe under RCW 74.39A.090(3):

(a) To provide case management services to individuals receiving Title XIX personal care services in their own home; and

(b) To reassess and reauthorize Title XIX personal care services or other home and community services as defined in RCW 74.39A.009 in home or in other settings for individuals consistent with the intent of this section:

(i) Who have been initially authorized by the department to receive Title XIX personal care services or other home and community services as defined in RCW 74.39A.009; and

(ii) Who, at the time of reassessment and reauthorization, are receiving such services in their own home.

(6) In the event that an area agency on aging or federally recognized Indian tribe is unwilling to enter into or satisfactorily fulfill a contract or an individual consumer's need for case management services will be met through an alternative delivery system, the department is authorized to:

(a) Obtain the services through competitive bid; and

(b) Provide the services directly until a qualified contractor can be found.

(7) Subject to the availability of amounts appropriated for this specific purpose, the authority may offer medicare part D prescription drug copayment coverage to full benefit dual eligible beneficiaries.

(8) Effective January 1, 2016, the authority shall require universal screening and provider payment for autism and developmental delays as recommended by the bright futures guidelines of the American academy of pediatrics, as they existed on August 27, 2015. This requirement is subject to the availability of funds.

(9) Subject to the availability of amounts appropriated for this specific purpose, effective January 1, 2018, the authority shall require provider payment for annual depression screening for youth ages twelve through eighteen as recommended by the bright futures guidelines of the American academy of pediatrics, as they existed on January 1, 2017. Providers may include, but are not limited to, primary care providers, public health nurses, and other providers in a clinical setting. This requirement is subject to the availability of funds appropriated for this specific purpose.

(10) Subject to the availability of amounts appropriated for this specific purpose, effective January 1, 2018, the authority shall require provider payment for maternal depression screening for mothers of children ages birth to six months. This requirement is subject to the availability of funds appropriated for this specific purpose.

(11) Subject to the availability of amounts appropriated for this specific purpose, the authority shall:

(a) Allow otherwise eligible reimbursement for the following related to mental health assessment and diagnosis of children from birth through five years of age:

(i) Up to five sessions for purposes of intake and assessment, if necessary;

(ii) Assessments in home or community settings, including reimbursement for provider travel; and

(b) Require providers to use the current version of the DC:0-5 diagnostic classification system for mental health assessment and diagnosis of children from birth through five years of age.

(12) Effective January 1, 2024, the authority shall require coverage for noninvasive preventive colorectal cancer screening tests assigned either a grade of A or grade of B by the United States preventive services task force and shall require coverage for colonoscopies performed as a result of a positive result from such a test.

(13)(a) The authority shall require or provide payment to the hospital for any day of a hospital stay in which an adult or child patient enrolled in medical assistance, including home and community services or with a medicaid managed care organization, under this chapter:

(i) Does not meet the criteria for acute inpatient level of care as defined by the authority;

(ii) Meets the criteria for discharge, as defined by the authority or department, to any appropriate placement including, but not limited to:

(A) A nursing home licensed under chapter 18.51 RCW;

(B) An assisted living facility licensed under chapter 18.20 RCW;

(C) An adult family home licensed under chapter 70.128 RCW; or

(D) A setting in which residential services are provided or funded by the developmental disabilities administration of the department, including supported living as defined in RCW 71A.10.020; and

(iii) Is not discharged from the hospital because placement in the appropriate location described in (a)(ii) of this subsection is not available.

(b) The authority shall adopt rules identifying which services are included in the payment described in (a) of this subsection and which services may be billed separately, including specific revenue codes or services required on the inpatient claim.

(c) Allowable medically necessary services performed during a stay described in (a) of this subsection shall be billed by and paid to the hospital separately. Such services may include but are not limited to hemodialysis, laboratory charges, and x-rays.

(d) Pharmacy services and pharmaceuticals shall be billed by and paid to the hospital separately.

(e) The requirements of this subsection do not alter requirements for billing or payment for inpatient care.

(f) The authority shall adopt, amend, or rescind such administrative rules as necessary to facilitate calculation and payment of the amounts described in this subsection, including for clients of medicaid managed care organizations.

(g) The authority shall adopt rules requiring medicaid managed care organizations to establish specific and uniform administrative and review processes for payment under this subsection.

(h) For patients meeting the criteria in (a)(ii)(A) of this subsection, hospitals must utilize swing beds or skilled nursing beds to the extent the services are available within their facility and the associated reimbursement methodology prior to the billing under the methodology in (a) of this subsection, if the hospital determines that such swing bed or skilled nursing bed placement is appropriate for the patient's care needs, the patient is appropriate for the existing patient mix, and appropriate staffing is available. [2023 c 315 § 1; 2023 c 299 § 1; 2022 c 255 § 4; 2021 c 126 § 2; 2017 c 202 § 4; 2015 1st sp.s. c 8 § 2; 2011 1st sp.s. c 15 § 27; 2007 c 3 § 1; 2004 c 141 § 2; 2003 c 279 § 1; 1998 c 245 § 145; 1995 1st sp.s. c 18 § 39; 1994 c 21 § 4. Prior: 1993 c 149 § 10; 1993 c 57 § 1; 1991 sp.s. c 8 § 9; prior: 1991 c 233 § 1; 1991 c 119 § 1; prior: 1990 c 33 § 594; 1990 c 25 § 1; prior: 1989 c 427 § 10; 1989 c 400 § 3; 1985 c 5 § 3; 1982 1st ex.s. c 19 § 4; 1981 1st ex.s. c 6 § 21; 1981 c 8 § 20; 1979 c 141 § 344; 1969 ex.s. c 173 § 11; 1967 ex.s. c 30 § 5.]

Reviser's note: This section was amended by 2023 c 299 § 1 and by 2023 c 315 § 1, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Findings—Intent—2017 c 202: See note following RCW 74.09.495.

Findings—2015 1st sp.s. c 8: "(1) The bright futures guidelines issued by the American academy of pediatrics outline recommended well-child visit schedules and universal screening of children for autism and developmental delays. Private health plans established after March 2010 are required to comply with the bright futures guidelines as the standard for preventive services. The federal law does not require medicaid programs to follow the guidelines; however, thirty states completely cover the bright futures guidelines, six states cover all but one well-child screen, and six additional states cover all but developmental and autism screens as part of their medicaid programs.

(2) The 2012 Washington state legislature directed the Washington state institute for public policy to assess the costs and benefits of implementing the guidelines. The research indicates that fewer than half of children with developmental delays are identified before starting school and roughly half of children with autism spectrum disorder are diagnosed only after entering school, by which time significant delays may have occurred and opportunities for treatment may have been missed. Adopting the universal screening guidelines improves early diagnosis and enables early intervention with appropriate therapies and services. The annual cost to society for caring for children with autism or developmental delays can be significant, including cost of services, special education, informal care, and lost productivity. Early intervention and access to appropriate therapies mitigate long-term societal costs and improve the health and opportunity for the child.

(3) The more adverse experiences a child has, such as the burden of family economic hardship and social bias, the greater the likelihood of developmental delays and later health problems. Over forty-six percent of Washington's children have medicaid apple health for kids and have a much greater likelihood of reporting poor to very poor health compared to children who have commercial insurance. Disparities also exist in the diagnosis and initiation of treatment services for children of color. Research shows that children of color are diagnosed later and begin receiving early intervention services later. This health equity gap can be addressed by identifying and supporting children early through universal screening.

(4) Primary care providers currently see ninety-nine percent of children between birth and three years of age and are uniquely situated to access nearly all children with universal screening." [2015 1st sp.s. c 8 § 1.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Conflict with federal requirements—Severability—Effective date—1995 1st sp.s. c 18: See notes following RCW 74.39A.030.

Conflict with federal requirements—Effective date—1994 c 21: See notes following RCW 43.20B.080.

Conflict with federal requirements—Severability—Effective dates—1993 c 149: See notes following RCW 28A.150.390.

Effective date—1991 sp.s. c 8: See note following RCW 18.51.050.

Purpose—Statutory references—Severability—1990 c 33: See RCW 28A.900.100 through 28A.900.102.

Intent—1989 c 400: See note following RCW 28A.150.390.

Effective date—1982 1st ex.s. c 19: See note following RCW 74.09.035.

Effective date—Severability—1981 1st ex.s. c 6: See notes following RCW 74.04.005.

Legislative confirmation of effect of 1994 c 21: RCW 43.20B.090.

RCW 74.09.522 Medical assistance—Agreements with managed care organizations for provision of services to medicaid recipients—Principles to be applied in purchasing managed health care. (1) For the purposes of this section, "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 care organization's provider network, but provides health care services to enrollees of programs authorized under this chapter or other applicable law whose health care services are provided by the managed care organization.

(2) The authority shall enter into agreements with managed care organizations to provide health care services to recipients of medicaid 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 programs as allowed for in the approved state plan amendment or federal waiver for Washington state's medicaid program;

(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: AND PROVIDED FURTHER, That the authority shall not restrict a recipient's right to terminate enrollment in a system for good cause as established by the authority 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 care organizations shall not enroll a disproportionate number of medical assistance recipients within the total numbers of persons served by the managed care organizations, except as authorized by the authority under federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act;

(e)(i) In negotiating with managed care organizations the authority shall adopt a uniform procedure to enter into contractual arrangements, including:

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

(B) The financial integrity of the responding system;

(C) Provider reimbursement methods that incentivize chronic care management within health homes, including comprehensive medication management services for patients with multiple chronic conditions consistent with the findings and goals established in RCW 74.09.5223;

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

(E) 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 organization is an integrated health delivery system that has programs in place for chronic care management;

(F) Provider reimbursement methods within the medical billing processes that incentivize pharmacists or other qualified providers licensed in Washington state to provide comprehensive medication management services consistent with the findings and goals established in RCW 74.09.5223;

(G) Evaluation and reporting on the impact of comprehensive medication management services on patient clinical outcomes and total health care costs, including reductions in emergency department utilization, hospitalization, and drug costs; and

(H) Established consistent processes to incentivize integration of behavioral health services in the primary care setting, promoting care that is integrated, collaborative, colocated, and preventive.

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

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

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

(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 care organization 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 authority 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 care organizations 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 care organization 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 care organizations 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 care organizations 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) Any contract with a managed care organization to provide services to medical assistance enrollees shall require that managed care organizations offer contracts to mental health providers and substance use disorder treatment providers to provide access to primary care services integrated into behavioral health clinical

settings, for individuals with behavioral health and medical comorbidities.

(8) Managed care organization contracts effective on or after April 1, 2016, shall serve geographic areas that correspond to the regional service areas established in RCW 74.09.870.

(9) A managed care organization shall pay a nonparticipating provider that provides a service covered under this chapter or other applicable law to the organization's enrollee no more than the lowest amount paid for that service under the managed care organization's contracts with similar providers in the state if the managed care organization has made good faith efforts to contract with the nonparticipating provider.

(10) For services covered under this chapter or other applicable law to medical assistance or medical care services enrollees, nonparticipating providers must accept as payment in full the amount paid by the managed care organization under subsection (9) 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 care organization contract to provide services under this section.

(11) Pursuant to federal managed care access standards, 42 C.F.R. Sec. 438, managed care organizations 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 authority, including hospital-based physician services. The authority will monitor and periodically report on the proportion of services provided by contracted providers and nonparticipating providers, by county, for each managed care organization to ensure that managed health care systems are meeting network adequacy requirements. No later than January 1st of each year, the authority will review and report its findings to the appropriate policy and fiscal committees of the legislature for the preceding state fiscal year.

(12) Payments under RCW 74.60.130 are exempt from this section. [2023 c 51 § 43; 2020 c 260 § 1; 2019 c 325 § 4004; 2018 c 201 § 7017; 2015 c 256 § 1; 2014 c 225 § 55; 2013 2nd sp.s. c 17 § 13; 2013 c 261 § 2. Prior: 2011 1st sp.s. c 15 § 29; 2011 1st sp.s. c 9 § 2; 2011 c 316 § 4; prior: 1997 c 59 § 15; 1997 c 34 § 1; 1989 c 260 § 2; 1987 1st ex.s. c 5 § 21; 1986 c 303 § 2.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—2013 2nd sp.s. c 17: See note following RCW 74.60.005.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Findings—Intent—2011 1st sp.s. c 9: See note following RCW 70.47.020.

Effective date—1997 c 34: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [April 16, 1997]." [1997 c 34 § 3.]

Legislative findings—Intent—1986 c 303: "(1) The legislature finds that:

(a) Good health care for indigent persons is of importance to the state;

(b) To ensure the availability of a good level of health care, efforts must be made to encourage cost consciousness on the part of providers and consumers, while maintaining medical assistance recipients within the mainstream of health care delivery;

(c) Managed health care systems have been found to be effective in controlling costs while providing good health care services;

(d) By enrolling medical assistance recipients within managed health care systems, the state's goal is to ensure that medical assistance recipients receive at least the same quality of care they currently receive.

(2) It is the intent of the legislature to develop and implement new strategies that promote the use of managed health care systems for medical assistance recipients by establishing prepaid capitated programs for both inpatient and outpatient services." [1986 c 303 § 1.]

RCW 74.09.5222 Medical assistance—Section 1115 demonstration waiver request. (1) The authority shall submit a section 1115 demonstration waiver request to the federal department of health and human services to expand and revise the medical assistance program as codified in Title XIX of the federal social security act. The waiver request should be designed to ensure the broadest federal financial participation under Title XIX and XXI of the federal social security act. To the extent permitted under federal law, the waiver request should include the following components:

(a) Establishment of a single eligibility standard for low-income persons, including expansion of categorical eligibility to include childless adults. The authority shall request that the single eligibility standard be phased in such that incremental steps are taken to cover additional low-income parents and individuals over time, with the goal of offering coverage to persons with household income at or below two hundred percent of the federal poverty level;

(b) Establishment of a single seamless application and eligibility determination system for all state low-income medical programs included in the waiver. Applications may be electronic and may include an electronic signature for verification and authentication. Eligibility determinations should maximize federal financing where possible;

(c) The delivery of all low-income coverage programs as a single program, with a common core benefit package that may be similar to the basic health benefit package or an alternative benefit package approved by the secretary of the federal department of health and human services, including the option of supplemental coverage for select categorical groups, such as children, and individuals who are aged, blind, and disabled;

(d) A program design to include creative and innovative approaches such as: Coverage for preventive services with incentives to use appropriate preventive care; enhanced medical home reimbursement and bundled payment methodologies; cost-sharing options; use of care management and care coordination programs to improve coordination of medical and behavioral health services; application of an innovative predictive risk model to better target care management services; and mandatory enrollment in managed care, as may be necessary;

(e) The ability to impose enrollment limits or benefit design changes for eligibility groups that were not eligible under the Title XIX state plan in effect on the date of submission of the waiver application;

(f) A premium assistance program whereby employers can participate in coverage options for employees and dependents of employees otherwise eligible under the waiver. The waiver should make every effort to maximize enrollment in employer-sponsored health insurance when it is cost-effective for the state to do so, and the purchase is consistent with the requirements of Titles XIX and XXI of the federal social security act. To the extent allowable under federal law, the authority shall require enrollment in available employer-sponsored coverage as a condition of eligibility for coverage under the waiver; and

(g) The ability to share savings that might accrue to the federal medicare program, Title XVIII of the federal social security act, from improved care management for persons who are eligible for both medicare and medicaid. Through the waiver application process, the authority shall determine whether the state could serve, directly or by contract, as a medicare special needs plan for persons eligible for both medicare and medicaid.

(2) The authority shall hold ongoing stakeholder discussions as it is developing the waiver request, and provide opportunities for public review and comment as the request is being developed.

(3) The authority shall identify statutory changes that may be necessary to ensure successful and timely implementation of the waiver request as submitted to the federal department of health and human services as the apple health program for adults.

(4) The legislature must authorize implementation of any waiver approved by the federal department of health and human services under this section. [2011 1st sp.s. c 15 § 30; 2009 c 545 § 4.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Findings—2009 c 545: See note following RCW 43.06.155.

RCW 74.09.5223 Findings—Chronic care management. The legislature finds that chronic care management, including comprehensive medication management services, provided by licensed pharmacists and qualified providers is a critical component of a collaborative, multidisciplinary, inter-professional approach to the treatment of chronic diseases for targeted individuals, to improve the quality of care and reduce overall cost in the treatment of such diseases. [2013 c 261 § 1.]

RCW 74.09.5225 Medical assistance—Payments for services provided by rural hospitals—Participation in Washington rural health access preservation pilot. *(Contingent expiration date.)* (1) Payments for recipients eligible for medical assistance programs under this chapter for services provided by hospitals, regardless of the beneficiary's managed care enrollment status, shall be made based on allowable costs incurred during the year, when services are provided by a rural hospital certified by the centers for medicare and medicaid services as a critical access hospital, unless the critical access hospital is participating in the Washington rural health access preservation pilot described in subsection (2)(b) of this section. Any additional payments made by the authority for the healthy options program shall be no more than the additional amounts per service paid under this section for other medical assistance programs.

(2)(a) Beginning on July 24, 2005, except as provided in (b) of this subsection, a moratorium shall be placed on additional hospital participation in critical access hospital payments under this section. However, rural hospitals that applied for certification to the centers for medicare and medicaid services prior to January 1, 2005, but have not yet completed the process or have not yet been approved for certification, remain eligible for medical assistance payments under this section.

(b)(i) The purpose of the Washington rural health access preservation pilot is to develop an alternative service and payment system to the critical access hospital authorized under section 1820 of the social security act to sustain essential services in rural communities.

(ii) For the purposes of state law, any rural hospital approved by the department of health for participation in critical access hospital payments under this section that participates in the Washington rural health access preservation pilot identified by the state office of rural health and ceases to participate in critical access hospital payments may renew participation in critical access hospital associated payment methodologies under this section at any time.

(iii) The Washington rural health access preservation pilot is subject to the following requirements:

(A) In the pilot formation or development, the department of health, health care authority, and Washington state hospital association will identify goals for the pilot project before any hospital joins the pilot project;

(B) Participation in the pilot is optional and no hospital may be required to join the pilot;

(C) Before a hospital enters the pilot program, the health care authority must provide information to the hospital regarding how the hospital could end its participation in the pilot if the pilot is not working in its community;

(D) Payments for services delivered by public health care service districts participating in the Washington rural health access preservation pilot to recipients eligible for medical assistance programs under this chapter must be based on an alternative, value-based payment methodology established by the authority. Subject to the availability of amounts appropriated for this specific purpose, the payment methodology must provide sufficient funding to sustain essential services in the areas served, including but not limited to emergency and primary care services. The methodology must adjust

payment amounts based on measures of quality and value, rather than volume. As part of the pilot, the health care authority shall encourage additional payers to use the adopted payment methodology for services delivered by the pilot participants to individuals insured by those payers;

(E) The department of health, health care authority, and Washington state hospital association will report interim progress to the legislature no later than December 1, 2018, and will report on the results of the pilot no later than six months following the conclusion of the pilot. The reports will describe any policy changes identified during the course of the pilot that would support small critical access hospitals; and

(F) Funds appropriated for the Washington rural health access preservation pilot will be used to help participating hospitals transition to a new payment methodology and will not extend beyond the anticipated three-year pilot period.

