

SSB 5394 - H COMM AMD

By Committee on Ways & Means

ADOPTED AS AMENDED 04/07/2011

1 Strike everything after the enacting clause and insert the
2 following:

3 "NEW SECTION. **Sec. 1.** A new section is added to chapter 74.09 RCW
4 to read as follows:

5 The legislature finds that:

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

12 (2) The primary care health home model has been demonstrated to
13 successfully constrain costs, while improving quality of care. Chronic
14 care management, occurring within a primary care health home, has been
15 shown to be especially effective at reducing costs and improving
16 quality. However, broad adoption of these models has been impeded by
17 a fee-for-service system that reimburses volume of services and does
18 not adequately support important primary care health home services,
19 such as case management and patient outreach. Furthermore, successful
20 implementation will require a broad adoption effort by private and
21 public payers, in coordination with providers.

22 Therefore the legislature intends to promote the adoption of
23 primary care health homes for children and adults and, within them,
24 advance the practice of chronic care management to improve health
25 outcomes and reduce unnecessary costs. To facilitate the best
26 coordination and patient care, primary care health homes are encouraged
27 to collaborate with other providers currently outside the medical
28 insurance model. Successful chronic care management for persons
29 receiving long-term care services in addition to medical care will
30 require close coordination between primary care providers, long-term

1 care workers, and other long-term care service providers, including
2 area agencies on aging. Primary care providers also should consider
3 oral health coordination through collaboration with dental providers
4 and, when possible, delivery of oral health prevention services. The
5 legislature also intends that the methods and approach of the primary
6 care health home become part of basic primary care medical education.

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

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

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

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

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

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

26 (b) Employs evidence-based clinical practices;

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

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

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

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

35 (a) A mental health condition;

36 (b) A substance use disorder;

37 (c) Asthma;

1 (d) Diabetes;

2 (e) Heart disease; and

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

5 (4) "County" means the board of county commissioners, county
6 council, county executive, or tribal jurisdiction, or its designee. A
7 combination of two or more county authorities or tribal jurisdictions
8 may enter into joint agreements ((to fulfill the requirements of RCW
9 74.09.415 through 74.09.435)).

10 ~~((+4))~~ (5) "Department" means the department of social and health
11 services.

12 ~~((+5))~~ (6) "Department of health" means the Washington state
13 department of health created pursuant to RCW 43.70.020.

14 ~~((+6))~~ (7) "Full benefit dual eligible beneficiary" means an
15 individual who, for any month: Has coverage for the month under a
16 medicare prescription drug plan or medicare advantage plan with part D
17 coverage; and is determined eligible by the state for full medicaid
18 benefits for the month under any eligibility category in the state's
19 medicaid plan or a section 1115 demonstration waiver that provides
20 pharmacy benefits.

21 ~~((+7))~~ (8) "Health home" or "primary care health home" means
22 coordinated health care provided by a licensed primary care provider
23 coordinating all medical care services, and a multidisciplinary health
24 care team comprised of clinical and nonclinical staff. The term
25 "coordinating all medical care services" shall not be construed to
26 require prior authorization by a primary care provider in order for a
27 patient to receive treatment for covered services by an optometrist
28 licensed under chapter 18.53 RCW. Primary care health home services
29 shall include those services defined as health home services in 42
30 U.S.C. Sec. 1396w-4 and, in addition, may include, but are not limited
31 to:

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

34 (b) Extended hours of service;

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

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

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

3 (f) Individual and family support including authorized
4 representatives;

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

7 (h) Ongoing performance reporting and quality improvement.

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

11 ~~((+8))~~ (10) "Limited casualty program" means the medical care
12 program provided to medically needy persons as defined under Title XIX
13 of the federal social security act, and to medically indigent persons
14 who are without income or resources sufficient to secure necessary
15 medical services.

16 ~~((+9))~~ (11) "Medical assistance" means the federal aid medical
17 care program provided to categorically needy persons as defined under
18 Title XIX of the federal social security act.

19 ~~((+10))~~ (12) "Medical care services" means the limited scope of
20 care financed by state funds and provided to disability lifeline
21 benefits recipients, and recipients of alcohol and drug addiction
22 services provided under chapter 74.50 RCW.

23 ~~((+11))~~ (13) "Multidisciplinary health care team" means an
24 interdisciplinary team of health professionals which may include, but
25 is not limited to, medical specialists, nurses, pharmacists,
26 nutritionists, dieticians, social workers, behavioral and mental health
27 providers including substance use disorder prevention and treatment
28 providers, doctors of chiropractic, physical therapists, licensed
29 complementary and alternative medicine practitioners, home care and
30 other long-term care providers, and physicians' assistants.

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

32 ~~((+12))~~ (15) "Poverty" means the federal poverty level determined
33 annually by the United States department of health and human services,
34 or successor agency.

35 ~~((+13))~~ (16) "Primary care provider" means a general practice
36 physician, family practitioner, internist, pediatrician, osteopath,
37 naturopath, physician assistant, osteopathic physician assistant, and
38 advanced registered nurse practitioner licensed under Title 18 RCW.

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

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

4 (1) The department shall conduct a program of training and
5 technical assistance regarding care of people with chronic conditions
6 for providers of primary care. The program shall emphasize evidence-
7 based high quality preventive and chronic disease care and shall
8 collaborate with the health care authority to promote the adoption of
9 primary care health homes established under this act. The department
10 may designate one or more chronic conditions to be the subject of the
11 program.

