

2SSB 5213 - H COMM AMD

By Committee on Appropriations

ADOPTED AS AMENDED 04/16/2013

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 chronic care management, including
6 comprehensive medication management services, provided by licensed
7 pharmacists and qualified providers is a critical component of a
8 collaborative, multidisciplinary, inter-professional approach to the
9 treatment of chronic diseases for targeted individuals, to improve the
10 quality of care and reduce overall cost in the treatment of such
11 diseases.

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

15 (1) For the purposes of this section:

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

25 (b) "Nonparticipating provider" means a person, health care
26 provider, practitioner, facility, or entity, acting within their scope
27 of practice, that does not have a written contract to participate in a
28 managed health care system's provider network, but provides health care

1 services to enrollees of programs authorized under this chapter whose
2 health care services 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 temporary
5 assistance for needy families 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 temporary assistance for needy families;

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

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

28 (e)(i) In negotiating with managed health care systems the
29 authority shall adopt a uniform procedure to enter into contractual
30 arrangements, to be included in contracts issued or renewed on or after
31 January 1, (~~2012~~) 2015, including:

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

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

34 (C) Provider reimbursement methods that incentivize chronic care
35 management within health homes, including comprehensive medication
36 management services for patients with multiple chronic conditions in
37 alignment with medication management services as described in section
38 3503(c) and (d) of P.L. 111-148 of 2010, as amended;

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; and

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 established
14 in section 1 of this act and in alignment with section 3503(c) and (d)
15 of P.L. 111-148 of 2010, as amended.

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

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

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

24 (g) The authority shall, wherever possible, enter into prepaid
25 capitation contracts that include inpatient care. However, if this is
26 not possible or feasible, the authority may enter into prepaid
27 capitation contracts that do not include inpatient care;

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

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

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

37 (3) The authority shall ensure that publicly supported community
38 health centers and providers in rural areas, who show serious intent

1 and apparent capability to participate as managed health care systems
2 are seriously considered as contractors. The authority shall
3 coordinate its managed care activities with activities under chapter
4 70.47 RCW.

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

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

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

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

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

31 (ii) Quality of services provided to enrollees;

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

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

36 (v) Payment rates; and

37 (vi) The ability to meet other specifically defined contract

1 requirements established by the authority, including consideration of
2 past and current performance and participation in other state or
3 federal health programs as a contractor.

4 (c) Consideration should be given to using multiple year
5 contracting periods.

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

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

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

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

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

30 (8) For services covered under this chapter to medical assistance
31 or medical care services enrollees and provided on or after August 24,
32 2011, nonparticipating providers must accept as payment in full the
33 amount paid by the managed health care system under subsection (7) of
34 this section in addition to any deductible, coinsurance, or copayment
35 that is due from the enrollee for the service provided. An enrollee is
36 not liable to any nonparticipating provider for covered services,
37 except for amounts due for any deductible, coinsurance, or copayment

1 under the terms and conditions set forth in the managed health care
2 system contract to provide services under this section.

3 (9) Pursuant to federal managed care access standards, 42 C.F.R.
4 Sec. 438, managed health care systems must maintain a network of
5 appropriate providers that is supported by written agreements
6 sufficient to provide adequate access to all services covered under the
7 contract with the ((department)) authority, including hospital-based
8 physician services. The ((department)) authority will monitor and
9 periodically report on the proportion of services provided by
10 contracted providers and nonparticipating providers, by county, for
11 each managed health care system to ensure that managed health care
12 systems are meeting network adequacy requirements. No later than
13 January 1st of each year, the ((department)) authority will review and
14 report its findings to the appropriate policy and fiscal committees of
15 the legislature for the preceding state fiscal year.

16 (10) Subsections (7) through (9) of this section expire July 1,
17 2016."

18 Correct the title.

EFFECT: Adds legislative findings that chronic care management,
including comprehensive medication management services, is a critical
component of a collaborative approach to treating chronic disease to
improve care and reduce cost.

Removes the definition of "comprehensive medication management
services" and specifies that the provision of comprehensive medication
management services must be in alignment with medication management
services as described in the federal Patient Protection and Affordable
Care Act.

Extends the time for including the comprehensive medication
management provisions in Medicaid managed care contracts from 2014 to
2015.

Corrects agency references.

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