(3)(a) Beginning January 1, 2015, payments for recipients eligible for medical assistance programs under this chapter for services provided by a hospital, regardless of the beneficiary's managed care enrollment status, shall be increased to one hundred twenty-five percent of the hospital's fee-for-service rates, when services are provided by a rural hospital that:

(i) Was certified by the centers for medicare and medicaid services as a sole community hospital as of January 1, 2013;

(ii) Had a level III adult trauma service designation from the department of health as of January 1, 2014;

(iii) Had less than one hundred fifty acute care licensed beds in fiscal year 2011; and

(iv) Is owned and operated by the state or a political subdivision.

(b) The enhanced payment rates under this subsection shall be considered the hospital's medicaid payment rate for purposes of any other state or private programs that pay hospitals according to medicaid payment rates.

(c) Hospitals participating in the certified public expenditures program may not receive the increased reimbursement rates provided in this subsection (3) for inpatient services.

(4) Beginning July 1, 2024, through December 31, 2028, payments for recipients eligible for medical assistance programs under this chapter for acute care services provided by a hospital, regardless of the beneficiary's managed care enrollment status, shall be increased to 120 percent of the hospital's fee-for-service rate for inpatient services and 200 percent of the hospital's fee-for-service rate for outpatient services, when services are provided by a hospital that:

(a) Is not currently designated as a critical access hospital, and does not meet current federal eligibility requirements for designation as a critical access hospital;

(b) Has medicaid inpatient days greater than 50 percent of all hospital inpatient days as reported on the hospital's most recently filed medicare cost report with the state; and

(c) Is located on the land of a federally recognized Indian tribe. [2023 c 443 § 2; 2017 c 198 § 1; 2016 sp.s. c 31 § 2; 2014 c 57 § 2; 2011 1st sp.s. c 15 § 31; 2005 c 383 § 1; 2001 2nd sp.s. c 2 § 2.]

Finding—2023 c 443: "The legislature finds that promoting a financially viable health care system in all parts of the state is a critical interest. The federal centers for medicare and medicaid services has recognized the crucial role hospitals play in providing care in rural areas by creating the sole community hospital program, which allows certain small rural hospitals to receive enhanced payments for medicare services. The state of Washington has created a similar program based on the federal criteria. The legislature further finds that some small, rural, low volume hospitals provide vital services to the communities they serve, but are not eligible for the federal or state programs. The legislature therefore finds that creating a similar reimbursement system for the state's medicaid program for small, rural, low volume hospitals will promote the long-term financial viability of the rural health care system in those communities." [2023 c 443 § 1.]

Contingent expiration date—2023 c 443: "(1) This act expires on the date that the federal centers for medicare and medicaid services approves the hospital safety net program as required by RCW 74.60.150(1)(a), including section 4(3)(e), chapter 430, Laws of 2023.

(2) The health care authority must provide written notice of the expiration date of this act to affected parties, the chief clerk of the house of representatives, the secretary of the senate, the office of the code reviser, and others as deemed appropriate by the authority." [2023 c 443 § 4.]

Finding—Intent—2016 sp.s. c 31: "The legislature finds that small critical access hospitals provide essential services to their communities. The legislature recognizes the need to offer small critical access hospitals the opportunity to pilot different delivery and payment models than may be currently allowed under the critical access hospital program. The legislature also intends to allow these participating hospitals to return to the critical access hospital program if they so choose." [2016 sp.s. c 31 § 1.]

Findings—2014 c 57: "The legislature finds that promoting a financially viable health care system in all parts of the state is a critical interest. The federal centers for medicare and medicaid services has recognized the crucial role hospitals play in providing care in rural areas by creating the sole community hospital program, which allows certain small rural hospitals to receive enhanced payments for medicare services. The legislature further finds that creating a similar reimbursement system for the state's medicaid program for sole community hospitals will promote the long-term financial viability of the rural health care system in those communities." [2014 c 57 § 1.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Findings—2001 2nd sp.s. c 2: "The legislature finds that promoting a financially viable health care system in all parts of the state is a paramount interest. The health care financing administration has recognized the crucial role that hospitals play in providing care in rural areas by creating the critical access hospital

program to allow small, rural hospitals that qualify to receive reasonable cost-based reimbursement for medicare services. The legislature further finds that creating a similar reimbursement system for the state's medical assistance programs in small, rural hospitals that qualify will help assure the long-term financial viability of the rural health system in those communities." [2001 2nd sp.s. c 2 § 1.]

RCW 74.09.5225 Medical assistance—Payments for services provided by rural hospitals—Participation in Washington rural health access preservation pilot. ***(Contingent effective date.)*** (1) Payments for recipients eligible for medical assistance programs under this chapter for services provided by hospitals, regardless of the beneficiary's managed care enrollment status, shall be made based on allowable costs incurred during the year, when services are provided by a rural hospital certified by the centers for medicare and medicaid services as a critical access hospital, unless the critical access hospital is participating in the Washington rural health access preservation pilot described in subsection (2)(b) of this section. Any additional payments made by the authority for the healthy options program shall be no more than the additional amounts per service paid under this section for other medical assistance programs.

(2)(a) Beginning on July 24, 2005, except as provided in (b) of this subsection, a moratorium shall be placed on additional hospital participation in critical access hospital payments under this section. However, rural hospitals that applied for certification to the centers for medicare and medicaid services prior to January 1, 2005, but have not yet completed the process or have not yet been approved for certification, remain eligible for medical assistance payments under this section.

(b)(i) The purpose of the Washington rural health access preservation pilot is to develop an alternative service and payment system to the critical access hospital authorized under section 1820 of the social security act to sustain essential services in rural communities.

(ii) For the purposes of state law, any rural hospital approved by the department of health for participation in critical access hospital payments under this section that participates in the Washington rural health access preservation pilot identified by the state office of rural health and ceases to participate in critical access hospital payments may renew participation in critical access hospital associated payment methodologies under this section at any time.

(iii) The Washington rural health access preservation pilot is subject to the following requirements:

(A) In the pilot formation or development, the department of health, health care authority, and Washington state hospital association will identify goals for the pilot project before any hospital joins the pilot project;

(B) Participation in the pilot is optional and no hospital may be required to join the pilot;

(C) Before a hospital enters the pilot program, the health care authority must provide information to the hospital regarding how the hospital could end its participation in the pilot if the pilot is not working in its community;

(D) Payments for services delivered by public health care service districts participating in the Washington rural health access preservation pilot to recipients eligible for medical assistance programs under this chapter must be based on an alternative, value-based payment methodology established by the authority. Subject to the availability of amounts appropriated for this specific purpose, the payment methodology must provide sufficient funding to sustain essential services in the areas served, including but not limited to emergency and primary care services. The methodology must adjust payment amounts based on measures of quality and value, rather than volume. As part of the pilot, the health care authority shall encourage additional payers to use the adopted payment methodology for services delivered by the pilot participants to individuals insured by those payers;

(E) The department of health, health care authority, and Washington state hospital association will report interim progress to the legislature no later than December 1, 2018, and will report on the results of the pilot no later than six months following the conclusion of the pilot. The reports will describe any policy changes identified during the course of the pilot that would support small critical access hospitals; and

(F) Funds appropriated for the Washington rural health access preservation pilot will be used to help participating hospitals transition to a new payment methodology and will not extend beyond the anticipated three-year pilot period.

(3)(a) Beginning January 1, 2015, payments for recipients eligible for medical assistance programs under this chapter for services provided by a hospital, regardless of the beneficiary's managed care enrollment status, shall be increased to one hundred twenty-five percent of the hospital's fee-for-service rates, when services are provided by a rural hospital that:

(i) Was certified by the centers for medicare and medicaid services as a sole community hospital as of January 1, 2013;

(ii) Had a level III adult trauma service designation from the department of health as of January 1, 2014;

(iii) Had less than one hundred fifty acute care licensed beds in fiscal year 2011; and

(iv) Is owned and operated by the state or a political subdivision.

(b) The enhanced payment rates under this subsection shall be considered the hospital's medicaid payment rate for purposes of any other state or private programs that pay hospitals according to medicaid payment rates.

(c) Hospitals participating in the certified public expenditures program may not receive the increased reimbursement rates provided in this subsection (3) for inpatient services. [2017 c 198 § 1; 2016 sp.s. c 31 § 2; 2014 c 57 § 2; 2011 1st sp.s. c 15 § 31; 2005 c 383 § 1; 2001 2nd sp.s. c 2 § 2.]

Finding—Intent—2016 sp.s. c 31: "The legislature finds that small critical access hospitals provide essential services to their communities. The legislature recognizes the need to offer small critical access hospitals the opportunity to pilot different delivery and payment models than may be currently allowed under the critical access hospital program. The legislature also intends to allow these

participating hospitals to return to the critical access hospital program if they so choose." [2016 sp.s. c 31 § 1.]

Findings—2014 c 57: "The legislature finds that promoting a financially viable health care system in all parts of the state is a critical interest. The federal centers for medicare and medicaid services has recognized the crucial role hospitals play in providing care in rural areas by creating the sole community hospital program, which allows certain small rural hospitals to receive enhanced payments for medicare services. The legislature further finds that creating a similar reimbursement system for the state's medicaid program for sole community hospitals will promote the long-term financial viability of the rural health care system in those communities." [2014 c 57 § 1.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Findings—2001 2nd sp.s. c 2: "The legislature finds that promoting a financially viable health care system in all parts of the state is a paramount interest. The health care financing administration has recognized the crucial role that hospitals play in providing care in rural areas by creating the critical access hospital program to allow small, rural hospitals that qualify to receive reasonable cost-based reimbursement for medicare services. The legislature further finds that creating a similar reimbursement system for the state's medical assistance programs in small, rural hospitals that qualify will help assure the long-term financial viability of the rural health system in those communities." [2001 2nd sp.s. c 2 § 1.]

RCW 74.09.5229 Primary care health homes—Chronic care management—Findings—Intent. The legislature finds that:

(1) Health care costs are growing rapidly, exceeding the consumer price index year after year. Consequently, state health programs are capturing a growing share of the state budget, even as state revenues have declined. Sustaining these critical health programs will require actions to effectively contain health care cost increases in the future; and

(2) The primary care health home model has been demonstrated to successfully constrain costs, while improving quality of care. Chronic care management, occurring within a primary care health home, has been 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. Successful chronic care management for persons receiving long-term care services in addition to medical care will require close coordination between primary care providers, long-term care workers, and other long-term care service providers, including area agencies on aging. Primary care providers also should consider oral health coordination through collaboration with dental providers and, when possible, delivery of oral health prevention services. The legislature also intends that the methods and approach of the primary care health home become part of basic primary care medical education. [2011 c 316 § 1.]

RCW 74.09.523 PACE program—Definitions—Requirements. (1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "PACE" means the program of all-inclusive care for the elderly, a managed care medicare/medicaid program authorized under sections 1894, 1905(a), and 1934 of the social security act and administered by the department.

(b) "PACE program agreement" means an agreement between a PACE organization, the health care financing administration, and the department.

(2) A PACE program may operate in the state only in accordance with a PACE program agreement with the department.

(3) A PACE program shall at the time of entering into the initial PACE program agreement, and at each renewal thereof, demonstrate cash reserves to cover expenses in the event of insolvency.

(a) The cash reserves at a minimum shall equal the sum of:

(i) One month's total capitation revenue; and

(ii) One month's average payment to subcontractors.

(b) The program may demonstrate cash reserves to cover expenses of insolvency with one or more of the following: Reasonable and sufficient net worth, insolvency insurance, or parental guarantees.

(4) A PACE program must provide full disclosure regarding the terms of enrollment and the option to disenroll at any time to all persons who seek to participate or who are participants in the program.

(5) The department must establish rules to authorize long-term care clients enrolled in a PACE program to elect to continue their enrollment in a PACE program regardless of improved status related to functional criteria for nursing facility level of care, consistent with 42 C.F.R. Sec. 460.160(b) (2013).

(6) The department must develop and implement a coordinated plan to provide education about PACE program site operations under this section. The plan must include:

(a) A strategy to assure that case managers and other staff with responsibilities related to eligibility determinations discuss the option and potential benefits of participating in a PACE program with all eligible long-term care clients;

(b) Requirements that all clients eligible for placement in the community options program entry system waiver program that are age fifty-five or over and reside in a PACE service area be referred to the PACE provider for evaluation. The department's plan must assure that referrals are conducted in a manner that is consistent with federal requirements of Title XIX of the federal social security act; and

(c) Requirements for additional and ongoing training for case managers and other staff with responsibilities related to eligibility determinations in those counties in which a PACE program is operating. The training must include instruction in recognizing the benefits of continued enrollment in a PACE program for those clients who have experienced improved status related to functional criteria for nursing facility level of care.

(7) The department must identify a private entity that operates PACE program sites in Washington to provide the training required under subsection (6) of this section at no cost to the state. [2013 c 258 § 1; 2001 c 191 § 2.]

Finding—2001 c 191: "The legislature finds that PACE programs provide essential care to the frail elderly in the state of Washington. PACE serves to enhance the quality of life and autonomy for frail, older adults, maximize the dignity of and respect for older adults, enable frail and older adults to live in their homes and their community as long as medically possible, and preserve and support the older adult's family unit." [2001 c 191 § 1.]

Effective date—2001 c 191: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [May 7, 2001]." [2001 c 191 § 4.]

RCW 74.09.530 Medical assistance—Powers and duties of authority. (1)(a) The authority is designated as the single state agency for purposes of Title XIX of the federal social security act.

(b) The amount and nature of medical assistance and the determination of eligibility of recipients for medical assistance shall be the responsibility of the authority.

(c) The authority shall establish reasonable standards of assistance and resource and income exemptions which shall be consistent with the provisions of the social security act and federal regulations for determining eligibility of individuals for medical assistance and the extent of such assistance to the extent that funds are available from the state and federal government. The authority shall not consider resources in determining continuing eligibility for recipients eligible under section 1931 of the social security act.

(d) The authority is authorized to collaborate with other state or local agencies and nonprofit organizations in carrying out its duties under this chapter or other applicable law and, to the extent appropriate, may enter into agreements with such other entities.

(2) Individuals eligible for medical assistance under RCW 74.09.510(3) shall be transitioned into coverage under that subsection immediately upon their termination from coverage under RCW 74.09.510(2)(a). The authority shall use income eligibility standards and eligibility determinations applicable to children placed in foster care. The authority shall provide information regarding basic health plan enrollment and shall offer assistance with the application and enrollment process to individuals covered under RCW 74.09.510(3) who are approaching their twenty-first birthday. [2018 c 201 § 7018; 2011 1st sp.s. c 15 § 32; 2007 c 315 § 2; 2000 c 218 § 2; 1979 c 141 § 345; 1967 ex.s. c 30 § 6.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Conflict with federal requirements—2007 c 315: See note following RCW 74.09.510.

RCW 74.09.540 Medical assistance—Working individuals with disabilities—Intent. (1) It is the intent of the legislature to remove barriers to employment for individuals with disabilities by providing medical assistance to working individuals with disabilities through a buy-in program in accordance with section 1902(a)(10)(A)(ii) of the social security act and eligibility and cost-sharing requirements established by the authority.

(2) The authority shall establish cost-sharing requirements for the buy-in program in accordance with federal law and any conditions or limitations specified in the omnibus appropriations act. The authority shall establish and modify eligibility and cost-sharing requirements in order to administer the program within available funds. The authority may consider a person's income when establishing cost-sharing requirements. The authority may not establish eligibility restrictions for the buy-in program based upon a person's income or maximum age. The authority shall make every effort to coordinate benefits with employer-sponsored coverage available to the working individuals with disabilities receiving benefits under this chapter or other applicable law.

(3) The authority shall seek federal approval to exclude resources accumulated in a separate account that results from earnings during an individual's enrollment in the buy-in program when determining the individual's subsequent eligibility for another medical assistance program. [2019 c 70 § 1; 2018 c 201 § 7019; 2011 1st sp.s. c 15 § 33; 2001 2nd sp.s. c 15 § 2.]

Effective date—2019 c 70: "This act takes effect January 1, 2020." [2019 c 70 § 2.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Findings—Intent—2001 2nd sp.s. c 15: "The legislature finds that individuals with disabilities face many barriers and disincentives to employment. Individuals with disabilities are often unable to obtain health insurance that provides the services and supports necessary to allow them to live independently and enter or rejoin the workforce. The legislature finds that there is a compelling public interest in eliminating barriers to work by continuing needed health care coverage for individuals with disabilities who enter and maintain employment.

The legislature intends to strengthen the state's policy of supporting individuals with disabilities in leading fully productive lives by supporting the implementation of the federal ticket to work and work incentives improvement act of 1999, Public Law 106-170. This shall include improving incentives to work by continuing coverage for health care and support services, by seeking federal funding for innovative programs, and by exploring options which provide individuals with disabilities a choice in receiving services needed to obtain and maintain employment." [2001 2nd sp.s. c 15 § 1.]

RCW 74.09.545 Medical assistance or limited casualty program—Eligibility—Agreements between spouses to transfer future income—Community income. (1) An agreement between spouses transferring or assigning rights to future income from one spouse to the other shall be invalid for purposes of determining eligibility for medical assistance or the limited casualty program for the medically needy, but this subsection does not affect agreements between spouses transferring or assigning resources, and income produced by transferred or assigned resources shall continue to be recognized as the separate income of the transferee; and

(2) In determining eligibility for medical assistance or the limited casualty program for the medically needy for a married person in need of institutional care, or care under home and community-based waivers as defined in Title XIX of the Social Security Act, if the community income received in the name of the nonapplicant spouse exceeds the community income received in the name of the applicant spouse, the applicant's interest in that excess shall be considered unavailable to the applicant. [1986 c 220 § 1.]

RCW 74.09.555 Medical assistance—Reinstatement upon release from confinement—Expedited eligibility determinations. (1) The authority shall adopt rules and policies providing that when persons who were enrolled in medical assistance immediately prior to confinement, or who become enrolled in medical assistance in suspense status during the period of confinement, are released from confinement, their medical assistance coverage shall be fully reinstated no later than at the moment of their release, subject to any expedited review of their continued eligibility for medical assistance coverage that is required under federal or state law. The authority may reinstate medical assistance prior to the day of release provided that no federal funds are expended for any purpose that is not authorized by the state's agreements with the federal government.