12 (2) The training and technical assistance program shall include the
13 following elements:

14 (a) Clinical information systems and sharing and organization of
15 patient data;

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

17 (c) Clinical delivery system design;

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

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

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

26 (4) For the purposes of this section, "health home" and "primary
27 care provider" have the same meaning as in RCW 74.09.010.

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

30 (1) For the purposes of this section, "managed health care system"
31 means any health care organization, including health care providers,
32 insurers, health care service contractors, health maintenance
33 organizations, health insuring organizations, or any combination
34 thereof, that provides directly or by contract health care services
35 covered under RCW 74.09.520 and rendered by licensed providers, on a
36 prepaid capitated basis and that meets the requirements of section

1 1903(m)(1)(A) of Title XIX of the federal social security act or
2 federal demonstration waivers granted under section 1115(a) of Title XI
3 of the federal social security act.

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

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

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

12 (c) To the extent that this provision is consistent with section
13 1903(m) of Title XIX of the federal social security act or federal
14 demonstration waivers granted under section 1115(a) of Title XI of the
15 federal social security act, recipients shall have a choice of systems
16 in which to enroll and shall have the right to terminate their
17 enrollment in a system: PROVIDED, That the department may limit
18 recipient termination of enrollment without cause to the first month of
19 a period of enrollment, which period shall not exceed twelve months:
20 AND PROVIDED FURTHER, That the department shall not restrict a
21 recipient's right to terminate enrollment in a system for good cause as
22 established by the department by rule;

23 (d) To the extent that this provision is consistent with section
24 1903(m) of Title XIX of the federal social security act, participating
25 managed health care systems shall not enroll a disproportionate number
26 of medical assistance recipients within the total numbers of persons
27 served by the managed health care systems, except as authorized by the
28 department under federal demonstration waivers granted under section
29 1115(a) of Title XI of the federal social security act;

30 (e)(i) In negotiating with managed health care systems the
31 department shall adopt a uniform procedure to (~~negotiate and~~) enter
32 into contractual arrangements, to be included in contracts issued or
33 renewed on or after January 1, 2012, including:

34 (A) Standards regarding the quality of services to be provided;
35 (~~and~~)

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

37 (C) Provider reimbursement methods that incentivize chronic care
38 management within health homes;

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

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

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

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

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

18 (g) The department shall, wherever possible, enter into prepaid
19 capitation contracts that include inpatient care. However, if this is
20 not possible or feasible, the department may enter into prepaid
21 capitation contracts that do not include inpatient care;

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

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

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

31 (3) The department shall ensure that publicly supported community
32 health centers and providers in rural areas, who show serious intent
33 and apparent capability to participate as managed health care systems
34 are seriously considered as contractors. The department shall
35 coordinate its managed care activities with activities under chapter
36 70.47 RCW.

37 (4) The department shall work jointly with the state of Oregon and
38 other states in this geographical region in order to develop

1 recommendations to be presented to the appropriate federal agencies and
2 the United States congress for improving health care of the poor, while
3 controlling related costs.

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

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

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

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

25 (ii) Quality of services provided to enrollees;

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

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

30 (v) Payment rates; and

31 (vi) The ability to meet other specifically defined contract
32 requirements established by the department, including consideration of
33 past and current performance and participation in other state or
34 federal health programs as a contractor.

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

37 (d) Quality, accessibility, and demonstrated commitment to serving

1 low-income populations shall be given significant weight in the
2 contracting, evaluation, and assignment process.

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

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

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

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

25 (1) A managed health care system participating in the plan shall do
26 so by contract with the administrator and shall provide, directly or by
27 contract with other health care providers, covered basic health care
28 services to each enrollee covered by its contract with the
29 administrator as long as payments from the administrator on behalf of
30 the enrollee are current. A participating managed health care system
31 may offer, without additional cost, health care benefits or services
32 not included in the schedule of covered services under the plan. A
33 participating managed health care system shall not give preference in
34 enrollment to enrollees who accept such additional health care benefits
35 or services. Managed health care systems participating in the plan
36 shall not discriminate against any potential or current enrollee based
37 upon health status, sex, race, ethnicity, or religion. The

1 administrator may receive and act upon complaints from enrollees
2 regarding failure to provide covered services or efforts to obtain
3 payment, other than authorized copayments, for covered services
4 directly from enrollees, but nothing in this chapter empowers the
5 administrator to impose any sanctions under Title 18 RCW or any other
6 professional or facility licensing statute.

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

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

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

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

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

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

36 (d) The administrator may adopt a policy that gives preference to
37 respondents, such as nonprofit community health clinics, that have a

1 history of providing quality health care services to low-income
2 persons.

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

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

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

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

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

22 (c) For the purposes of this subsection, "chronic care management,"
23 "chronic condition," and "health home" have the same meaning as in RCW
24 74.09.010.

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

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

34 (7) The administrator may implement a self-funded or self-insured
35 method of providing insurance coverage to subsidized enrollees, as
36 provided under RCW 41.05.140. Prior to implementing a self-funded or
37 self-insured method, the administrator shall ensure that funding
38 available in the basic health plan self-insurance reserve account is

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

7 Correct the title.

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