
SENATE BILL 5540

State of Washington

68th Legislature

2023 Regular Session

By Senators Cleveland and Rivers

1 AN ACT Relating to legislative authorization of medicaid managed
2 health care system reprocurement; 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 2020 c 260 s 1 are each amended to
5 read as follows:

6 (1) For the purposes of this section:

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

17 (b) "Nonparticipating provider" means a person, health care
18 provider, practitioner, facility, or entity, acting within their
19 scope of practice, that does not have a written contract to
20 participate in a managed health care system's provider network, but
21 provides health care services to enrollees of programs authorized

1 under this chapter or other applicable law whose health care services
2 are provided by the managed health care system.

3 (2) The authority shall enter into agreements with managed health
4 care systems to provide health care services to recipients of
5 medicaid under the following conditions:

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

8 (b) Agreements in at least one county shall include enrollment of
9 all recipients of programs as allowed for in the approved state plan
10 amendment or federal waiver for Washington state's medicaid program;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30 (g) The authority shall, wherever possible, enter into prepaid
31 capitation contracts that include inpatient care. However, if this is
32 not possible or feasible, the authority may enter into prepaid
33 capitation contracts that do not include inpatient care;

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

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

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

4 (3) The authority shall ensure that publicly supported community
5 health centers and providers in rural areas, who show serious intent
6 and apparent capability to participate as managed health care systems
7 are seriously considered as contractors. The authority shall
8 coordinate its managed care activities with activities under chapter
9 70.47 RCW.

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

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

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

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

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

36 (ii) Quality of services provided to enrollees;

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

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

1 (v) Payment rates; and

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

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

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

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

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

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

28 (7) Any contract with a managed health care system to provide
29 services to medical assistance enrollees shall require that managed
30 health care systems offer contracts to mental health providers and
31 substance use disorder treatment providers to provide access to
32 primary care services integrated into behavioral health clinical
33 settings, for individuals with behavioral health and medical
34 comorbidities.

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

38 (9) A managed health care system shall pay a nonparticipating
39 provider that provides a service covered under this chapter or other
40 applicable law to the system's enrollee no more than the lowest

1 amount paid for that service under the managed health care system's
2 contracts with similar providers in the state if the managed health
3 care system has made good faith efforts to contract with the
4 nonparticipating provider.

5 (10) For services covered under this chapter or other applicable
6 law to medical assistance or medical care services enrollees,
7 nonparticipating providers must accept as payment in full the amount
8 paid by the managed health care system under subsection (9) of this
9 section in addition to any deductible, coinsurance, or copayment that
10 is due from the enrollee for the service provided. An enrollee is not
11 liable to any nonparticipating provider for covered services, except
12 for amounts due for any deductible, coinsurance, or copayment under
13 the terms and conditions set forth in the managed health care system
14 contract to provide services under this section.

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

28 (12) Payments under RCW 74.60.130 are exempt from this section.

29 (13)(a) The authority shall reprocure state contracts with
30 medicaid managed care organizations only when specific authorization
31 and funding for the reprocurement process is provided by the
32 legislature. Within one month prior to any legislative session where
33 it will be requesting such authorization and funding, the authority
34 shall submit to the legislature a detailed reprocurement plan
35 addressing at least the following:

36 (i) The specific objectives to be served by the reprocurement,
37 identifying program strengths to be maintained, problems to be
38 solved, and how the reprocurement will achieve this, and evaluating
39 any alternatives to the reprocurement which could serve these same
40 objectives;

1 (ii) The value of any changes to the design or structure of the
2 medicaid program that could be made through the reprocurement, such
3 as increasing or decreasing the number of managed care organizations
4 operating in the state or within substate regions or moving
5 additional medicaid services from fee-for-service to managed care;

6 (iii) Key contractual provisions to be maintained, deleted, or
7 added through the reprocurement process related to cost, quality, and
8 access to incent the long-term efficiency and effectiveness of the
9 medicaid program;

10 (iv) The anticipated impact of the reprocurement on:

11 (A) Medicaid enrollees, including enrollees' ability to be served
12 by a managed care organization and health care providers of their
13 choice, and to maintain continuous care if they cycle between
14 medicaid and subsidized coverage through the health benefit exchange;

15 (B) Participating health care providers, including potential rate
16 changes, payment and contractual disruptions, and any costs
17 associated with the reprocurement for which providers will not be
18 reimbursed;

19 (C) Implementation of the state's federal medicaid waivers,
20 particularly those in which managed care organizations play an
21 integral role;

22 (D) Health equity, including any disproportionate impact the
23 reprocurement could have on minority or marginalized communities
24 within the state; and

25 (E) Medicaid costs;

26 (v) The steps to be taken by the authority to mitigate any
27 adverse impacts identified in (a)(iv) of this subsection;

28 (vi) The additional staff and corresponding funding needed by the
29 authority and other agencies to successfully implement the plan,
30 including responding to any associated litigation;

31 (vii) Any changes needed to state statutes governing medicaid or
32 the procurement of medicaid managed care organizations to
33 successfully implement the plan; and

34 (viii) The proposed timeline for successfully implementing the
35 plan.

36 (b) In developing the plan, the authority shall solicit and
37 consider input from Indian tribes and stakeholders affected by or
38 with an interest in the medicaid program, including physical and
39 behavioral health care providers, medicaid enrollees, community-based
40 organizations, the Washington state office of equity, and other state

1 agencies. The authority shall also survey other states to help
2 determine the impact of and current best practices regarding medicaid
3 reprocurement.

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