(2) The authority, in collaboration with the Washington association of sheriffs and police chiefs, the department of corrections, the department of children, youth, and families, managed care organizations, and behavioral health administrative services organizations, shall establish procedures for coordination between the authority and department field offices, institutions for mental disease, and correctional institutions, as defined in RCW 9.94.049, that result in prompt reinstatement of eligibility and speedy eligibility determinations for medical assistance services upon release from confinement. Procedures developed under this subsection must address:

(a) Mechanisms for receiving medical assistance services applications on behalf of confined persons in anticipation of their release from confinement;

(b) Expeditious review of applications filed by or on behalf of confined persons and, to the extent practicable, completion of the review before the person is released;

(c) Mechanisms for providing medical assistance services identity cards to persons eligible for medical assistance services before their release from confinement;

(d) Coordination with the federal social security administration, through interagency agreements or otherwise, to expedite processing of applications for federal supplemental security income or social security disability benefits, including federal acceptance of applications on behalf of confined persons; and

(e) Assuring that notification of the person's release date, current location, and other appropriate information is provided to the person's managed care organization before the person's scheduled release from confinement, or as soon as practicable thereafter.

(3) Where medical or psychiatric examinations during a person's confinement indicate that the person is disabled, the correctional institution or institution for mental diseases shall provide the authority with that information for purposes of making medical assistance eligibility and enrollment determinations prior to the person's release from confinement. The authority shall, to the maximum extent permitted by federal law, use the examination in making its determination whether the person is disabled and eligible for medical assistance.

(4) For purposes of this section, "confined" or "confinement" means incarcerated in a correctional institution, as defined in RCW 9.94.049, or admitted to an institute for mental disease, as defined in 42 C.F.R. part 435, Sec. 1009 on July 24, 2005.

(5) The economic services administration within the department shall adopt standardized statewide screening and application practices and forms designed to facilitate the application of a confined person for medicaid. [2021 c 243 § 3; 2019 c 325 § 4005; 2014 c 225 § 102. Prior: 2011 1st sp.s. c 36 § 32; 2011 1st sp.s. c 15 § 34; 2010 1st sp.s. c 8 § 30; 2005 c 503 § 12.]

Findings—2021 c 243: See note following RCW 74.09.670.

Effective date—2019 c 325: See note following RCW 71.24.011.

Effective date—2014 c 225: See note following RCW 71.24.016.

Findings—Intent—2011 1st sp.s. c 36: See RCW 74.62.005.

Effective date—2011 1st sp.s. c 36: See note following RCW 74.62.005.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Findings—Intent—Short title—Effective date—2010 1st sp.s. c 8: See notes following RCW 74.04.225.

Correction of references—Savings—Severability—2005 c 503: See notes following RCW 71.24.015.

RCW 74.09.557 Medical assistance—Complex rehabilitation technology products. (1) The authority shall establish a separate recognition for individually configured, complex rehabilitation technology products and services for complex needs patients with the medical assistance program. This separate recognition shall:

(a) Establish a budget and services category separate from other categories, such as durable medical equipment and supplies;

(b) Take into consideration the customized nature of complex rehabilitation technology and the broad range of services necessary to meet the unique medical and functional needs of people with complex medical needs; and

(c) Establish standards for the purchase of complex rehabilitation technology exclusively from qualified complex rehabilitation technology suppliers.

(2) The authority shall require complex needs patients receiving complex rehabilitation technology to be evaluated by:

(a) A licensed health care provider who performs specialty evaluations within his or her scope of practice, including a physical therapist licensed under chapter 18.74 RCW and an occupational therapist licensed under chapter 18.59 RCW, and has no financial relationship with the qualified complex rehabilitation technology supplier; and

(b) A qualified complex rehabilitation technology professional, as identified in subsection (3)(d)(iii) of this section.

(3) As used in this section:

(a) "Complex needs patient" means an individual with a diagnosis or medical condition that results in significant physical or functional needs and capacities. "Complex needs patient" does not negate the requirement that an individual meet medical necessity requirements under authority rules to qualify for receiving a complex rehabilitation product.

(b) "Complex rehabilitation technology" means wheelchairs and seating systems classified as durable medical equipment within the medicare program as of January 1, 2013, that:

(i) Are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living identified as medically necessary to prevent hospitalization or institutionalization of a complex needs patient;

(ii) Are primarily used to serve a medical purpose and generally not useful to a person in the absence of an illness or injury; and

(iii) Require certain services to allow for appropriate design, configuration, and use of such item, including patient evaluation and equipment fitting and configuration.

(c) "Individually configured" means a device has a combination of features, adjustments, or modifications specific to a complex needs patient that a qualified complex rehabilitation technology supplier provides by measuring, fitting, programming, adjusting, or adapting the device as appropriate so that the device is consistent with an assessment or evaluation of the complex needs patient by a health care professional and consistent with the complex needs patient's medical

condition, physical and functional needs and capacities, body size, period of need, and intended use.

(d) "Qualified complex rehabilitation technology supplier" means a company or entity that:

(i) Is accredited by a recognized accrediting organization as a supplier of complex rehabilitation technology;

(ii) Meets the supplier and quality standards established for durable medical equipment suppliers under the medicare program;

(iii) For each site that it operates, employs at least one complex rehabilitation technology professional, who has been certified by the rehabilitation engineering and assistive technology society of North America as an assistive technology professional, to analyze the needs and capacities of complex needs patients, assist in selecting appropriate covered complex rehabilitation technology items for such needs and capacities, and provide training in the use of the selected covered complex rehabilitation technology items;

(iv) Has the complex rehabilitation technology professional physically present for the evaluation and determination of the appropriate individually configured complex rehabilitation technologies for the complex needs patient;

(v) Provides service and repairs by qualified technicians for all complex rehabilitation technology products it sells; and

(vi) Provides written information to the complex needs patient at the time of delivery about how the individual may receive service and repair. [2013 c 178 § 2.]

Intent—2013 c 178: "The legislature intends to:

(1) Protect access for complex needs patients to important technology and supporting services;

(2) Establish and improve safeguards relating to the delivery and provision of medically necessary complex rehabilitation technology; and

(3) Provide supports for complex needs patients to stay in the home or community setting, prevent institutionalization, and prevent hospitalizations and other costly secondary complications." [2013 c 178 § 1.]

Effective date—2013 c 178: "This act takes effect January 1, 2014." [2013 c 178 § 3.]

RCW 74.09.565 Medical assistance for institutionalized persons—Treatment of income between spouses. (1) An agreement between spouses transferring or assigning rights to future income from one spouse to the other shall be invalid for purposes of determining eligibility for medical assistance or the limited casualty program for the medically needy, but this subsection does not affect agreements between spouses transferring or assigning resources, and income produced by transferred or assigned resources shall continue to be recognized as the separate income of the transferee.

(2) In determining eligibility for medical assistance or the limited casualty program for the medically needy for a married person in need of institutional care, or care under home and community-based waivers as defined in Title XIX of the social security act, if the community income received in the name of the nonapplicant spouse exceeds the community income received in the name of the applicant

spouse, the applicant's interest in that excess shall be considered unavailable to the applicant.

(3) The department or authority, as appropriate, shall adopt rules consistent with the provisions of section 1924 of the social security act entitled "Treatment of Income and Resources for Certain Institutionalized Spouses," in determining the allocation of income between an institutionalized and community spouse.

(4) The department or authority, as appropriate, shall establish the monthly maintenance needs allowance for the community spouse up to the maximum amount allowed by state appropriation or within available funds and permitted in section 1924 of the social security act. The total monthly needs allowance shall not exceed one thousand five hundred dollars, subject to adjustment provided in section 1924 of the social security act. [2011 1st sp.s. c 15 § 35; 1989 c 87 § 4.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Captions not law—1989 c 87: "Section captions, as found in sections 4 through 8 of this act, constitute no part of the law." [1989 c 87 § 10.]

Effective dates—1989 c 87: See note following RCW 74.09.510.

RCW 74.09.575 Medical assistance for institutionalized persons—Treatment of resources. (1) The department or authority, as appropriate, shall promulgate rules consistent with the treatment of resources provisions of section 1924 of the social security act in determining the allocation of resources between the institutionalized and community spouse.

(2) In the interest of supporting the community spouse the department or authority, as appropriate, shall allow the maximum resource allowance amount permissible under the social security act for the community spouse for persons institutionalized before August 1, 2003.

(3) For persons institutionalized on or after August 1, 2003, the department or authority, as appropriate, in the interest of supporting the community spouse, shall allow up to a maximum of forty thousand dollars in resources for the community spouse. For the fiscal biennium beginning July 1, 2005, and each fiscal biennium thereafter, the maximum resource allowance amount for the community spouse shall be adjusted for economic trends and conditions by increasing the amount allowable by the consumer price index as published by the federal bureau of labor statistics. However, in no case shall the amount allowable exceed the maximum resource allowance permissible under the social security act. [2011 1st sp.s. c 15 § 36; 2003 1st sp.s. c 28 § 1; 1989 c 87 § 5.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Effective date—2003 1st sp.s. c 28: "This act is necessary for the immediate preservation of the public peace, health, or safety, or

support of the state government and its existing public institutions, and takes effect July 1, 2003." [2003 1st sp.s. c 28 § 2.]

Effective dates—1989 c 87: See note following RCW 74.09.510.

Captions not law—1989 c 87: See note following RCW 74.09.565.

RCW 74.09.585 Medical assistance for institutionalized persons—Period of ineligibility for transfer of resources. (1) The department or authority, as appropriate, shall establish standards consistent with section 1917 of the social security act in determining the period of ineligibility for medical assistance due to the transfer of resources.

(2) There shall be no penalty imposed for the transfer of assets that are excluded in a determination of the individual's eligibility for medicaid to the extent such assets are protected by the long-term care insurance policy or contract pursuant to chapter 48.85 RCW.

(3) The department or authority, as appropriate, may waive a period of ineligibility if the department or authority determines that denial of eligibility would work an undue hardship. [2011 1st sp.s. c 15 § 37; 1995 1st sp.s. c 18 § 81; 1989 c 87 § 7.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Conflict with federal requirements—Severability—Effective date—1995 1st sp.s. c 18: See notes following RCW 74.39A.030.

Effective dates—1989 c 87: See note following RCW 74.09.510.

Captions not law—1989 c 87: See note following RCW 74.09.565.

RCW 74.09.595 Medical assistance for institutionalized persons—Due process procedures. The department or authority, as appropriate, shall in compliance with section 1924 of the social security act adopt procedures which provide due process for institutionalized or community spouses who request a fair hearing as to the valuation of resources, the amount of the community spouse resource allowance, or the monthly maintenance needs allowance. [2011 1st sp.s. c 15 § 38; 1989 c 87 § 8.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Effective dates—1989 c 87: See note following RCW 74.09.510.

Captions not law—1989 c 87: See note following RCW 74.09.565.

RCW 74.09.597 Medical assistance—Durable medical equipment and medical supplies—Providers. The following must be medicare providers

in order to be paid under the medicaid program: Providers of durable medical equipment and related supplies and providers of medical supplies and related services. [2012 c 241 § 105.]

Intent—Finding—2012 c 241: See note following RCW 74.66.010.

RCW 74.09.600 Post audit examinations by state auditor. Nothing in this chapter shall preclude the state auditor from conducting post audit examinations of public funds pursuant to RCW 43.09.330 or other applicable law. [1977 ex.s. c 260 § 6.]

Severability—1977 ex.s. c 260: "If any provision of this act, or its application to any person or circumstance is held invalid, the remainder of the act, or the application of the provision to other persons or circumstances is not affected." [1977 ex.s. c 260 § 8.]

RCW 74.09.605 Incorporation of outcomes/criteria into contracts with managed care organizations. The authority shall incorporate the expected outcomes and criteria to measure the performance of service coordination organizations as provided in chapter 70.320 RCW into contracts with managed care organizations that provide services to clients under this chapter. [2013 c 320 § 7.]

RCW 74.09.611 Hospital quality incentive payments—Noncritical access hospitals. (1) If sufficient funds are made available as provided in subsection (2) of this section the authority, in collaboration with the Washington state hospital association, shall design a system of hospital quality incentive payments for noncritical access hospitals. The system must be based upon the following principles:

(a) Evidence-based treatment and processes must be used to improve health care outcomes for hospital patients;

(b) Effective purchasing strategies to improve the quality of health care services should involve the use of common quality improvement measures by public and private health care purchasers, while recognizing that some measures may not be appropriate for application to specialty pediatric, psychiatric, or rehabilitation hospitals;

(c) Quality measures chosen for the system should be consistent with the standards that have been developed by national quality improvement organizations, such as the national quality forum, the federal centers for medicare and medicaid services, or the federal agency for healthcare research and quality. New reporting burdens to hospitals should be minimized by giving priority to measures hospitals are currently required to report to governmental agencies, such as the hospital compare measures collected by the federal centers for medicare and medicaid services;

(d) Benchmarks for each quality improvement measure should be set at levels that are feasible for hospitals to achieve, yet represent real improvements in quality and performance for a majority of hospitals in Washington state; and

(e) Hospital performance and incentive payments should be designed in a manner such that all noncritical access hospitals are

able to receive the incentive payments if performance is at or above the benchmark score set in the system established under this section.

(2) If hospital safety net assessment funds under RCW 74.60.020 are made available, such funds must be used to support an additional one percent increase in inpatient hospital rates for noncritical access hospitals that:

(a) Meet the quality incentive benchmarks established under this section; and

(b) Participate in Washington state hospital association collaboratives related to the benchmarks in order to improve care and promote sharing of best practices with other hospitals.

(3) Funds directed from any other lawful source may also be used to support the purposes of this section. [2013 2nd sp.s. c 17 § 18.]

Effective date—2013 2nd sp.s. c 17: See note following RCW 74.60.005.

RCW 74.09.630 Opioid overdose reversal medications—Reimbursement. Until the opioid overdose reversal medication bulk purchasing and distribution program established in RCW 70.14.170 is operational:

(1) All medicaid managed care organizations must reimburse a hospital or behavioral health agency for dispensing or distributing opioid overdose reversal medication to a covered person under RCW 70.41.485 and 71.24.594.

(2) If the person is not enrolled in a medicaid managed care organization and does not have any other available insurance coverage, the authority must reimburse a hospital, behavioral health agency, or pharmacy for dispensing or distributing opioid overdose reversal medication under RCW 70.41.485 and 71.24.594. [2023 c 51 § 44; 2021 c 273 § 5.]

Findings—Intent—2021 c 273: See note following RCW 70.41.480.

RCW 74.09.632 Opioid overdose reversal medications—Technical assistance—Written materials. (1) The authority, in consultation with the department of health, the office of the insurance commissioner, and the addictions, drug, and alcohol institute at the University of Washington, shall provide technical assistance to hospitals and licensed or certified, behavioral health agencies to assist these entities, practitioners, and providers in complying with RCW 70.41.485 and 71.24.594. The technical assistance provided to behavioral health agencies must include:

(a) Training nonmedical providers on distributing and providing client education and directions for use of opioid overdose reversal medication;

(b) Providing written guidance for billing for opioid overdose reversal medication; and

(c) Analyzing the cost of additional behavioral health agency staff time to carry out the activities in RCW 71.24.594, and providing written guidance no later than January 1, 2022, for funding and billing direct service activities related to assisting clients to obtain opioid overdose reversal medication.

(2) The authority shall develop written materials in all relevant languages for each hospital and applicable licensed or certified behavioral health agency to comply with RCW 70.41.485 and 71.24.594, including directions for the use of opioid overdose reversal medication, and provide them to all hospitals and behavioral health agencies by January 1, 2022. [2021 c 273 § 6.]

Findings—Intent—2021 c 273: See note following RCW 70.41.480.

RCW 74.09.634 Opioid overdose reversal medications—Bulk purchasing and distribution program. (1) All medicaid contracted managed health care organizations must participate in the opioid overdose reversal medication bulk purchasing and distribution program established in RCW 70.14.170 once the program is operational.

(2) The health care authority must participate in the opioid overdose reversal medication bulk purchasing and distribution program established in RCW 70.14.170 once the program is operational for purposes of individuals enrolled in medical assistance under this chapter that are not enrolled in a managed care organization and are uninsured individuals. [2023 c 51 § 45; 2021 c 273 § 12.]

Rules—2021 c 273 §§ 7-12: See note following RCW 70.14.170.

Findings—Intent—2021 c 273: See note following RCW 70.41.480.

RCW 74.09.640 Opioid use disorder—Nonpharmacologic treatments. (1) In order to support prevention of potential opioid use disorders, the authority must develop and recommend for coverage nonpharmacologic treatments for acute, subacute, and chronic noncancer pain and must report to the governor and the appropriate committees of the legislature, including any requests for funding necessary to implement the recommendations under this section. The recommendations must contain the following elements:

(a) A list of which nonpharmacologic treatments will be covered;

(b) Recommendations as to the duration, amount, and type of treatment eligible for coverage;

(c) Guidance on the type of providers eligible to provide these treatments; and

(d) Recommendations regarding the need to add any provider types to the list of currently eligible medicaid provider types.

(2) The authority must ensure only treatments that are evidence-based for the treatment of the specific acute, subacute, and chronic pain conditions will be eligible for coverage recommendations. [2019 c 314 § 35.]

Declaration—2019 c 314: See note following RCW 18.22.810.

RCW 74.09.645 Opioid use disorder—Coverage without prior authorization. All medicaid contracted managed care organizations shall provide coverage without prior authorization of at least one federal food and drug administration approved product for the treatment of opioid use disorder in the drug classes opioid agonists,

opioid antagonists, and opioid partial agonists. [2023 c 51 § 46; 2019 c 314 § 38.]

Declaration—2019 c 314: See note following RCW 18.22.810.

RCW 74.09.650 Prescription drug assistance program. (1) To the extent funds are appropriated specifically for this purpose, and subject to any conditions placed on appropriations made for this purpose, the authority shall design a medicaid prescription drug assistance program. Neither the benefits of, nor eligibility for, the program is considered to be an entitlement.

(2) The authority shall request any federal waiver necessary to implement this program. Consistent with federal waiver conditions, the department may charge enrollment fees, premiums, or point-of-service cost-sharing to program enrollees.

(3) Eligibility for this program is limited to persons:

(a) Who are eligible for medicare or age sixty-five and older;

(b) Whose family income does not exceed two hundred percent of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services;

(c) Who lack insurance that provides prescription drug coverage; and

(d) Who are not otherwise eligible under Title XIX of the federal social security act.

