CERTIFICATION OF ENROLLMENT

SUBSTITUTE SENATE BILL 5394

Chapter 316, Laws of 2011

62nd Legislature
2011 Regular Session

PRIMARY CARE HEALTH HOMES--CHRONIC CARE MANAGEMENT

EFFECTIVE DATE: 07/22/11

Passed by the Senate April 18, 2011
YEAS 48 NAYS 0

BRAD OWEN

President of the Senate

Passed by the House April 7, 2011
YEAS 53 NAYS 39

FRANK CHOPP

Speaker of the House of Representatives

Approved May 11, 2011, 2:01 p.m.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **SUBSTITUTE SENATE BILL 5394** as passed by the Senate and the House of Representatives on the dates hereon set forth.

THOMAS HOEMANN

Secretary

FILED

May 11, 2011

Secretary of State
State of Washington

SUBSTITUTE SENATE BILL 5394

AS AMENDED BY THE HOUSE

Passed Legislature - 2011 Regular Session

State of Washington 62nd Legislature 2011 Regular Session

By Senate Health & Long-Term Care (originally sponsored by Senators Keiser, Becker, Pflug, Conway, Kline, and Parlette)

READ FIRST TIME 02/15/11.

AN ACT Relating to primary care health homes and chronic care management; amending RCW 43.70.533 and 70.47.100; reenacting and amending RCW 74.09.010 and 74.09.522; adding a new section to chapter 74.09 RCW; and adding new sections to chapter 41.05 RCW.

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

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

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.

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

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

(1) "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.

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

~~(3)~~)) "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.

(3) "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.

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

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

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

((~~(6)~~)) (7) "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.

((~~(7)~~)) (8) "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.

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

((~~(8)~~)) (10) "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.

((~~(9)~~)) (11) "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.

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

((~~(11)~~)) (13) "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.

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

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

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

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

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

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

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

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

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

(c) Clinical delivery system design;

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

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

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

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

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

(1) For the purposes of this section, "managed health care system" means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, health insuring organizations, or any combination thereof, that provides directly or by contract health care services covered under RCW 74.09.520 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.

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

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

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

(c) To the extent that this provision is consistent with section 1903(m) of Title XIX of the federal social security act or federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act, recipients shall have a choice of systems in which to enroll and shall have the right to terminate their enrollment in a system: PROVIDED, That the department 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 department shall not restrict a

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

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

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

(B) The financial integrity of the responding system;

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

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

(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 system is an integrated health delivery system that has programs in place for chronic care management.

(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 (E) of this subsection must not exceed the rates that would be paid in the absence of these provisions;

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

(g) The department shall, wherever possible, enter into prepaid capitation contracts that include inpatient care. However, if this is

not possible or feasible, the department may enter into prepaid capitation contracts that do not include inpatient care;

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

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

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

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

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

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

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

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

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

(ii) Quality of services provided to enrollees;

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

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

(v) Payment rates; and

(vi) The ability to meet other specifically defined contract requirements established by the department, 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 department 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 department 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 department and contract bidders or the department 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. In designing such procedures, the department shall give strong consideration to the negotiation and dispute resolution processes used by the Washington state health care authority in its managed health care contracting activities.

(6) The department 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.

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

(1) A managed health care system participating in the plan shall do so by contract with the administrator and shall provide, directly or by contract with other health care providers, covered basic health care services to each enrollee covered by its contract with the administrator as long as payments from the administrator on behalf of the enrollee are current. A participating managed health care system may offer, without additional cost, health care benefits or services not included in the schedule of covered services under the plan. A participating managed health care system shall not give preference in enrollment to enrollees who accept such additional health care benefits or services. Managed health care systems participating in the plan shall not discriminate against any potential or current enrollee based upon health status, sex, race, ethnicity, or religion. The administrator may receive and act upon complaints from enrollees regarding failure to provide covered services or efforts to obtain payment, other than authorized copayments, for covered services directly from enrollees, but nothing in this chapter empowers the administrator to impose any sanctions under Title 18 RCW or any other professional or facility licensing statute.

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

(3) Prior to negotiating with any managed health care system, the administrator shall determine, on an actuarially sound basis, the reasonable cost of providing the schedule of basic health care

services, expressed in terms of upper and lower limits, and recognizing variations in the cost of providing the services through the various systems and in different areas of the state.

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

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

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

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

(d) The administrator may adopt a policy that gives preference to respondents, such as nonprofit community health clinics, that have a history of providing quality health care services to low-income persons.

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

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

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

(iii) 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 system is an integrated health delivery system that has programs in place for chronic care management.

(b) Health home services contracted for under this subsection may

be prioritized to enrollees with complex, high cost, or multiple chronic conditions.

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

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

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

(7) The administrator may implement a self-funded or self-insured method of providing insurance coverage to subsidized enrollees, as provided under RCW 41.05.140. Prior to implementing a self-funded or self-insured method, the administrator shall ensure that funding available in the basic health plan self-insurance reserve account is sufficient for the self-funded or self-insured risk assumed, or expected to be assumed, by the administrator. If implementing a self-funded or self-insured method, the administrator may request funds to be moved from the basic health plan trust account or the basic health plan subscription account to the basic health plan self-insurance reserve account established in RCW 41.05.140.

NEW SECTION. **Sec. 6.** A new section is added to chapter 41.05 RCW to read as follows:

(1) Effective January 1, 2013, the authority must contract with all of the public employees benefits board managed care plans and the self-insured plan or plans to include provider reimbursement methods that incentivize chronic care management within health homes resulting in reduced emergency department and inpatient use.

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

(3) For the purposes of this section, "chronic care management," and "health home" have the same meaning as in RCW 74.09.010.

(4) Contracts with fully insured plans and with any third-party administrator for the self-funded plan that include the items in subsection (1) of this section must be funded within the resources provided by employer funding rates provided for employee health benefits in the omnibus appropriations act.

(5) Nothing in this section shall require contracted third-party health plans administering the self-insured contract to expend resources to implement items in subsection (1) of this section beyond the resources provided by employer funding rates provided for employee health benefits in the omnibus appropriations act or from other sources in the absence of these provisions.

NEW SECTION. **Sec. 7.** A new section is added to chapter 41.05 RCW to read as follows:

The authority shall coordinate a discussion with carriers to learn from successful chronic care management models and develop principles for effective reimbursement methods to align incentives in support of patient centered chronic care health homes. The authority shall submit a report to the appropriate committees of the legislature by December 1, 2012, describing the principles developed from the discussion and any steps taken by the public employees benefits board or carriers in Washington state to implement the principles through their payment methodologies.

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