
SECOND SUBSTITUTE SENATE BILL 5213

State of Washington

63rd Legislature

2013 Regular Session

By Senate Ways & Means (originally sponsored by Senators Becker, Tom, Bailey, Honeyford, and Frockt)

READ FIRST TIME 03/01/13.

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

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

4 **Sec. 1.** RCW 74.09.522 and 2011 1st sp.s. c 15 s 29, 2011 1st sp.s.
5 c 9 s 2, and 2011 c 316 s 4 are each reenacted and amended to read as
6 follows:

7 (1) For the purposes of this section:

8 (a) "Comprehensive medication management services" means the
9 provision of the following services utilizing the professional practice
10 of pharmaceutical care by a pharmacist or primary care provider
11 licensed in Washington state for patients taking five or more
12 medications for two or more chronic medical conditions:

13 (i) Assessment of the patient's health status including the
14 personal medication experience and use patterns of all prescribed and
15 over-the-counter medications;

16 (ii) Documentation of the patient's current clinical status and
17 clinical goals of therapy;

18 (iii) Assessment of each medication for appropriateness,

1 effectiveness, safety, and adherence focusing on achievement of desired
2 clinical goals;

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

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

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

10 (b) "Managed health care system" means any health care
11 organization, including health care providers, insurers, health care
12 service contractors, health maintenance organizations, health insuring
13 organizations, or any combination thereof, that provides directly or by
14 contract health care services covered under this chapter and rendered
15 by licensed providers, on a prepaid capitated basis and that meets the
16 requirements of section 1903(m)(1)(A) of Title XIX of the federal
17 social security act or federal demonstration waivers granted under
18 section 1115(a) of Title XI of the federal social security act;

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

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

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

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

32 (c) To the extent that this provision is consistent with section
33 1903(m) of Title XIX of the federal social security act or federal
34 demonstration waivers granted under section 1115(a) of Title XI of the
35 federal social security act, recipients shall have a choice of systems
36 in which to enroll and shall have the right to terminate their
37 enrollment in a system: PROVIDED, That the authority may limit
38 recipient termination of enrollment without cause to the first month of

1 a period of enrollment, which period shall not exceed twelve months:
2 AND PROVIDED FURTHER, That the authority shall not restrict a
3 recipient's right to terminate enrollment in a system for good cause as
4 established by the authority by rule;

5 (d) To the extent that this provision is consistent with section
6 1903(m) of Title XIX of the federal social security act, participating
7 managed health care systems shall not enroll a disproportionate number
8 of medical assistance recipients within the total numbers of persons
9 served by the managed health care systems, except as authorized by the
10 authority under federal demonstration waivers granted under section
11 1115(a) of Title XI of the federal social security act;

12 (e)(i) In negotiating with managed health care systems the
13 authority shall adopt a uniform procedure to enter into contractual
14 arrangements, to be included in contracts issued or renewed on or after
15 January 1, ((2012)) 2014, including:

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

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

18 (C) Provider reimbursement methods that incentivize chronic care
19 management and comprehensive medication management services within
20 health homes;

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

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

30 (F) Provide reimbursement methods within the medical billing
31 processes that incentivize pharmacists and primary care providers
32 licensed in Washington state to provide comprehensive medication
33 management services.

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

37 (B) Contracts that include the items in (e)(i)(C) through (E) of

1 this subsection must not exceed the rates that would be paid in the
2 absence of these provisions;

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

5 (g) The authority shall, wherever possible, enter into prepaid
6 capitation contracts that include inpatient care. However, if this is
7 not possible or feasible, the authority may enter into prepaid
8 capitation contracts that do not include inpatient care;

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

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

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

18 (3) The authority shall ensure that publicly supported community
19 health centers and providers in rural areas, who show serious intent
20 and apparent capability to participate as managed health care systems
21 are seriously considered as contractors. The authority shall
22 coordinate its managed care activities with activities under chapter
23 70.47 RCW.

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

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

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

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

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

12 (ii) Quality of services provided to enrollees;

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

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

17 (v) Payment rates; and

18 (vi) The ability to meet other specifically defined contract
19 requirements established by the authority, including consideration of
20 past and current performance and participation in other state or
21 federal health programs as a contractor.

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

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

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

35 (f) Procedures for resolution of disputes between the authority and
36 contract bidders or the authority and contracting carriers related to
37 the award of, or failure to award, a managed care contract must be
38 clearly set out in the procurement document.

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

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

10 (8) For services covered under this chapter to medical assistance
11 or medical care services enrollees and provided on or after August 24,
12 2011, nonparticipating providers must accept as payment in full the
13 amount paid by the managed health care system under subsection (7) of
14 this section in addition to any deductible, coinsurance, or copayment
15 that is due from the enrollee for the service provided. An enrollee is
16 not liable to any nonparticipating provider for covered services,
17 except for amounts due for any deductible, coinsurance, or copayment
18 under the terms and conditions set forth in the managed health care
19 system contract to provide services under this section.

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

33 (10) Subsections (7) through (9) of this section expire July 1,
34 2016.

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