(4) The authority shall use a cost-effective prescription drug benefit design. Consistent with federal waiver conditions, this benefit design may be different than the benefit design offered under the medical assistance program. The benefit design may include a deductible benefit that provides coverage when enrollees incur higher prescription drug costs as defined by the department. The authority also may offer more than one benefit design.

(5) The authority shall limit enrollment of persons who qualify for the program so as to prevent an overexpenditure of appropriations for this program or to assure necessary compliance with federal waiver budget neutrality requirements. The authority may not reduce existing medical assistance program eligibility or benefits to assure compliance with federal waiver budget neutrality requirements.

(6) Premiums paid by medicaid enrollees not in the medicaid prescription drug assistance program may not be used to finance the medicaid prescription drug assistance program.

(7) This program will be terminated within twelve months after implementation of a prescription drug benefit under Title XVIII of the federal social security act. [2023 c 51 § 47; 2003 1st sp.s. c 29 § 2.]

Finding—Intent—2003 1st sp.s. c 29: "The legislature finds that prescription drugs are an effective and important part of efforts to maintain and improve the health of Washington state residents. However, their increased cost and utilization is straining the resources of many state health care programs, and is particularly hard on low-income elderly people who lack insurance coverage for such drugs. Furthermore, inappropriate use of prescription drugs can result in unnecessary expenditures and lead to serious health consequences. It is therefore the intent of the legislature to support the establishment by the state of an evidence-based prescription drug

program that identifies preferred drugs, develop programs to provide prescription drugs at an affordable price to those in need, and increase public awareness regarding their safe and cost-effective use." [2003 1st sp.s. c 29 § 1.]

Severability—2003 1st sp.s. c 29: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [2003 1st sp.s. c 29 § 14.]

Conflict with federal requirements—2003 1st sp.s. c 29: "If any part of this act is found to be in conflict with federal requirements that are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this act is inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and this finding does not affect the operation of the remainder of this act in its application to the agencies concerned. Rules adopted under this act must meet federal requirements that are a necessary condition to the receipt of federal funds by the state." [2003 1st sp.s. c 29 § 15.]

Effective date—2003 1st sp.s. c 29: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [June 26, 2003]." [2003 1st sp.s. c 29 § 16.]

RCW 74.09.653 Drug reimbursement policy recommendations. A committee or council required by federal law, within the health care authority, that makes policy recommendations regarding reimbursement for drugs under the requirements of federal law or regulations is subject to chapter 42.30 RCW. [2023 c 51 § 48; 2011 1st sp.s. c 15 § 60; 1997 c 430 § 2. Formerly RCW 43.20A.365.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.655 Smoking cessation assistance. The authority shall provide coverage under this chapter for smoking cessation counseling services, as well as prescription and nonprescription agents when used to promote smoking cessation, so long as such agents otherwise meet the definition of "covered outpatient drug" in 42 U.S.C. Sec. 1396r-8(k). However, the authority may initiate an individualized inquiry and determine and implement by rule appropriate coverage limitations as may be required to encourage the use of effective, evidence-based services and prescription and nonprescription agents. [2023 c 51 § 49; 2011 1st sp.s. c 15 § 39; 2008 c 245 § 1.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.657 Findings—Family planning services expansion. The legislature finds that:

(1) Over half of all births in Washington state are covered by public programs;

(2) Research has demonstrated that children of unintended pregnancies receive less prenatal care and are at higher risk for premature birth, low birth weight, neurological disorders, and poor academic performance;

(3) In Washington state, over 50 percent of unintended pregnancies occur in women age 25 years and older;

(4) Washington state's take charge program has been successful in helping women avoid unintended pregnancies; however, when the caseload declined due to federally mandated changes, the rate of unintended pregnancies increased dramatically;

(5) Expanding family planning services to cover women to 260 percent of the federal poverty level would align that program's eligibility standard with income eligibility for publicly funded maternity care service; and

(6) Such an expansion would reduce unintended pregnancies and associated costs to the state. [2023 c 51 § 50; 2011 1st sp.s. c 41 § 1.]

Funding reduction—2011 1st sp.s. c 41: "Upon implementation of the expansion directed in RCW 74.09.659, the office of financial management shall reduce general fund—state allotments for the medical assistance program by one million five hundred thousand dollars for fiscal year 2012 and by two million three hundred fifty thousand dollars for fiscal year 2013. The amounts reduced from allotments shall be placed in reserve status and remain unexpended." [2011 1st sp.s. c 41 § 3.]

RCW 74.09.658 Home health—Reimbursement—Telemedicine. (1) The home health program shall require registered nurse oversight and intervention, as appropriate. In-person contact between a home health care registered nurse and a patient is not required under the state's medical assistance program for home health services that are: (a) Delivered with the assistance of telemedicine and (b) otherwise eligible for reimbursement as a medically necessary skilled home health nursing visit under the program.

(2) The department or authority, as appropriate, in consultation with home health care service providers shall develop reimbursement rules and, in rule, define the requirements that must be met for a reimbursable skilled nursing visit when services are rendered without a face-to-face visit and are assisted by telemedicine.

(3)(a) The department or authority, as appropriate, shall establish the reimbursement rate for skilled home health nursing services delivered with the assistance of telemedicine that meet the requirements of a reimbursable visit as defined by the department or authority, as appropriate.

(b) Reimbursement is not provided for purchase or lease of telemedicine equipment.

(4) Any home health agency licensed under chapter 70.127 RCW and eligible for reimbursement under the medical programs authorized under this chapter may be reimbursed for services under this section if the

service meets the requirements for a reimbursable skilled nursing visit.

(5) Nothing in this section shall be construed to alter the scope of practice of any home health care services provider or authorizes the delivery of home health care services in a setting or manner not otherwise authorized by law.

(6) The use of telemedicine is not intended to replace registered nurse health care visits when necessary.

(7) For the purposes of this section, "telemedicine" means the use of telemonitoring to enhance the delivery of certain home health medical services through:

(a) The provision of certain education related to health care services using audio, video, or data communication instead of a face-to-face visit; or

(b) The collection of clinical data and the transmission of such data between a patient at a distant location and the home health provider through electronic processing technologies. Objective clinical data that may be transmitted includes, but is not limited to, weight, blood pressure, pulse, respirations, blood glucose, and pulse oximetry. [2011 1st sp.s. c 15 § 40; 2009 c 326 § 1.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.659 Family planning waiver program request. (1) The authority shall continue to submit applications for the family planning waiver program.

(2) The authority shall submit a request to the federal department of health and human services to amend the current family planning waiver program as follows:

(a) Provide coverage for sexually transmitted disease testing and treatment; and

(b) Return to the eligibility standards used in 2005 including, but not limited to, citizenship determination based on declaration or matching with federal social security databases, insurance eligibility standards comparable to 2005, and confidential service availability for minors and survivors of domestic and sexual violence. [2023 c 51 § 51. Prior: 2011 1st sp.s. c 41 § 2; 2011 1st sp.s. c 15 § 41; 2009 c 545 § 5.]

Funding reduction—2011 1st sp.s. c 41: See note following RCW 74.09.657.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Findings—2009 c 545: See note following RCW 43.06.155.

RCW 74.09.660 Prescription drug education for seniors—Grant qualifications. Each of the state's area agencies on aging shall implement a program intended to inform and train persons sixty-five years of age and older in the safe and appropriate use of prescription

and nonprescription medications. To further this purpose, the department shall award development grants averaging up to twenty-five thousand dollars to each of the agencies upon a showing that:

(1) The agency has the ability to effectively administer such a program, including an understanding of the relevant issues and appropriate outreach and follow-up;

(2) The agency can bring resources to the program in addition to those funded by the grant; and

(3) The program will be a collaborative effort between the agency and other health care programs and providers in the location to be served, including doctors, pharmacists, and long-term care providers. [2003 1st sp.s. c 29 § 8.]

Finding—Intent—Severability—Conflict with federal requirements—Effective date—2003 1st sp.s. c 29: See notes following RCW 74.09.650.

RCW 74.09.670 Medical assistance benefits—Incarcerated or committed persons—Suspension. (1) Except as provided in subsection (2) of this section, when the authority receives information that a person enrolled in medical assistance is confined in a setting in which federal financial participation is disallowed by the state's agreements with the federal government, the authority shall suspend, rather than terminate, medical assistance benefits for these persons, including those who are incarcerated in a correctional institution as defined in RCW 9.94.049, or committed to a state hospital or other treatment facility. A person who is not currently enrolled in medical assistance must be allowed to apply for medical assistance in suspense status during confinement, and the ability to apply may not depend upon knowledge of the release or discharge date of the person.

(2)(a) During the first 29 days of a person's incarceration in a correctional institution, as defined in RCW 9.94.049:

(i) A person's incarceration status may not affect the person's enrollment in medical assistance if the person was enrolled in medical assistance at the time of incarceration; and

(ii) A person not enrolled in medical assistance at the time of incarceration must have the ability to apply for medical assistance during incarceration, which may not depend on knowledge of the release date of the person. If the person is enrolled in medical assistance during the first 29 days of the person's incarceration, the person's incarceration status may not affect the person's enrollment in medical assistance.

(b) After the first 29 days of the person's incarceration, the person's medical assistance status is subject to suspension or application in suspense status under subsection (1) of this section. [2021 c 243 § 2; 2021 c 166 § 2; 2016 c 154 § 2.]

Reviser's note: This section was amended by 2021 c 166 § 2 and by 2021 c 243 § 2, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Findings—2021 c 243: "The legislature finds that when considering releasing persons from state and local institutions, realizing the safety of the public is the primary concern. The legislature also finds that the success of persons with behavioral

health needs being released from confinement in a prison, jail, juvenile rehabilitation facility, state hospital, and other state and local institutions can be increased with access to continuity of medical assistance, supportive services, and other targeted assistance. The legislature finds that this act provides strategies to prevent interruption of medical assistance benefits and to allow for a seamless transfer between systems of care. The legislature further finds that this act removes stigmatizing language from the program created under RCW 72.09.370 and 71.24.470 and creates a work group to study how to expand the cost-effective strategies of this program to other populations and settings to enhance recovery, reduce recidivism, and improve safety." [2021 c 243 § 1.]

Amendments—Waivers—2021 c 166 § 2: "The health care authority is authorized to seek any necessary state plan amendments or waivers from the federal department of health and human services that are necessary to implement section 2 of this act." [2021 c 166 § 4.]

Findings—Intent—2021 c 166: "(1) The legislature finds that:

(a) Having access to same day and next day physical and behavioral health services is imperative to facilitate successful reentry for individuals releasing from jails;

(b) The overwhelming majority of individuals in jails are incarcerated for less than 30 days;

(c) Suspending medicaid for individuals on short-term jail stays causes significant delays in medicaid reinstatement upon release; and

(d) Delays in medicaid reinstatement impede access to physical and behavioral health appointments and prescription medications upon release.

(2) The legislature intends to facilitate successful jail reentry by not suspending medicaid for individuals who are incarcerated for less than 30 days." [2021 c 166 § 1.]

Conflict with federal requirements—2021 c 166: "If any part of this act is found to be in conflict with federal requirements that are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this act is inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and this finding does not affect the operation of the remainder of this act in its application to the agencies concerned. Rules adopted under this act must meet federal requirements that are a necessary condition to the receipt of federal funds by the state." [2021 c 166 § 5.]

Intent—2016 c 154: "Persons with mental illness and persons with substance use disorders in the custody of the criminal justice system need seamless access to community treatment networks and medical assistance upon release from custody to prevent gaps in treatment and reduce barriers to accessing care. Access to care is critical to reduce recidivism and reduce costs associated with relapse, decompensation, and crisis care. In accord with the recommendations of the adult behavioral health system task force, persons should be allowed to apply or retain their enrollment in medical assistance during periods of incarceration. The legislature intends for the Washington state health care authority and the department of social and health services to raise awareness of best clinical practices to

engage persons with behavioral health disorders and other chronic conditions during periods of incarceration and confinement to highlight opportunities for good preventive care and standardize reporting and payment practices for services reimbursable by federal law that support the safe transition of the person back into the community." [2016 c 154 § 1.]

RCW 74.09.671 Incarcerated persons—Local jails—Behavioral health services—Federal funding. The authority shall collaborate with the department, the Washington state association of counties, the Washington association of sheriffs and police chiefs, and accountable communities of health to improve population health and reduce avoidable use of intensive services and settings by requesting expenditure authority from the federal government to provide behavioral health services to persons who are incarcerated in local jails. The authority in consultation with its partners may narrow its submission to discrete programs or regions of the state as deemed advisable to effectively demonstrate the potential to achieve savings by integrating medical assistance across community and correctional settings. [2016 c 154 § 4.]

Intent—2016 c 154: See note following RCW 74.09.670.

RCW 74.09.672 Inmates of a public institution—Exclusion from medicaid coverage—Work release and partial confinement programs. It is the understanding of the legislature that persons participating in a work release program or other partial confinement programs at the state, county, or city level which allow regular freedom during the day to pursue rehabilitative community activities such as participation in work, treatment, or medical care should not be considered "inmates of a public institution" for the purposes of exclusion from medicaid coverage under the social security act. The authority is instructed to obtain any permissions from the federal government necessary to confirm this understanding, and report back to the governor and relevant committees of the legislature. [2016 c 154 § 5.]

Intent—2016 c 154: See note following RCW 74.09.670.

RCW 74.09.675 Gender-affirming care services—Prohibited discrimination. (1) In the provision of gender-affirming care services through programs under this chapter, the authority, managed care plans, and providers that administer or deliver such services may not discriminate in the delivery of a service provided through a program of the authority based on the covered person's gender identity or expression.

(2) Beginning January 1, 2022:

(a) The authority and any managed care plans delivering or administering services purchased or contracted for by the authority may not apply categorical cosmetic or blanket exclusions to gender-affirming treatment.

(b) Facial feminization surgeries and facial gender-affirming treatment, such as tracheal shaves, hair electrolysis, and other care

such as mastectomies, breast reductions, breast implants, or any combination of gender-affirming procedures, including revisions to prior treatment, when prescribed as gender-affirming treatment, may not be excluded as cosmetic.

(c) The authority and managed care plans administering services purchased or contracted for by the authority may not issue an adverse benefit determination denying or limiting access to gender-affirming treatment, unless a health care provider with experience prescribing or delivering gender-affirming treatment has reviewed and confirmed the appropriateness of the adverse benefit determination.

(d) If the authority and managed care plans administering services purchased or contracted for by the authority do not have an adequate network for gender-affirming treatment, they shall ensure the delivery of timely and geographically accessible medically necessary gender-affirming treatment at no greater expense than if they had an in-network, geographically accessible provider available. This includes, but is not limited to, providing case management services to secure out-of-network gender-affirming treatment options that are available to the enrollee in a timely manner within their geographic region. The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.

(3) For the purposes of this section, "gender-affirming treatment" means a service or product that a health care provider, as defined in RCW 70.02.010, prescribes to an individual to support and affirm the individual's gender identity. Gender-affirming treatment includes, but is not limited to, treatment for gender dysphoria. Gender-affirming treatment can be prescribed to two spirit, transgender, nonbinary, and other gender diverse individuals.

(4) Nothing in this section may be construed to mandate coverage of a service that is not medically necessary.

(5) The authority shall adopt rules necessary to implement this section. [2021 c 280 § 4.]

Short title—2021 c 280: See note following RCW 49.60.178.

RCW 74.09.700 Medical care—Limited casualty program. (1) To the extent of available funds and subject to any conditions placed on appropriations made for this purpose, medical care may be provided under the limited casualty program to persons not eligible for medical assistance or medical care services who are medically needy as defined in the social security Title XIX state plan and medical indigents in accordance with eligibility requirements established by the authority. The eligibility requirements may include minimum levels of incurred medical expenses. This includes residents of nursing facilities, residents of intermediate care facilities for persons with intellectual disabilities, and individuals who are otherwise eligible for section 1915(c) of the federal social security act home and community-based waiver services, administered by the department who are aged, blind, or disabled as defined in Title XVI of the federal social security act and whose income exceeds three hundred percent of the federal supplement security income benefit level.

(2) Determination of the amount, scope, and duration of medical coverage under the limited casualty program shall be the responsibility of the authority, subject to the following:

(a) Only the following services may be covered:

(i) For persons who are medically needy as defined in the social security Title XIX state plan: Inpatient and outpatient hospital services, and home and community-based waiver services;

(ii) For persons who are medically needy as defined in the social security Title XIX state plan, and for persons who are medical indigents under the eligibility requirements established by the authority: Rural health clinic services; physicians' and clinic services; prescribed drugs, dentures, prosthetic devices, and eyeglasses; nursing facility services; and intermediate care facility services for persons with intellectual disabilities; home health services; hospice services; other laboratory and X-ray services; rehabilitative services, including occupational therapy; medically necessary transportation; and other services for which funds are specifically provided in the omnibus appropriations act;

(b) Medical care services provided to the medically indigent and received no more than seven days prior to the date of application shall be retroactively certified and approved for payment on behalf of a person who was otherwise eligible at the time the medical services were furnished: PROVIDED, That eligible persons who fail to apply within the seven-day time period for medical reasons or other good cause may be retroactively certified and approved for payment.

(3) The authority shall establish standards of assistance and resource and income exemptions. All nonexempt income and resources of limited casualty program recipients shall be applied against the cost of their medical care services. [2011 1st sp.s. c 15 § 42; 2010 c 94 § 25; 2001 c 269 § 1; 1993 c 57 § 2. Prior: 1991 sp.s. c 9 § 7; 1991 sp.s. c 8 § 10; 1991 c 233 § 2; 1989 c 87 § 3; 1985 c 5 § 4; 1983 1st ex.s. c 43 § 1; 1982 1st ex.s. c 19 § 1; 1981 2nd ex.s. c 10 § 6; 1981 2nd ex.s. c 3 § 6; 1981 1st ex.s. c 6 § 22.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Purpose—2010 c 94: See note following RCW 44.04.280.

Effective dates—1991 sp.s. c 9: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect on July 1, 1991, except sections 1 through 6 and 9 of this act which shall take effect on September 1, 1991." [1991 sp.s. c 9 § 11.]

Effective date—1991 sp.s. c 8: See note following RCW 18.51.050.

Effective dates—1989 c 87: See note following RCW 74.09.510.

Effective date—1983 1st ex.s. c 43: "This act is necessary for the immediate preservation of the public peace, health, and safety, the support of the state government and its existing public institutions, and shall take effect on July 1, 1983." [1983 1st ex.s. c 43 § 3.]

Effective date—1982 1st ex.s. c 19: See note following RCW 74.09.035.

Severability—1981 2nd ex.s. c 3: See note following RCW 74.09.510.

Effective date—Severability—1981 1st ex.s. c 6: See notes following RCW 74.04.005.

RCW 74.09.710 Chronic care management programs—Medical homes—Definitions. (1) The authority, in collaboration with the department of health and the department of social and health services, shall:

(a) Design and implement medical homes for its aged, blind, and disabled clients in conjunction with chronic care management programs to improve health outcomes, access, and cost-effectiveness. Programs must be evidence based, facilitating the use of information technology to improve quality of care, must acknowledge the role of primary care providers and include financial and other supports to enable these providers to effectively carry out their role in chronic care management, and must improve coordination of primary, acute, and long-term care for those clients with multiple chronic conditions. The authority shall consider expansion of existing medical home and chronic care management programs and build on the Washington state collaborative initiative. The authority shall use best practices in identifying those clients best served under a chronic care management model using predictive modeling through claims or other health risk information; and

(b) Evaluate the effectiveness of current chronic care management efforts in the authority and the department, comparison to best practices, and recommendations for future efforts and organizational structure to improve chronic care management.

(2) For purposes of this section:

(a) "Medical home" means a site of care that provides comprehensive preventive and coordinated care centered on the patient needs and assures high quality, accessible, and efficient care.

(b) "Chronic care management" means the authority's program that provides care management and coordination activities for medical assistance clients determined to be at risk for high medical costs. "Chronic care management" provides education and training and/or coordination that assist program participants in improving self-management skills to improve health outcomes and reduce medical costs by educating clients to better utilize services. [2011 1st sp.s. c 15 § 43; 2007 c 259 § 4.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Subheadings not law—2007 c 259: See note following RCW 7.70.060.

RCW 74.09.715 Access to dental care. Within funds appropriated for this purpose, the authority shall establish two dental access projects to serve seniors and other adults who are categorically needy blind or disabled. The projects shall provide:

(1) Enhanced reimbursement rates for certified dentists for specific procedures, to begin no sooner than July 1, 2009;

(2) Reimbursement for trained medical providers for preventive oral health services, to begin no sooner than July 1, 2009;

(3) Training, development, and implementation through a partnership with the University of Washington school of dentistry;

(4) Local program coordination including outreach and case management; and

(5) An evaluation that measures the change in utilization rates and cost savings. [2011 1st sp.s. c 15 § 44; 2008 c 146 § 13.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Findings—Intent—Severability—2008 c 146: See notes following RCW 74.41.040.

RCW 74.09.717 Dental health aide therapist services—Federal funding. (1) It is the intent of the legislature to provide that dental health aide therapist services are eligible for medicaid funding in order to promote increased dental care access for persons served in settings operated by Indian tribes, tribal organizations, and urban Indian organizations.

(2) The health care authority is directed to coordinate with the centers for medicare and medicaid services to provide that dental health aide therapist services authorized in chapter 70.350 RCW are eligible for federal funding of up to one hundred percent. [2017 c 5 § 8.]

RCW 74.09.719 Compact of free association islander dental care program. (1) The COFA islander dental care program is established to provide dental services to COFA citizens who meet the requirements in subsection (2) of this section. The authority shall begin administering this program by January 1, 2020.

(2) Subject to the availability of amounts appropriated for this specific purpose, the program shall provide dental services as covered under RCW 74.09.520 to an individual who is eligible for the COFA premium assistance program under RCW 43.71A.020, or:

(a) Is a resident;

(b) Is a COFA citizen;

(c) Has income that is less than one hundred thirty-three percent of the federal poverty level; and

(d) Is enrolled in medicare coverage under Title XVIII of the social security act (42 U.S.C. Sec. 1395 et seq., as amended).

(3) The authority may disqualify a participant from the program if the participant:

(a) No longer meets the eligibility criteria in subsection (2) of this section;

(b) Fails, without good cause, to comply with procedural or documentation requirements established by the authority in accordance with subsection (4) of this section;

(c) Fails, without good cause, to notify the authority of a change of address in a timely manner; or

(d) Withdraws the participant's application or requests termination of coverage.

(4) The authority shall establish:

(a) Application, enrollment, and renewal processes for the COFA islander dental care program; and

(b) Procedural requirements for continued participation in the program, including participant documentation requirements that are necessary for the authority to administer the program.

(5) For the purposes of this section, "COFA citizen" has the same meaning as in RCW 43.71A.010. [2019 c 311 § 4.]

Findings—Intent—2019 c 311: "(1) The legislature finds that:

(a) The legislature recognized the important relationship between the citizens of the compact of free association (COFA) nations and the United States by enacting the COFA premium assistance program in 2018 to pay for premiums and out-of-pocket expenses for COFA citizens who purchase qualifying health coverage;

(b) While other Washingtonians who are income-eligible for medicaid receive dental coverage through apple health, individuals enrolled in the COFA premium assistance program do not currently have affordable access to dental coverage;

(c) Affordable access to dental care, including preventative care, is critical to treating the whole body health of an individual and preventing systemic health problems such as stroke, heart attack, and diabetes. Poor oral health is also associated with a wide range of hardships including difficulty obtaining employment, work absences due to pain, and decreased productivity; and

(d) Research shows that people living in households in which the primary language spoken at home is not English, seniors, people with disabilities, and people who identify as Native Hawaiian or Pacific Islanders are disproportionately impacted by oral health inequities.

(2) The legislature therefore intends to increase access to dental services for COFA islanders residing in Washington by establishing a dental services program that provides dental coverage to income-eligible members of this population." [2019 c 311 § 1.]

RCW 74.09.725 Prostate cancer screening. The authority shall provide coverage for prostate cancer screening under this chapter, provided that the screening is delivered upon the recommendation of the patient's physician, advanced registered nurse practitioner, or physician assistant. [2011 1st sp.s. c 15 § 46; 2006 c 367 § 8.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.730 Disproportionate share hospital adjustment. (1) In establishing Title XIX payments for inpatient hospital services:

(a) To the extent funds are appropriated specifically for this purpose, and subject to any conditions placed on appropriations made for this purpose, the authority shall provide a disproportionate share hospital adjustment considering the following components:

(i) A low-income care component based on a hospital's medicaid utilization rate, its low-income utilization rate, its provision of obstetric services, and other factors authorized by federal law;

(ii) A medical indigency care component based on a hospital's services to persons who are medically indigent; and

(iii) A state-only component, to be paid from available state funds to hospitals that do not qualify for federal payments under (a)(ii) of this subsection, based on a hospital's services to persons who are medically indigent;

(b) The payment methodology for disproportionate share hospitals shall be specified by the authority in regulation.

(2) Nothing in this section shall be construed as a right or an entitlement by any hospital to any payment from the authority. [2018 c 201 § 7020; 2011 1st sp.s. c 15 § 47; 2009 c 538 § 1; 1991 sp.s. c 9 § 8; 1989 c 260 § 1; 1987 1st ex.s. c 5 § 20.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Effective dates—1991 sp.s. c 9: See note following RCW 74.09.700.

RCW 74.09.741 Adjudicative proceedings. (1) The following persons have the right to an adjudicative proceeding:

(a) Any applicant or recipient who is aggrieved by a decision of the authority or an authorized agency of the authority; or

(b) A current or former recipient who is aggrieved by the authority's claim that he or she owes a debt for overpayment of assistance.

(2) For purposes of this section:

(a) "Applicant" means any person who has made a request, or on behalf of whom a request has been made to the authority for any medical services program established under this chapter.

(b) "Recipient" means a person who is receiving benefits from the authority for any medical services program established in this chapter.

(3) An applicant or recipient has no right to an adjudicative proceeding when the sole basis for the authority's decision is a federal or state law requiring an assistance adjustment for a class of applicants or recipients.

(4) An applicant or recipient may file an application for an adjudicative proceeding with either the authority or the department and must do so within 90 calendar days after receiving notice of the aggrieving decision unless good cause is shown, to the extent allowable under federal law. The authority shall determine which agency is responsible for representing the state of Washington in the hearing, in accordance with agreements entered pursuant to RCW 41.05.021.

(a) For the purpose of this subsection, good cause is defined as a substantive reason or legal justification for failing to meet a hearing deadline. Good cause to fail to meet a hearing deadline may include, but is not limited to: Military deployment, medical reasons, housing instability, language barriers, or domestic violence.

(b) The authority or the department shall not grant a request for a hearing for good cause if the request is filed more than one year after the aggrieving decision.

(5)(a) The adjudicative proceeding is governed by the administrative procedure act, chapter 34.05 RCW, and this subsection. The following requirements shall apply to adjudicative proceedings in which an appellant seeks review of decisions made by more than one agency. When an appellant files a single application for an adjudicative proceeding seeking review of decisions by more than one agency, this review shall be conducted initially in one adjudicative proceeding. The presiding officer may sever the proceeding into multiple proceedings on the motion of any of the parties, when:

(i) All parties consent to the severance; or

(ii) Either party requests severance without another party's consent, and the presiding officer finds there is good cause for severing the matter and that the proposed severance is not likely to prejudice the rights of an appellant who is a party to any of the severed proceedings.

(b) If there are multiple adjudicative proceedings involving common issues or parties where there is one appellant and both the authority and the department are parties, upon motion of any party or upon his or her own motion, the presiding offer may consolidate the proceedings if he or she finds that the consolidation is not likely to prejudice the rights of the appellant who is a party to any of the consolidated proceedings.

(c) The adjudicative proceeding shall be conducted at the local community services office or other location in Washington convenient to the applicant or recipient and, upon agreement by the applicant or recipient, may be conducted telephonically.

(d) The applicant or recipient, or his or her representative, has the right to inspect his or her file from the authority and, upon request, to receive copies of authority documents relevant to the proceedings free of charge.

(e) The applicant or recipient has the right to a copy of the audio recording of the adjudicative proceeding free of charge.

(f) If a final adjudicative order is issued in favor of an applicant, medical services benefits must be provided from the date of earliest eligibility, the date of denial of the application for assistance, or 45 days following the date of application, whichever is soonest. If a final adjudicative order is issued in favor of a recipient, medical services benefits must be provided from the effective date of the authority's decision.

(g) The authority is limited to recovering an overpayment arising from assistance being continued pending the adjudicative proceeding to the amount recoverable up to the 60th day after the director's receipt of the application for an adjudicative proceeding.

(6) If the director requires that a party seek administrative review of an initial order to an adjudicative proceeding governed by this section, in order for the party to exhaust administrative remedies pursuant to RCW 34.05.534, the director shall adopt and implement rules in accordance with this subsection.

(a) The director, in consultation with the secretary, shall adopt rules to create a process for parties to seek administrative review of initial orders issued pursuant to RCW 34.05.461 in adjudicative proceedings governed by this subsection when multiple agencies are parties.

(b) This process shall seek to minimize any procedural complexities imposed on appellants that result from multiple agencies being parties to the matter, without prejudicing the rights of parties who are public assistance applicants or recipients.

(c) Nothing in this subsection shall impose or modify any legal requirement that a party seek administrative review of initial orders in order to exhaust administrative remedies pursuant to RCW 34.05.534.

(7) This subsection only applies to an adjudicative proceeding in which the appellant is an applicant for or recipient of medical services programs established under this chapter and the issue is his or her eligibility or ineligibility due to the assignment or transfer of a resource. The burden is on the authority or its authorized agency to prove by a preponderance of the evidence that the person knowingly and willingly assigned or transferred the resource at less than market value for the purpose of qualifying or continuing to qualify for medical services programs established under this chapter. If the prevailing party in the adjudicative proceeding is the applicant or recipient, he or she is entitled to reasonable attorneys' fees.

(8) When an applicant or recipient files a petition for judicial review as provided in RCW 34.05.514 of an adjudicative order entered with respect to the medical services program, no filing fee may be collected from the person and no bond may be required on any appeal. In the event that the superior court, the court of appeals, or the supreme court renders a decision in favor of the applicant or recipient, the person is entitled to reasonable attorneys' fees and costs. If a decision of the court is made in favor of an applicant, assistance shall be paid from the date of earliest eligibility, the date of the denial of the application for assistance, or 45 days following the date of application, whichever is soonest. If a decision of the court is made in favor of a recipient, assistance shall be paid from the effective date of the authority's decision.

(9) The provisions of RCW 74.08.080 do not apply to adjudicative proceedings requested or conducted with respect to the medical services program pursuant to this section.

(10) The authority shall adopt any rules it deems necessary to implement this section. [2022 c 163 § 2; 2011 1st sp.s. c 15 § 53.]

Conflict with federal requirements—Effective date—2022 c 163: See notes following RCW 74.08.080.

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.745 Medicaid funding for home visiting services—Recommendations to legislature. (1) The authority shall collaborate with the department of children, youth, and families to identify opportunities to leverage medicaid funding for home visiting services.

(2) The authority must provide a set of recommendations relevant to subsection (1) of this section to the legislature by December 1, 2018, that builds upon the research and strategies developed in the Washington state home visiting and medicaid financing strategies report submitted by the authority to the department of early learning in August 2017. [2018 c 175 § 4.]

Findings—Intent—2018 c 175: See note following RCW 74.09.495.

RCW 74.09.748 Regional service areas—Certain reimbursements required or allowed upon adoption of fully integrated managed health care system. Upon adoption of a fully integrated managed health care system pursuant to chapter 71.24 RCW, regional service areas:

(1) Must allow reimbursement for time spent supervising persons working toward satisfying supervision requirements established for the relevant practice areas pursuant to RCW 18.225.090; and

(2) May allow reimbursement for services delivered through a partial hospitalization or intensive outpatient program as described in RCW 71.24.385. [2018 c 175 § 8.]

Findings—Intent—2018 c 175: See note following RCW 74.09.495.

RCW 74.09.758 Medicaid procurement of services—Value-based contracting for medicaid and public employee purchasing. (1) The authority and the department may restructure medicaid procurement of health care services and agreements with managed care systems on a phased basis to better support integrated physical health, mental health, and substance use disorder treatment, consistent with assumptions in Second Substitute Senate Bill No. 6312, Laws of 2014, and recommendations provided by the behavioral health task force. The authority and the department may develop and utilize innovative mechanisms to promote and sustain integrated clinical models of physical and behavioral health care.

(2) The authority and the department may incorporate the following principles into future medicaid procurement efforts aimed at integrating the delivery of physical and behavioral health services:

(a) Medicaid purchasing must support delivery of integrated, person-centered care that addresses the spectrum of individuals' health needs in the context of the communities in which they live and with the availability of care continuity as their health needs change;

(b) Accountability for the client outcomes established in RCW 71.24.435 and 71.36.025 and performance measures linked to those outcomes;

(c) Medicaid benefit design must recognize that adequate preventive care, crisis intervention, and support services promote a recovery-focused approach;

(d) Evidence-based care interventions and continuous quality improvement must be enforced through contract specifications and performance measures that provide meaningful integration at the patient care level with broadly distributed accountability for results;

(e) Active purchasing and oversight of medicaid managed care contracts is a state responsibility;

(f) A deliberate and flexible system change plan with identified benchmarks to promote system stability, provide continuity of treatment for patients, and protect essential existing behavioral health system infrastructure and capacity; and

(g) Community and organizational readiness are key determinants of implementation timing; a phased approach is therefore desirable.

(3) The principles identified in subsection (2) of this section are not intended to create an individual entitlement to services.

(4) The authority shall increase the use of value-based contracting, alternative quality contracting, and other payment incentives that promote quality, efficiency, cost savings, and health improvement, for medicaid and public employee purchasing. The authority shall also implement additional chronic disease management techniques that reduce the subsequent need for hospitalization or readmissions. It is the intent of the legislature that the reforms the authority implements under this subsection are anticipated to reduce extraneous medical costs, across all medical programs, when fully phased in by fiscal year 2017 to generate budget savings identified in the omnibus appropriations act. [2019 c 325 § 5029; 2014 c 223 § 7.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Finding—2014 c 223: See note following RCW 41.05.690.

MATERNITY CARE ACCESS PROGRAM

RCW 74.09.760 Short title—1989 1st ex.s. c 10. This act may be known and cited as the "maternity care access act of 1989." [1989 1st ex.s. c 10 § 1.]

RCW 74.09.770 Maternity care access system established. (1) The legislature finds that Washington state and the nation as a whole have a high rate of infant illness and death compared with other industrialized nations. This is especially true for minority and low-income populations. Premature and low weight births have been directly linked to infant illness and death. The availability of adequate maternity care throughout the course of pregnancy has been identified as a major factor in reducing infant illness and death. Further, the investment in preventive health care programs, such as maternity care, contributes to the growth of a healthy and productive society and is a sound approach to health care cost containment. The legislature further finds that access to maternity care for low-income women in the state of Washington has declined significantly in recent years and has reached a crisis level.

(2) It is the purpose of this subchapter to provide, consistent with appropriated funds, maternity care necessary to ensure healthy birth outcomes for low-income families. To this end, a maternity care access system is established based on the following principles:

(a) The family is the fundamental unit in our society and should be supported through public policy.

(b) Access to maternity care for eligible persons to ensure healthy birth outcomes should be made readily available in an expeditious manner through a single service entry point.

(c) Unnecessary barriers to maternity care for eligible persons should be removed.

(d) Access to preventive and other health care services should be available for low-income children.

(e) Each woman should be encouraged to and assisted in making her own informed decisions about her maternity care.

(f) Unnecessary barriers to the provision of maternity care by qualified health professionals should be removed.

(g) The system should be sensitive to cultural differences among eligible persons.

(h) To the extent possible, decisions about the scope, content, and delivery of services should be made at the local level involving a broad representation of community interests.

(i) The maternity care access system should be evaluated at appropriate intervals to determine effectiveness and need for modification.

(j) Maternity care services should be delivered in a cost-effective manner. [2011 1st sp.s. c 15 § 48; 1989 1st ex.s. c 10 § 2.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.780 Reservation of legislative power. The legislature reserves the right to amend or repeal all or any part of this subchapter at any time and there shall be no vested private right of any kind against such amendment or repeal. All rights, privileges, or immunities conferred by this subchapter or any acts done pursuant thereto shall exist subject to the power of the legislature to amend or repeal this subchapter at any time. [2018 c 201 § 7021; 1989 1st ex.s. c 10 § 3.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

RCW 74.09.790 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout RCW 74.09.760 through 74.09.820 and 74.09.510:

(1) "At-risk eligible person" means an eligible person determined by the authority to need special assistance in applying for and obtaining maternity care, including pregnant women who are substance abusers, pregnant and parenting adolescents, pregnant minority women, and other eligible persons who need special assistance in gaining access to the maternity care system.

(2) "Authority" means the Washington state health care authority.

(3) "County authority" means the board of county commissioners, county council, or county executive having the authority to participate in the maternity care access program or its designee. Two or more county authorities may enter into joint agreements to fulfill the requirements of this chapter.

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

(5) "Eligible person" means a woman in need of maternity care or a child, who is eligible for medical assistance pursuant to this chapter or the prenatal care program administered by the authority.

(6) "Family planning services" means planning the number of one's children by use of contraceptive techniques.

(7) "Maternity care services" means inpatient and outpatient medical care, case management, and support services necessary during prenatal, delivery, and postpartum periods.

(8) "Support services" means, at least, public health nursing assessment and follow-up, health and childbirth education, psychological assessment and counseling, outreach services, nutritional assessment and counseling, needed vitamin and nonprescriptive drugs, transportation, family planning services, and child care. Support services may include alcohol and substance abuse treatment for pregnant women who are addicted or at risk of being addicted to alcohol or drugs to the extent funds are made available for that purpose. [2011 1st sp.s. c 15 § 49; 1993 c 407 § 9; 1990 c 151 § 4; 1989 1st ex.s. c 10 § 4.]

Reviser's note: The definitions in this section have been alphabetized pursuant to RCW 1.08.015(2)(k).

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.800 Maternity care access program established. The authority shall, consistent with the state budget act, develop a maternity care access program designed to ensure healthy birth outcomes as follows:

(1) Provide maternity care services to low-income pregnant women and health care services to children in poverty to the maximum extent allowable under the medical assistance program, Title XIX of the federal social security act;

(2) Provide maternity care services to low-income women who are not eligible to receive such services under the medical assistance program, Title XIX of the federal social security act;

(3) Have the following procedures in place to improve access to maternity care services and eligibility determinations for pregnant women applying for maternity care services under the medical assistance program, Title XIX of the federal social security act:

(a) Use of a shortened and simplified application form;

(b) Outstationing authority staff to make eligibility determinations;

(c) Establishing local plans at the county and regional level, coordinated by the authority; and

(d) Conducting an interview for the purpose of determining medical assistance eligibility within five working days of the date of an application by a pregnant woman and making an eligibility determination within fifteen working days of the date of application by a pregnant woman;

(4) Establish a maternity care case management system that shall assist at-risk eligible persons with obtaining medical assistance benefits and receiving maternity care services, including transportation and child care services;

(5) Within available resources, establish appropriate reimbursement levels for maternity care providers;

(6) Implement a broad-based public education program that stresses the importance of obtaining maternity care early during pregnancy;

(7) Refer persons eligible for maternity care services under the program established by this section to persons, agencies, or organizations with maternity care service practices that primarily emphasize healthy birth outcomes;

(8) Provide family planning services including information about the synthetic progestin capsule implant form of contraception, for twelve months immediately following a pregnancy to women who were eligible for medical assistance under the maternity care access program during that pregnancy or who were eligible only for emergency labor and delivery services during that pregnancy; and

(9) Within available resources, provide family planning services to women who meet the financial eligibility requirements for services under subsections (1) and (2) of this section. [2011 1st sp.s. c 15 § 50; 1993 c 407 § 10; 1989 1st ex.s. c 10 § 5.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.810 Alternative maternity care service delivery system established—Remedial action report. (1) The authority shall establish an alternative maternity care service delivery system, if it determines that a county or a group of counties is a maternity care distressed area. A maternity care distressed area shall be defined by the authority, in rule, as a county or a group of counties where eligible women are unable to obtain adequate maternity care. The authority shall include the following factors in its determination:

(a) Higher than average percentage of eligible persons in the distressed area who receive late or no prenatal care;

(b) Higher than average percentage of eligible persons in the distressed area who go out of the area to receive maternity care;

(c) Lower than average percentage of obstetrical care providers in the distressed area who provide care to eligible persons;

(d) Higher than average percentage of infants born to eligible persons per obstetrical care provider in the distressed area; and

(e) Higher than average percentage of infants that are of low birth weight, five and one-half pounds or two thousand five hundred grams, born to eligible persons in the distressed area.

(2) If the authority determines that a maternity care distressed area exists, it shall notify the relevant county authority. The county authority shall, within one hundred twenty days, submit a brief report to the authority recommending remedial action. The report shall be prepared in consultation with the authority and with the department's local community service offices, the local public health officer, community health clinics, health care providers, hospitals, the business community, labor representatives, and low-income advocates in the distressed area. A county authority may contract with a local nonprofit entity to develop the report. If the county authority is unwilling or unable to develop the report, it shall notify the authority within thirty days, and the authority shall develop the report for the distressed area.

(3) The authority shall review the report and use it, to the extent possible, in developing strategies to improve maternity care access in the distressed area. The authority may contract with or directly employ qualified maternity care health providers to provide maternity care services, if access to such providers in the distressed area is not possible by other means. In such cases, the authority is authorized to pay that portion of the health care providers' malpractice liability insurance that represents the percentage of

maternity care provided to eligible persons by that provider through increased medical assistance payments. [2011 1st sp.s. c 15 § 51; 1989 1st ex.s. c 10 § 6.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

RCW 74.09.820 Maternity care provider's loan repayment program. To the extent that federal matching funds are available, the authority or the department of health shall establish, in consultation with the health science programs of the state's colleges and universities, and community health clinics, a loan repayment program that will encourage maternity care providers to practice in medically underserved areas in exchange for repayment of part or all of their health education loans. [2011 1st sp.s. c 15 § 52; 1989 1st ex.s. c 10 § 7.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Health professional scholarships: Chapter 28B.115 RCW.

RCW 74.09.825 Donor human milk—Standards—Federal funding. (1) The authority shall provide coverage under this chapter for medically necessary donor human milk for inpatient use when ordered by a licensed health care provider with prescriptive authority or an international board certified lactation consultant certified by the international board of lactation consultant examiners for an infant who is medically or physically unable to receive maternal human milk or participate in chest feeding or whose parent is medically or physically unable to produce maternal human milk in sufficient quantities or caloric density or participate in chest feeding, if the infant meets at least one of the following criteria:

(a) An infant birth weight of below 2,500 grams;

(b) An infant gestational age equal to or less than 34 weeks;

(c) Infant hypoglycemia;

(d) A high risk for development of necrotizing enterocolitis, bronchopulmonary dysplasia, or retinopathy of prematurity;

(e) A congenital or acquired gastrointestinal condition with long-term feeding or malabsorption complications;

(f) Congenital heart disease requiring surgery in the first year of life;

(g) An organ or bone marrow transplant;

(h) Sepsis;

(i) Congenital hypotonias associated with feeding difficulty or malabsorption;

(j) Renal disease requiring dialysis in the first year of life;

(k) Craniofacial anomalies;

(l) An immunologic deficiency;

(m) Neonatal abstinence syndrome;

(n) Any other serious congenital or acquired condition for which the use of pasteurized donor human milk and donor human milk derived

products is medically necessary and supports the treatment and recovery of the child; or

(o) Any baby still inpatient within 72 hours of birth without sufficient human milk available.

(2) Donor human milk covered under this section must be obtained from a milk bank that meets minimum standards adopted by the department of health pursuant to RCW 43.70.645.

(3) The authority may require an enrollee to obtain expedited prior authorization to receive coverage for donor human milk as required under this section.

(4) In administering this program, the authority must seek any available federal financial participation under the medical assistance program, as codified at Title XIX of the federal social security act, the state children's health insurance program, as codified at Title XXI of the federal social security act, and any other federal funding sources that are now available or may become available.

(5) For purposes of this section:

(a) "Donor human milk" means human milk that has been contributed to a milk bank by one or more donors.

(b) "Milk bank" means an organization that engages in the procurement, processing, storage, distribution, or use of human milk contributed by donors. [2022 c 236 § 4.]

RCW 74.09.830 Postpartum health care coverage. (1) The authority shall extend health care coverage from 60 days postpartum to one year postpartum for pregnant or postpartum persons who, on or after the expiration date of the federal public health emergency declaration related to COVID-19, are receiving postpartum coverage provided under this chapter.

(2) By June 1, 2022, the authority must:

(a) Provide health care coverage to postpartum persons who reside in Washington state, have countable income equal to or below 193 percent of the federal poverty level, and are not otherwise eligible under Title XIX or Title XXI of the federal social security act; and

(b) Ensure all persons approved for pregnancy or postpartum coverage at any time are continuously eligible for postpartum coverage for 12 months after the pregnancy ends regardless of whether they experience a change in income during the period of eligibility.

(3) Health care coverage under this section must be provided during the 12-month period beginning on the last day of the pregnancy.

(4) The authority shall not provide health care coverage under this section to individuals who are eligible to receive health care coverage under Title XIX or Title XXI of the federal social security act. Health care coverage for these individuals shall be provided by a program that is funded by Title XIX or Title XXI of the federal social security act. Further, the authority shall make every effort to expedite and complete eligibility determinations for individuals who are presumptively eligible to receive health care coverage under Title XIX or Title XXI of the federal social security act to ensure the state is receiving the maximum federal match. This includes, but is not limited to, working with the managed care organizations to provide continuous outreach in various modalities until the individual's eligibility determination is completed. Beginning January 1, 2022, the authority must submit quarterly reports to the caseload forecast work group on the number of individuals who are presumptively eligible to receive health care coverage under Title XIX or Title XXI of the

federal social security act but are awaiting for the authority to complete eligibility determination, the number of individuals who were presumptively eligible but are now receiving health care coverage with the maximum federal match under Title XIX or Title XXI of the federal social security act, and outreach activities including the work with managed care organizations.

(5) To ensure continuity of care and maximize the efficiency of the program, the amount and scope of health care services provided to individuals under this section must be the same as that provided to pregnant and postpartum persons under medical assistance, as defined in RCW 74.09.520.

(6) In administering this program, the authority must seek any available federal financial participation under the medical assistance program, as codified at Title XIX of the federal social security act, the state children's health insurance program, as codified at Title XXI of the federal social security act, and any other federal funding sources that are now available or may become available. This includes, but is not limited to, ensuring the state is receiving the maximum federal match for individuals who are presumptively eligible to receive health care coverage under Title XIX or Title XXI of the federal social security act by expediting completion of the individual's eligibility determination.

(7) Working with stakeholder and community organizations and the Washington health benefit exchange, the authority must establish a comprehensive community education and outreach campaign to facilitate applications for and enrollment in the program or into a more appropriate program where the state receives maximum federal match. Subject to the availability of amounts appropriated for this specific purpose, the education and outreach campaign must provide culturally and linguistically accessible information to facilitate participation in the program, including but not limited to enrollment procedures, program services, and benefit utilization.

(8) Beginning January 1, 2022, the managed care organizations contracted with the authority to provide postpartum coverage must annually report to the legislature on their work to improve maternal health for enrollees, including but not limited to postpartum services offered to enrollees, the percentage of enrollees utilizing each postpartum service offered, outreach activities to engage enrollees in available postpartum services, and efforts to collect eligibility information for the authority to ensure the enrollee is in the most appropriate program for the state to receive the maximum federal match. [2021 c 90 § 2.]

Intent—2021 c 90: "(1) In Washington and across the country, maternal mortality rates continue to be unacceptably high. The maternal mortality rate in the United States is higher than in most developed countries. Approximately 700 people die each year in the United States due to pregnancy-related conditions. The majority of these deaths are preventable.

(2) National and state maternal mortality data reveals significant racial and ethnic disparities. Nationally, black women are two to three times more likely to die from a pregnancy-related cause than white women. In this state, data from the maternal mortality review panel reveals that American Indian and Alaska Native women are six to seven times as likely to die from a pregnancy-related cause

than white women. Significant disparities in maternal mortality rates also exist for Hispanic, Asian, and multiracial women in Washington.

(3) Over 50 percent of pregnancy-related deaths in Washington state are women enrolled in medicaid. In 2019, medicaid covered almost 37,000 births which is nearly half of the total of nonmilitary births in Washington state.

(4) The centers for disease control and prevention find pregnancy-related deaths occur up to one year postpartum, and data shows that health needs continue during that entire year. In Washington, nearly one-third of all pregnancy-related deaths and the majority of suicides and accidental overdoses occurred between 43 and 365 days postpartum.

(5) The maternal mortality review panel has identified access to health care services and gaps in continuity of care, especially during the postpartum period, as factors that contribute to preventable pregnancy-related deaths. In their October 2019 report to the legislature, the panel recommended ensuring funding and access to postpartum care and support through the first year after pregnancy. The panel also recommended addressing social determinants of health, structural racism, provider biases, and other social inequities to reduce maternal mortality in priority populations.

(6) Approximately 50,000 people also experience serious complications from childbirth each year, resulting in increased medical costs, longer hospitalization stays, and long-term health effects.

(7) Postpartum medicaid coverage currently ends 60 days after pregnancy, creating an unsafe gap in coverage. Continuity of care is critical during this vulnerable time, and uninterrupted health care coverage provides birthing parents with access to stable and consistent care. Extending health care coverage through the first year postpartum is one of the best tools for increasing access to care and improving maternal and infant health. A health impact review published by the state board of health found very strong evidence that this policy would decrease inequities by race and ethnicity, immigration status, socioeconomic status, and geography.

(8) During the public health emergency, a federal maintenance of effort requirement has extended medicaid coverage beyond 60 days postpartum. This extension is critical, with pregnancy-related deaths increasing due to COVID-19. Pregnant women are more likely to be admitted to the intensive care unit and receive invasive ventilation and are at increased risk of death compared to nonpregnant women. The pandemic has also exacerbated the behavioral health challenges normally faced in the pregnancy and postpartum period. It has also highlighted and contributed to increased housing crises. Even outside of the pandemic, research shows that pregnancy can increase a woman's risk of becoming homeless, and pregnant women face significantly greater health risks while unstably housed. The legislature is committed to continuing coverage for this population beyond the maintenance of effort requirement.

(9) Pending federal legislation, the helping moms act, would provide federal matching funds to states that provide one year of postpartum coverage under medicaid and the children's health insurance program.

(10) The legislature therefore intends to extend health care coverage from 60 days to 12 months postpartum." [2021 c 90 § 1.]

RCW 74.09.840 Prior authorization. (1) Beginning January 1, 2024, the authority shall require each managed care organization to comply with the following standards related to prior authorization for health care services and prescription drugs:

(a) The managed care organization shall meet the following time frames for prior authorization determinations and notifications to a participating provider or facility that submits the prior authorization request through an electronic prior authorization process, as designated by each managed care organization:

(i) For electronic standard prior authorization requests, the managed care organization shall make a decision and notify the provider or facility of the results of the decision within three calendar days, excluding holidays, of submission of an electronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the managed care organization to make a decision, the managed care organization shall request any additional information from the provider or facility within one calendar day of submission of the electronic prior authorization request.

(ii) For electronic expedited prior authorization requests, the managed care organization shall make a decision and notify the provider or facility of the results of the decision within one calendar day of submission of an electronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the managed care organization to make a decision, the managed care organization shall request any additional information from the provider or facility within one calendar day of submission of the electronic prior authorization request.

(b) The managed care organization shall meet the following time frames for prior authorization determinations and notifications to a participating provider or facility that submits the prior authorization request through a process other than an electronic prior authorization process described in subsection (2) of this section:

(i) For nonelectronic standard prior authorization requests, the managed care organization shall make a decision and notify the provider or facility of the results of the decision within five calendar days of submission of a nonelectronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the managed care organization to make a decision, the managed care organization shall request any additional information from the provider or facility within five calendar days of submission of the nonelectronic prior authorization request.

(ii) For nonelectronic expedited prior authorization requests, the managed care organization shall make a decision and notify the provider or facility of the results of the decision within two calendar days of submission of a nonelectronic prior authorization request by the provider or facility that contains the necessary information to make a determination. If insufficient information has been provided to the managed care organization to make a decision, the managed care organization shall request any additional information from the provider or facility within one calendar day of submission of the nonelectronic prior authorization request.

(c) In any instance in which a managed care organization has determined that a provider or facility has not provided sufficient information for making a determination under (a) and (b) of this

subsection, a managed care organization may establish a specific reasonable time frame for submission of the additional information. This time frame must be communicated to the provider and enrollee with a managed care organization's request for additional information.

(d) The prior authorization requirements of the managed care organization must be described in detail and written in easily understandable language. The managed care organization shall make its most current prior authorization requirements and restrictions, including the written clinical review criteria, available to providers and facilities in an electronic format upon request. The prior authorization requirements must be based on peer-reviewed clinical review criteria. The clinical review criteria must be evidence-based criteria and must accommodate new and emerging information related to the appropriateness of clinical criteria with respect to black and indigenous people, other people of color, gender, and underserved populations. The clinical review criteria must be evaluated and updated, if necessary, at least annually.

(2)(a) Each managed care organization shall build and maintain a prior authorization application programming interface that automates the process for in-network providers to determine whether a prior authorization is required for health care services, identify prior authorization information and documentation requirements, and facilitate the exchange of prior authorization requests and determinations from its electronic health records or practice management system. The application programming interface must support the exchange of prior authorization requests and determinations for health care services beginning January 1, 2025, and must:

(i) Use health level 7 fast health care interoperability resources in accordance with standards and provisions defined in 45 C.F.R. Sec. 170.215 and 45 C.F.R. Sec. 156.22(3)(b);

(ii) Automate the process to determine whether a prior authorization is required for durable medical equipment or a health care service;

(iii) Allow providers to query the managed care organization's prior authorization documentation requirements;

(iv) Support an automated approach using nonproprietary open workflows to compile and exchange the necessary data elements to populate the prior authorization requirements that are compliant with the federal health insurance portability and accountability act of 1996 or have an exception from the federal centers for medicare and medicaid services; and

(v) Indicate that a prior authorization denial or authorization of a service less intensive than that included in the original request is an adverse benefit determination and is subject to the managed care organization's grievance and appeal process under RCW 48.43.535.

(b) Each managed care organization shall establish and maintain an interoperable electronic process or application programming interface that automates the process for in-network providers to determine whether a prior authorization is required for a covered prescription drug. The application programming interface must support the exchange of prior authorization requests and determinations for prescription drugs, including information on covered alternative prescription drugs, beginning January 1, 2027, and must:

(i) Allow providers to identify prior authorization information and documentation requirements;

(ii) Facilitate the exchange of prior authorization requests and determinations from its electronic health records or practice

management system, and may include the necessary data elements to populate the prior authorization requirements that are compliant with the federal health insurance portability and accountability act of 1996 or have an exception from the federal centers for medicare and medicaid services; and

(iii) Indicate that a prior authorization denial or authorization of a drug other than the one included in the original prior authorization request is an adverse benefit determination and is subject to the managed care organization's grievance and appeal process under RCW 48.43.535.

(c) If federal rules related to standards for using an application programming interface to communicate prior authorization status to providers are not finalized by September 13, 2023, the requirements of (a) of this subsection may not be enforced until January 1, 2026.

(d)(i) If a managed care organization determines that it will not be able to satisfy the requirements of (a) of this subsection by January 1, 2025, the managed care organization shall submit a narrative justification to the authority on or before September 1, 2024, describing:

(A) The reasons that the managed care organization cannot reasonably satisfy the requirements;

(B) The impact of noncompliance upon providers and enrollees;

(C) The current or proposed means of providing health information to the providers; and

(D) A timeline and implementation plan to achieve compliance with the requirements.

(ii) The authority may grant a one-year delay in enforcement of the requirements of (a) of this subsection (2) if the authority determines that the managed care organization has made a good faith effort to comply with the requirements.

(iii) This subsection (2)(d) shall not apply if the delay in enforcement in (c) of this subsection takes effect because the federal centers for medicare and medicaid services did not finalize the applicable regulations by September 13, 2023.

(3) Nothing in this section applies to prior authorization determinations made pursuant to RCW 71.24.618 or 74.09.490.

(4) For the purposes of this section:

(a) "Expedited prior authorization request" means a request by a provider or facility for approval of a health care service or prescription drug where:

(i) The passage of time:

(A) Could seriously jeopardize the life or health of the enrollee;

(B) Could seriously jeopardize the enrollee's ability to regain maximum function; or

(C) In the opinion of a provider or facility with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the health care service or prescription drug that is the subject of the request; or

(ii) The enrollee is undergoing a current course of treatment using a nonformulary drug.

(b) "Standard prior authorization request" means a request by a provider or facility for approval of a health care service or prescription drug where the request is made in advance of the enrollee obtaining a health care service or prescription drug that is not required to be expedited. [2023 c 382 § 3.]

RCW 74.09.850 Conflict with federal requirements. If any part of this chapter is found to conflict with federal requirements which are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this chapter is hereby declared to be inoperative solely to the extent of the conflict, and such finding or determination shall not affect the operation of the remainder of this chapter. [1981 2nd ex.s. c 3 § 7.]

Severability—1981 2nd ex.s. c 3: See note following RCW 74.09.510.

RCW 74.09.860 Request for proposals—Foster children—Integrated managed health and behavioral health care—Continuation of health care benefits following reunification. (1) The authority shall issue a request for proposals to provide integrated managed health and behavioral health care for foster children receiving care through the medical assistance program. Behavioral health services provided under chapters 71.24 and 71.34 RCW must be integrated into the managed care organization for foster children beginning January 1, 2019. The request for proposals must address the program elements described in section 110, chapter 225, Laws of 2014, including development of a service delivery system, benefit design, reimbursement mechanisms, incorporation or coordination of services currently provided by the regional support networks, and standards for contracting with health organizations. The request for proposals must be issued and completed in time for services under the integrated managed care plan to begin on October 1, 2016.

(2) The parent or guardian of a child who is no longer a dependent child pursuant to chapter 13.34 RCW may choose to continue in the transitional foster care eligibility category for up to twelve months following reunification with the child's parents or guardian if the child:

(a) Is under eighteen years of age;

(b) Was in foster care under the legal responsibility of the department of social and health services, the department of children, youth, and families, or a federally recognized Indian tribe located within the state; and

(c) Meets income and other eligibility standards for medical assistance coverage. [2023 c 51 § 52; 2018 c 27 § 1; 2015 c 283 § 1.]

Effective date—2018 c 27: "This act takes effect July 1, 2018." [2018 c 27 § 2.]

RCW 74.09.870 Regional service areas—Establishment. (1) Upon receipt of guidance for the creation of common regional service areas from the adult behavioral health system task force established in section 1, chapter 338, Laws of 2013, the authority shall establish regional service areas as provided in this section.

(2) Counties, through the Washington state association of counties, must be given the opportunity to propose the composition of regional service areas. Each service area must:

(a) Include a sufficient number of medicaid lives to support full financial risk managed care contracting for services included in contracts with the department or the authority;

(b) Include full counties that are contiguous with one another; and

(c) Reflect natural medical and behavioral health service referral patterns and shared clinical, health care service, behavioral health service, and behavioral health crisis response resources.

(3) The Washington state association of counties must submit their recommendations to the department, the authority, and the task force described in section 1, chapter 225, Laws of 2014 on or before August 1, 2014. [2018 c 201 § 2006; 2014 c 225 § 2. Formerly RCW 43.20A.893.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

RCW 74.09.871 Behavioral health services—Contracting process. (1) Any agreement or contract by the authority to provide behavioral health services as defined under RCW 71.24.025 to persons eligible for benefits under medicaid, Title XIX of the social security act, and to persons not eligible for medicaid must include the following:

(a) Contractual provisions consistent with the intent expressed in RCW 71.24.015 and 71.36.005;

(b) Standards regarding the quality of services to be provided, including increased use of evidence-based, research-based, and promising practices, as defined in RCW 71.24.025;

(c) Accountability for the client outcomes established in RCW 71.24.435, 70.320.020, and 71.36.025 and performance measures linked to those outcomes;

(d) Standards requiring behavioral health administrative services organizations and managed care organizations to 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 authority and to protect essential behavioral health system infrastructure and capacity, including a continuum of substance use disorder services;

(e) Provisions to require that medically necessary substance use disorder and mental health treatment services be available to clients;

(f) Standards requiring the use of behavioral health service provider reimbursement methods that incentivize improved performance with respect to the client outcomes established in RCW 71.24.435 and 71.36.025, integration of behavioral health and primary care services at the clinical level, and improved care coordination for individuals with complex care needs;

(g) Standards related to the financial integrity of the contracting entity. This subsection does not limit the authority of the authority to take action under a contract upon finding that a contracting entity's financial status jeopardizes the contracting entity's ability to meet its contractual obligations;

(h) Mechanisms for monitoring performance under the contract and remedies for failure to substantially comply with the requirements of the contract including, but not limited to, financial deductions, termination of the contract, receivership, reprocurement of the contract, and injunctive remedies;

(i) Provisions to maintain the decision-making independence of designated crisis responders; and

(j) Provisions stating that public funds appropriated by the legislature may not be used to promote or deter, encourage, or discourage employees from exercising their rights under Title 29, chapter 7, subchapter II, United States Code or chapter 41.56 RCW.

(2) At least six months prior to releasing a medicaid integrated managed care procurement, but no later than January 1, 2025, the authority shall adopt statewide network adequacy standards that are assessed on a regional basis for the behavioral health provider networks maintained by managed care organizations pursuant to subsection (1)(d) of this section. The standards shall require a network that ensures access to appropriate and timely behavioral health services for the enrollees of the managed care organization who live within the regional service area. At a minimum, these standards must address each behavioral health services type covered by the medicaid integrated managed care contract. This includes, but is not limited to: Outpatient, inpatient, and residential levels of care for adults and youth with a mental health disorder; outpatient, inpatient, and residential levels of care for adults and youth with a substance use disorder; crisis and stabilization services; providers of medication for opioid use disorders; specialty care; other facility-based services; and other providers as determined by the authority through this process. The authority shall apply the standards regionally and shall incorporate behavioral health system needs and considerations as follows:

(a) Include a process for an annual review of the network adequacy standards;

(b) Provide for participation from counties and behavioral health providers in both initial development and subsequent updates;

(c) Account for the regional service area's population; prevalence of behavioral health conditions; types of minimum behavioral health services and service capacity offered by providers in the regional service area; number and geographic proximity of providers in the regional service area; an assessment of the needs or gaps in the region; and availability of culturally specific services and providers in the regional service area to address the needs of communities that experience cultural barriers to health care including but not limited to communities of color and the LGBTQ+ community;

(d) Include a structure for monitoring compliance with provider network standards and timely access to the services;

(e) Consider how statewide services, such as residential treatment facilities, are utilized cross-regionally; and

(f) Consider how the standards would impact requirements for behavioral health administrative service organizations.

(3) Before releasing a medicaid integrated managed care procurement, the authority shall identify options that minimize provider administrative burden, including the potential to limit the number of managed care organizations that operate in a regional service area.

(4) The following factors must be given significant weight in any medicaid integrated managed care procurement process under this section:

(a) Demonstrated commitment and experience in serving low-income populations;

(b) Demonstrated commitment and experience serving persons who have mental illness, substance use disorders, or co-occurring disorders;

(c) Demonstrated commitment to and experience with partnerships with county and municipal criminal justice systems, housing services, and other critical support services necessary to achieve the outcomes established in RCW 71.24.435, 70.320.020, and 71.36.025;

(d) The ability to provide for the crisis service needs of medicaid enrollees, consistent with the degree to which such services are funded;

(e) Recognition that meeting enrollees' physical and behavioral health care needs is a shared responsibility of contracted behavioral health administrative services organizations, managed care organizations, service providers, the state, and communities;

(f) Consideration of past and current performance and participation in other state or federal behavioral health programs as a contractor;

(g) The ability to meet requirements established by the authority;

(h) The extent to which a managed care organization's approach to contracting simplifies billing and contracting burdens for community behavioral health provider agencies, which may include but is not limited to a delegation arrangement with a provider network that leverages local, federal, or philanthropic funding to enhance the effectiveness of medicaid-funded integrated care services and promote medicaid clients' access to a system of services that addresses additional social support services and social determinants of health as defined in RCW 43.20.025;

(i) Demonstrated prior national or in-state experience with a full continuum of behavioral health services that are substantially similar to the behavioral health services covered under the Washington medicaid state plan, including evidence through past and current data on performance, quality, and outcomes; and

(j) Demonstrated commitment by managed care organizations to the use of alternative pricing and payment structures between a managed care organization and its behavioral health services providers, including provider networks described in subsection (b) of this section, and between a managed care organization and a behavioral administrative service organization, in any of their agreements or contracts under this section, which may include but are not limited to:

(i) Value-based purchasing efforts consistent with the authority's value-based purchasing strategy, such as capitated payment arrangements, comprehensive population-based payment arrangements, or case rate arrangements; or

(ii) Payment methods that secure a sufficient amount of ready and available capacity for levels of care that require staffing 24 hours per day, 365 days per year, to serve anyone in the regional service area with a demonstrated need for the service at all times, regardless of fluctuating utilization.

(5) The authority may use existing cross-system outcome data such as the outcomes and related measures under subsection (4)(c) of this section and chapter 338, Laws of 2013, to determine that the alternative pricing and payment structures referenced in subsection (4)(j) of this section have advanced community behavioral health system outcomes more effectively than a fee-for-service model may have been expected to deliver.

(6)(a) The authority shall urge managed care organizations to establish, continue, or expand delegation arrangements with a provider network that exists on July 23, 2023, and that leverages local,

federal, or philanthropic funding to enhance the effectiveness of medicaid-funded integrated care services and promote medicaid clients' access to a system of services that addresses additional social support services and social determinants of health as defined in RCW 43.20.025. Such delegation arrangements must meet the requirements of the integrated managed care contract and the national committee for quality assurance accreditation standards.

(b) The authority shall recognize and support, and may not limit or restrict, a delegation arrangement that a managed care organization and a provider network described in (a) of this subsection have agreed upon, provided such arrangement meets the requirements of the integrated managed care contract and the national committee for quality assurance accreditation standards. The authority may periodically review such arrangements for effectiveness according to the requirements of the integrated managed care contract and the national committee for quality assurance accreditation standards.

(c) Managed care organizations and the authority may evaluate whether to establish or support future delegation arrangements with any additional provider networks that may be created after July 23, 2023, based on the requirements of the integrated managed care contract and the national committee for quality assurance accreditation standards.

(7) The authority shall expand the types of behavioral health crisis services that can be funded with medicaid to the maximum extent allowable under federal law, including seeking approval from the centers for medicare and medicaid services for amendments to the medicaid state plan or medicaid state directed payments that support the 24 hours per day, 365 days per year capacity of the crisis delivery system when necessary to achieve this expansion.

(8) The authority shall, in consultation with managed care organizations, review reports and recommendations of the involuntary treatment act work group established pursuant to section 103, chapter 302, Laws of 2020 and develop a plan for adding contract provisions that increase managed care organizations' accountability when their enrollees require long-term involuntary inpatient behavioral health treatment and shall explore opportunities to maximize medicaid funding as appropriate.

(9) In recognition of the value of community input and consistent with past procurement practices, the authority shall include county and behavioral health provider representatives in the development of any medicaid integrated managed care procurement process. This shall include, at a minimum, two representatives identified by the association of county human services and two representatives identified by the Washington council for behavioral health to participate in the review and development of procurement documents.

(10) For purposes of purchasing behavioral health services and medical care services for persons eligible for benefits under medicaid, Title XIX of the social security act and for persons not eligible for medicaid, the authority must use regional service areas. The regional service areas must be established by the authority as provided in RCW 74.09.870.

(11) Consideration must be given to using multiple-biennia contracting periods.

(12) Each behavioral health administrative services organization operating pursuant to a contract issued under this section shall serve clients within its regional service area who meet the authority's eligibility criteria for mental health and substance use disorder

services within available resources. [2023 c 292 § 2; 2019 c 325 § 4006; 2018 c 201 § 2007; 2014 c 225 § 3. Formerly RCW 43.20A.894.]

Findings—Intent—2023 c 292: "(1) The legislature finds that:

(a) Medicaid enrollees in Washington are challenged with accessing needed behavioral health care. According to the Washington state department of social and health services, as of 2021, among medicaid enrollees with an identified mental health need, only 50 percent of adults and 66 percent of youth received treatment, while among medicaid enrollees with an identified substance use disorder need, only 37 percent of adults and 23 percent of youth received treatment. Furthermore, the national council for mental wellbeing's 2022 access to care survey found that 43 percent of adults in the United States who say they need mental health or substance use care did not receive that care, and they face numerous barriers to receiving needed treatment. Lack of necessary care can cause behavioral health conditions to deteriorate and crises to escalate, driving increasing use of intensive services such as inpatient care and involuntary treatment. As a result, the behavioral health system is reaching a crisis point in communities across the state.

(b) As of December 2022, 1,953,153 Washington residents rely on apple health managed care organizations to provide for their physical and behavioral health needs. During the integration of physical and behavioral health care pursuant to chapter 225, Laws of 2014, the health care authority most recently procured managed care services in 2018 and selected five managed care organizations to serve as Washington's apple health plans to provide for the physical and behavioral health care needs of medicaid enrollees. The health care authority has begun considering when to conduct a new procurement for managed care organizations, including an allowance for possible new entrants that do not currently serve Washington's medicaid population.

(c) Medicaid managed care procurement presents a need and an opportunity for the state to reset expectations for managed care organizations related to behavioral health services to ensure that Washington residents are being served by qualified and experienced health plans that can deliver on the access to care and quality of care that residents need and deserve. (2) It is the intent of the legislature to seize this opportunity to address ongoing challenges Washington's medicaid enrollees face in accessing behavioral health care. The legislature intends to establish robust new standards defining the levels of medicaid-funded behavioral health service capacity and resources that are adequate to meet medicaid enrollees' treatment needs; to ensure that managed care organizations that serve Washington's medicaid enrollees have a track record of success in delivering a broad range of behavioral health care services to safety net populations; and to advance payment structures and provider network delivery models that improve equitable access, promote integration of care, and deliver on outcomes.

(3) The legislature finds that increased access to behavioral health services for American Indians and Alaska Natives, children in foster care, and the aged, blind, and disabled through the preservation and enhancement of the fee-for-service system is also critical to reducing health disparities among these vulnerable populations. The legislature also intends to increase access to timely and robust behavioral health services for American Indians and Alaska

Natives, children in foster care, and the aged, blind, and disabled, in the fee-for-service system they access." [2023 c 292 § 1.]

Effective date—2019 c 325: See note following RCW 71.24.011.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

RCW 74.09.875 Reproductive health care services—Prohibited discrimination. (1) In the provision of reproductive health care services through programs under this chapter, the authority, managed care plans, and providers that administer or deliver such services may not discriminate in the delivery of a service provided through a program of the authority based on the covered person's gender identity or expression.

(2) The authority and any managed care plans delivering or administering services purchased or contracted for by the authority, may not issue automatic initial denials of coverage for reproductive health care services that are ordinarily or exclusively available to individuals of one gender, based on the fact that the individual's gender assigned at birth, gender identity, or gender otherwise recorded in one or more government-issued documents, is different from the one to which such health services are ordinarily or exclusively available.

(3) Denials as described in subsection (2) of this section are prohibited discrimination under chapter 49.60 RCW.

(4) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Gender expression" means a person's gender-related appearance and behavior, whether or not stereotypically associated with the person's gender assigned at birth.

(b) "Gender identity" means a person's internal sense of the person's own gender, regardless of the person's gender assigned at birth.

(c) "Reproductive health care services" means any medical services or treatments, including pharmaceutical and preventive care service or treatments, directly involved in the reproductive system and its processes, functions, and organs involved in reproduction, in all stages of life. Reproductive health care services does not include infertility treatment.

(d) "Reproductive system" includes, but is not limited to: Genitals, gonads, the uterus, ovaries, fallopian tubes, and breasts.

(5) This section must not be construed to authorize discrimination on the basis of a covered person's gender identity or expression in the administration of any other medical assistance programs administered by the authority. [2019 c 399 § 2.]

Effective dates—2019 c 399 §§ 2 and 3: "(1) Section 2 of this act takes effect January 1, 2020.

(2) Section 3 of this act takes effect January 1, 2021." [2019 c 399 § 9.]

Findings—2019 c 399: "The legislature finds and declares:

(1) It is the public policy of this state to provide the maximum access to reproductive health care and reproductive health care coverage for all people in Washington state.

(2) In 2018, the legislature passed Substitute Senate Bill No. 6219. Along with reproductive health care coverage requirements, the bill mandated a literature review of barriers to reproductive health care. As documented by the report submitted to the legislature on January 1, 2019, young people, immigrants, people living in rural communities, transgender and gender nonconforming people, and people of color still face significant barriers to getting the reproductive health care they need.

(3) Washingtonians who are transgender and gender nonconforming have important reproductive health care needs as well. These needs go unmet when, in the process of seeking care, transgender and gender nonconforming people are stigmatized or are denied critical health services because of their gender identity or expression.

(4) The literature review mandated by Substitute Senate Bill No. 6219 found that, "[a]ccording to 2015 U.S. Transgender Survey data, thirty-two percent of transgender respondents in Washington State reported that in the previous year they did not see a doctor when needed because they could not afford it."

(5) Existing state law should be enhanced to ensure greater coverage of and timely access to reproductive health care for the benefit of all Washingtonians, regardless of gender identity or expression.

(6) Because stigma is also a key barrier to access to reproductive health care, all Washingtonians, regardless of gender identity, should be free from discrimination in the provision of health care services, health care plan coverage, and in access to publicly funded health coverage.

(7) All people should have access to robust reproductive health services to maintain and improve their reproductive health." [2019 c 399 § 1.]

Short title—2019 c 399: "This act may be known and cited as the reproductive health care access for all act." [2019 c 399 § 8.]

Recommendations—Preexposure and postexposure prophylaxis financial support awareness—2019 c 399: See note following RCW 48.43.072.

RCW 74.09.877 Statewide plan to implement coordinated specialty care programs providing early identification and intervention for psychosis. *(Expires June 30, 2024.)* (1) Subject to the availability of amounts appropriated for this specific purpose, the authority shall collaborate with the University of Washington and a professional association of licensed community behavioral health agencies to develop a statewide plan to implement evidence-based coordinated specialty care programs that provide early identification and intervention for psychosis in licensed and certified community behavioral health agencies. The authority must submit the statewide plan to the governor and the legislature by March 1, 2020. The statewide plan must include:

(a) Analysis of existing benefit packages, payment rates, and resource gaps, including needs for nonmedicaid resources;

(b) Development of a discrete benefit package and case rate for coordinated specialty care;

(c) Identification of costs for statewide start-up, training, and community outreach;

(d) Determination of the number of coordinated specialty care teams needed in each regional service area; and

(e) A timeline for statewide implementation.

(2) The authority shall ensure that:

(a) At least one coordinated specialty care team is starting up or in operation in each regional service area by October 1, 2020; and

(b) Each regional service area has an adequate number of coordinated specialty care teams based on incidence and population across the state by December 31, 2023.

(3) This section expires June 30, 2024. [2019 c 360 § 6.]

Findings—Intent—2019 c 360: See note following RCW 74.09.4951.

RCW 74.09.880 Z code collection—Incentives and funding. To improve health outcomes and address health inequities, the authority shall evaluate incentive approaches and recommend funding options to increase the collection of Z codes on individual medicaid claims, in accordance with standard billing guidance and regulations. [2022 c 215 § 5.]

Finding—Intent—2022 c 215: See note following RCW 70.320.020.

RCW 74.09.885 Apple health and homes program—Definitions. The definitions in this section apply throughout RCW 74.09.886 and 74.09.888 unless the context clearly requires otherwise.

(1) "Community support services" means active search and promotion of access to, and choice of, appropriate, safe, and affordable housing and ongoing supports to assure ongoing successful tenancy. The term includes, but is not limited to, services to medical assistance clients who are homeless or at risk of becoming homeless through outreach, engagement, and coordination of services with shelter and housing. The term includes benefits offered through the foundational community supports program established pursuant to the authority's federal waiver, entitled "medicaid transformation project," as amended and reauthorized.

(2) "Community support services provider" means a local entity that contracts with a coordinating entity to provide community support services. A community support services provider may also separately perform the functions of a housing provider.

(3) "Coordinating entity" means one or more organizations, including medicaid managed care organizations, under contract with the authority to coordinate community support services as required under RCW 74.09.886 and 74.09.888. There may only be one coordinating entity per regional service area.

(4) "Department" means the department of commerce.

(5) "Homeless person" has the same meaning as in RCW 43.185C.010.

(6) "Housing provider" means a public or private organization that supplies permanent supportive housing units consistent with RCW 36.70A.030 to meet the housing needs of homeless persons. A housing provider may supply permanent supportive housing in a site-based or

scattered site arrangement using a variety of public, private, philanthropic, or tenant-based sources of funds to cover operating costs or rent. A housing provider may also perform the functions of a community support services provider.

(7) "Office" means the office of apple health and homes created in RCW 43.330.181.

(8) "Program" means the apple health and homes program established in RCW 74.09.886.

(9) "Permanent supportive housing" has the same meaning as in RCW 36.70A.030. [2022 c 216 § 2.]

Findings—Intent—2022 c 216: "(1) The legislature finds that:

(a) The epidemic of homelessness apparent in communities throughout Washington is creating immense suffering. It is threatening the health of homeless families and individuals, sapping their human potential, eroding public confidence, and undermining the shared values that have driven our state's prosperity, including public safety and access to public streets, parks, and facilities;

(b) In seeking to identify the causes of this epidemic, a large proportion of those unsheltered also suffer from serious behavioral health or physical health conditions that will inevitably grow worse without timely and effective health care;

(c) Housing is an indispensable element of effective health care. Stable housing is a prerequisite to addressing behavioral health needs and lack of housing is a precursor to poor health outcomes;

(d) A home, health care, and wellness are fundamental for Washington residents;

(e) Reducing homelessness is a priority of the people of Washington state and that reducing homelessness through policy alignment and reform lessens fiscal impact to the state and improves the economic vitality of our businesses;

(f) The impact of this epidemic is falling most heavily on those communities that already suffer the most serious health disparities: Black, indigenous, people of color, and historically marginalized and underserved communities. It is a moral imperative to shelter chronically homeless populations; and

(g) Washington state has many of the tools needed to address this challenge, including a network of safety net health and behavioral health care providers in both urban and rural areas, an effective system of health care coverage through apple health, and excellent public and nonprofit affordable housing providers. Yet far too many homeless families and individuals are going without the housing and health care resources they need because these tools have yet to be combined in an effective way across the state.

(2) It is the intent of the legislature to treat chronic homelessness as a medical condition and that the apple health and homes act address the needs of chronically homeless populations by pairing a health care problem with a health care solution." [2022 c 216 § 1.]

Short title—2022 c 216: "This act may be known and cited as the apple health and homes act." [2022 c 216 § 10.]

RCW 74.09.886 Apple health and homes program—Establishment—Eligibility—Services. (1) Subject to the availability of amounts

appropriated for this specific purpose, the apple health and homes program is established to provide a permanent supportive housing benefit and a community support services benefit through a network of community support services providers for persons assessed with specific health needs and risk factors.

(a) The program shall operate through the collaboration of the department, the authority, the department of social and health services, local governments, the coordinating entity or entities, community support services providers, local housing providers, local health care entities, and community-based organizations in contact with potentially eligible individuals, to assure seamless integration of community support services, stable housing, and health care services.

(b) The entities operating the program shall coordinate resources, technical assistance, and capacity building efforts to help match eligible individuals with community support services, health care, including behavioral health care and long-term care services, and stable housing.

(2) To be eligible for community support services and permanent supportive housing under subsection (3) of this section, a person must:

(a) Be 18 years of age or older;

(b)(i) Be enrolled in a medical assistance program under this chapter and eligible for community support services;

(ii)(A) Have a countable income that is at or below 133 percent of the federal poverty level, adjusted for family size, and determined annually by the federal department of health and human services; and

(B) Not be eligible for categorically needy medical assistance, as defined in the social security Title XIX state plan; or

(iii) Be assessed as likely eligible for, but not yet enrolled in, a medical assistance program under this chapter due to the severity of behavioral health symptom acuity level which creates barriers to accessing and receiving conventional services;

(c) Have been assessed:

(i) By a licensed behavioral health agency to have a behavioral health need which is defined as meeting one or both of the following criteria:

(A) Having mental health needs, including a need for improvement, stabilization, or prevention of deterioration of functioning resulting from the presence of a mental illness; or

(B) Having substance use disorder needs indicating the need for outpatient substance use disorder treatment which may be determined by an assessment using the American society of addiction medicine criteria or a similar assessment tool approved by the authority;

(ii) By the department of social and health services as needing either assistance with at least three activities of daily living or hands-on assistance with at least one activity of daily living and have the preliminary determination confirmed by the department of social and health services through an in-person assessment conducted by the department of social and health services; or

(iii) To be a homeless person with a long-continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning, including the ability to live independently without support; and

(d) Have at least one of the following risk factors:

(i)(A) Be a homeless person at the time of the eligibility determination for the program and have been homeless for 12 months prior to the eligibility determination; or

(B) Have been a homeless person on at least four separate occasions in the three years prior to the eligibility determination for the program, as long as the combined occasions equal at least 12 months;

(ii) Have a history of frequent or lengthy institutional contact, including contact at institutional care facilities such as jails, substance use disorder or mental health treatment facilities, hospitals, or skilled nursing facilities; or

(iii) Have a history of frequent stays at adult residential care facilities or residential treatment facilities.

(3) Once a coordinating entity verifies that a person has met the eligibility criteria established in subsection (2) of this section, it must connect the eligible person with a community support services provider. The community support services provider must:

(a) Deliver pretenancy support services to determine the person's specific housing needs and assist the person in identifying permanent supportive housing options that are appropriate and safe for the person;

(b) Fully incorporate the eligible person's available community support services into the case management services provided by the community support services provider; and

(c) Deliver ongoing tenancy-sustaining services to support the person in maintaining successful tenancy.

(4) Housing options offered to eligible participants may vary, subject to the availability of housing and funding.

(5) The community support services benefit must be sustained or renewed in accordance with the eligibility standards in subsection (2) of this section, except that the standards related to homelessness shall be replaced with an assessment of the person's likelihood to become homeless in the event that the community support services benefit is terminated. The coordinating entity must adopt procedures to conduct community support services benefit renewals, according to authority standards. [2022 c 216 § 3.]

Findings—Intent—Short title—2022 c 216: See notes following RCW 74.09.885.

RCW 74.09.888 Apple health and homes program—Authority duties—Funding—Reports to legislature. (1) To establish and administer RCW 74.09.886, the authority shall:

(a)(i) Establish or amend a contract with a coordinating entity to:

(A) Assure the availability of access to eligibility determinations services for community support services benefits and permanent supportive housing benefits;

(B) Verify that persons meet the eligibility standards of RCW 74.09.886(2);

(C) Coordinate enrollment in medical assistance programs for persons who meet the eligibility standards of RCW 74.09.886(2), except for actual enrollment in a medical assistance program under this chapter; and

(D) Coordinate with a network of community support services providers to arrange with local housing providers for the placement of an eligible person in permanent supportive housing appropriate to the person's needs and assure that community support services are provided to the person by a community support services provider.

(ii) The primary role of the coordinating entity or entities is administrative and operational, while the authority shall establish the general policy parameters for the work of the coordinating entity or entities.

(iii) In selecting the coordinating entity or entities, the authority shall: Choose one or more organizations that are capable of coordinating access to both community support services and permanent supportive housing services to eligible persons under RCW 74.09.886; and select no more than one coordinating entity per region which is served by medicaid managed care organizations;

(b) Report to the office for the ongoing monitoring of the program; and

(c) Adopt any rules necessary to implement the program.

(2) The authority shall establish a work group to provide feedback to the agency on its foundational community supports program as it aligns with the work of the housing benefit. The work group may include representatives of state agencies, behavioral health administrative services organizations, the coordinating entity or entities, and contracted agencies providing foundational community supports services. Topics may include, but are not limited to, best practices in eligibility screening processes and case rate billing for foundational community supports housing, regional cost differentials, costs consistent with specialized needs, improved data access and data sharing with foundational community supports providers, and requirements related to the use of a common practice tool among community support services providers to integrate social determinants of health into service delivery. The authority, in consultation with foundational community supports providers and their stakeholders, shall engage each region on case management tools and programs, evaluate effectiveness, and inform the appropriate committees of the legislature on the use of case management tools. Case management shall also be a regular item of engagement in the work group. The authority shall convene the work group at least once each quarter and may expand upon, but not duplicate, existing work groups or advisory councils at the authority or other state agencies.

(3) To support the goals of the program and the goals of other statewide initiatives to identify and address social needs, including efforts within the 1115 waiver renewal to advance health equity and health-related supports, the authority shall work with the office and the department of social and health services to research, identify, and implement statewide universal measures to identify and consider social determinants of health domains, including housing, food security, transportation, financial strain, and interpersonal safety. The authority shall select an accredited or nationally vetted tool, including criteria for prioritization, for the community support services provider to use when making determinations about housing options and other support services to offer individuals eligible for the program. This screening and prioritization process may not exclude clients transitioning from inpatient or other behavioral health residential treatment settings. The authority shall inform the governor and the appropriate committees of the legislature on progress to this end.

(4)(a) The authority and the department may seek and accept funds from private and federal sources to support the purposes of the program.

(b) The authority shall seek approval from the federal department of health and human services to:

(i) Receive federal matching funds for administrative costs and services provided under the program to persons enrolled in medicaid;

(ii) Align the eligibility and benefit standards of the foundational community supports program established pursuant to the waiver, entitled "medicaid transformation project" and initially approved November 2017, between the authority and the federal centers for medicare and medicaid services, as amended and reauthorized, with the standards of the program, including extending the duration of the benefits under the foundational community supports program to not less than 12 months; and

(iii) Implement a medical and psychiatric respite care benefit for certain persons enrolled in medicaid.

(5)(a) By December 1, 2022, the authority and the office shall report to the governor and the legislature on preparedness for the first year of program implementation, including the estimated enrollment, estimated program costs, estimated supportive housing unit availability, funding availability for the program from all sources, efforts to improve billing and administrative burdens for foundational community supports providers, efforts to streamline continuity of care and system connection for persons who are potentially eligible for foundational community supports, and any statutory or budgetary needs to successfully implement the first year of the program.

(b) By December 1, 2023, the authority and the office shall report to the governor and the legislature on the progress of the first year of program implementation and preparedness for the second year of program implementation.

(c) By December 1, 2024, the authority and the office shall report to the governor and the legislature on the progress of the first two years of program implementation and preparedness for ongoing housing acquisition and development.

(d) By December 1, 2026, the authority and the office shall report to the governor and the legislature on the full implementation of the program, including the number of persons served by the program, available permanent supportive housing units, estimated unmet demand for the program, ongoing funding requirements for the program, and funding availability for the program from all sources. Beginning December 1, 2027, the authority and the office shall provide annual updates to the governor and the legislature on the status of the program. [2022 c 216 § 4.]

Findings—Intent—Short title—2022 c 216: See notes following RCW 74.09.885.

RCW 74.09.890 Medicaid program integrity—Administrative oversight—Strategic plan—Best practices. (1) The authority shall provide administrative oversight for all funds received under the medical assistance program, as codified in Title XIX of the federal social security act, the state children's health insurance program, as codified in Title XXI of the federal social security act, and any other federal medicaid funding to ensure that:

(a) All funds are spent according to federal and state laws and regulations;

(b) Delivery of services aligns with federal statutes and regulations;

(c) Corrective action plans are put in place if expenditures or services do not align with federal requirements; and

(d) Sound fiscal stewardship of medicaid funding in all agencies where medicaid funding is provided.

(2) The authority shall develop a strategic plan and performance measures for medicaid program integrity. The strategic plan must include stated strategic goals, agreed-upon objectives, performance measures, and a system to monitor progress and hold responsible parties accountable. In developing the strategic plan, the authority shall create a management information and reporting strategy with performance measures and management reports.

(3) The authority shall oversee the medicaid program resources of any state agency expending medicaid funding, including but not limited to:

(a) Regularly reviewing delegated work;

(b) Jointly reviewing required reports on terminated or sanctioned providers, compliance data, and application data;

(c) Requiring assurances that operational functions have been implemented;

(d) Reviewing audits performed on the sister state agency; and

(e) Assisting with risk assessments, setting goals, and developing policies and procedures.

(4) The authority shall develop and maintain a single, statewide medicaid fraud and abuse prevention plan consistent with the national medicaid fraud and abuse initiative or current federal best practice as recognized by the centers for medicare and medicaid services.

(5) The authority must follow best practices for identifying improper medicaid spending when implementing its program integrity activities, including but not limited to:

(a) Conducting risk assessments or evaluating leads with established risk factors;

(b) Relying on data analytics to generate leads;

(c) Conducting a preliminary review of incoming leads, which includes analyzing data about the lead and may include reviewing records such as billing histories;

(d) Determining the credibility of all allegations of potential fraud prior to referral to the state's medicaid fraud control unit;

(e) Analyzing all leads under review by the state's managed care organizations;

(f) Working with federally recognized experts that help state integrity programs improve their data analytics and identify potential fraud across medicare and medicaid such as unified program integrity contractors; and

(g) Maintaining a current fraud and abuse detection system. [2023 c 439 § 3.]

Intent—Finding—2023 c 439: See note following RCW 74.04.050.

RCW 74.09.892 Medicaid program integrity—Managed care organizations—Contracts—Best practices. (1) Beginning January 1, 2024, the authority's contracts with managed care organizations must

clearly detail each party's requirements for maintaining program integrity and the consequences the managed care organizations face if they do not meet the requirements. The contract must ensure the penalties are adequate to ensure compliance.

(2) The authority shall follow leading program integrity practices as recommended by the centers for medicare and medicaid services, including but not limited to:

(a) Monthly reporting and quarterly meetings with managed care organizations to discuss program integrity issues and findings as well as trends in fraud and other improper payments;

(b) Financial penalties for failure to fulfill program integrity requirements, including liquidated damages and sanctions;

(c) Directly auditing providers and:

(i) Recovering overpayments from the providers; or

(ii) Assessing liquidated damages against the managed care organizations;

(d) Ensuring recoveries and liquidated damages resulting from overpayments are properly accounted for and applied to managed care encounters to ensure accurate future rate setting; and

(e) Ensuring all contracts with managed care organizations are updated as appropriate to reflect program integrity requirements. [2023 c 439 § 4.]

Intent—Finding—2023 c 439: See note following RCW 74.04.050.

RCW 74.09.900 Other laws applicable. All the provisions of Title 74 RCW, not otherwise inconsistent herewith, shall apply to the provisions of this chapter. [1959 c 26 § 74.09.900. Prior: 1955 c 273 § 22.]

RCW 74.09.920 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521. For the purposes of this chapter, the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin, and family shall be interpreted as applying equally to state registered domestic partnerships or individuals in state registered domestic partnerships as well as to marital relationships and married persons, and references to dissolution of marriage shall apply equally to state registered domestic partnerships that have been terminated, dissolved, or invalidated, to the extent that such interpretation does not conflict with federal law. Where necessary to implement chapter 521, Laws of 2009, gender-specific terms such as husband and wife used in any statute, rule, or other law shall be construed to be gender neutral, and applicable to individuals in state registered domestic partnerships. [2009 c 521 § 175.]

Effective dates—2009 c 521 §§ 5-8, 79, 87-103, 107, 151, 165, 166, 173-175, and 190-192: See note following RCW 2.10.900.