
ENGROSSED SUBSTITUTE SENATE BILL 5124

State of Washington

69th Legislature

2025 Regular Session

By Senate Health & Long-Term Care (originally sponsored by Senators Muzzall, Chapman, and Dozier)

READ FIRST TIME 02/10/25.

1 AN ACT Relating to increasing patient access to timely and
2 medically necessary postacute care by establishing network adequacy
3 standards for nursing homes and inpatient rehabilitation facilities
4 within managed care contracts for medical assistance programs;
5 amending RCW 74.09.522; and adding a new section to chapter 74.09
6 RCW.

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

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

10 (1) The legislature finds medicaid enrollees are entitled to
11 timely access to postacute care services when apple health managed
12 care organizations have determined such services are medically
13 necessary for quality of care and health outcomes.

14 (2) In order to facilitate more access to postacute care
15 services, the authority shall establish and adopt network adequacy
16 standards for postacute care services by no later than January 1,
17 2028. Network adequacy standards development must include nursing
18 homes licensed under chapter 18.51 RCW and inpatient rehabilitation
19 facilities licensed under chapter 70.41 RCW.

20 (a) Network adequacy standards for nursing homes must take into
21 consideration the Washington medicaid principle of keeping care local

1 to an enrollee's community and any geographic adequacy threshold
2 should not be broader than the regional service area a managed care
3 organization is contracted to serve. The authority may narrow the
4 geographic standards during development. These standards must also
5 consider:

6 (i) Provider availability in a regional service area;

7 (ii) Timeliness of care, which is defined as the reasonable
8 amount of time in which patients can receive access to postacute care
9 based on their medical needs; and

10 (iii) Any other network adequacy standard required to maintain
11 compliance with federal medicaid regulations.

12 (b) Network adequacy standards for inpatient rehabilitation
13 facilities must take into consideration the Washington medicaid
14 principle of keep care local to an enrollee's community and the
15 geographic adequacy threshold must not be narrower than the regional
16 service area a managed care organization is contracted to serve and
17 must take into consideration patient referral and practice patterns.
18 The authority may narrow the geographic standards during development.
19 These standards must also consider:

20 (i) Provider availability in a regional service area;

21 (ii) Timeliness of care, which is defined as the reasonable
22 amount of time in which patients can receive access to postacute care
23 based on their medical needs; and

24 (iii) Any other network adequacy standard required to maintain
25 compliance with federal medicaid regulations.

26 (3) As part of the development of network adequacy standards, the
27 authority shall obtain stakeholder feedback.

28 (a) Stakeholders must include hospitals, nursing homes, managed
29 care organizations, and any associations representing members of
30 these groups. If the authority chooses to include additional provider
31 types in developing postacute care network standards, it must include
32 representatives from those facility types in the stakeholder feedback
33 process.

34 (b) Feedback must be obtained at least three times, including:

35 (i) For initial criteria used to develop standards;

36 (ii) To review draft standards; and

37 (iii) To review final standards prior to publication and
38 inclusion in the managed care contract.

39 (4) Network adequacy standards for postacute care services do not
40 alter the ability of a facility to determine whether the facility can

1 meet the needs of a prospective resident through available staffing
2 and reasonable accommodations.

3 **Sec. 2.** RCW 74.09.522 and 2023 c 51 s 43 are each amended to
4 read as follows:

5 (1) For the purposes of this section, "nonparticipating provider"
6 means a person, health care provider, practitioner, facility, or
7 entity, acting within their scope of practice, that does not have a
8 written contract to participate in a managed care organization's
9 provider network, but provides health care services to enrollees of
10 programs authorized under this chapter or other applicable law whose
11 health care services are provided by the managed care organization.

12 (2) The authority shall enter into agreements with managed care
13 organizations to provide health care services to recipients of
14 medicaid under the following conditions:

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

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

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

31 (d) To the extent that this provision is consistent with section
32 1903(m) of Title XIX of the federal social security act,
33 participating managed care organizations shall not enroll a
34 disproportionate number of medical assistance recipients within the
35 total numbers of persons served by the managed care organizations,
36 except as authorized by the authority under federal demonstration
37 waivers granted under section 1115(a) of Title XI of the federal
38 social security act;

1 (e)(i) In negotiating with managed care organizations the
2 authority shall adopt a uniform procedure to enter into contractual
3 arrangements, including:

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

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

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

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

13 (E) 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
16 to support provider participation in the training, unless the managed
17 care organization is an integrated health delivery system that has
18 programs in place for chronic care management;

19 (F) Provider reimbursement methods within the medical billing
20 processes that incentivize pharmacists or other qualified providers
21 licensed in Washington state to provide comprehensive medication
22 management services consistent with the findings and goals
23 established in RCW 74.09.5223;

24 (G) Evaluation and reporting on the impact of comprehensive
25 medication management services on patient clinical outcomes and total
26 health care costs, including reductions in emergency department
27 utilization, hospitalization, and drug costs; and

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

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

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

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

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

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

3 (h) The authority shall define those circumstances under which a
4 managed care organization is responsible for out-of-plan services and
5 assure that recipients shall not be charged for such services;

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

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

12 (3) The authority shall ensure that publicly supported community
13 health centers and providers in rural areas, who show serious intent
14 and apparent capability to participate as managed care organizations
15 are seriously considered as contractors. The authority shall
16 coordinate its managed care activities with activities under chapter
17 70.47 RCW.

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

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

33 (a) All managed care organizations should have an opportunity to
34 contract with the authority to the extent that minimum contracting
35 requirements defined by the authority are met, at payment rates that
36 enable the authority to operate as far below appropriated spending
37 levels as possible, consistent with the principles established in
38 this section.

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

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

6 (ii) Quality of services provided to enrollees;

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

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

11 (v) Payment rates; and

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

16 (c) Consideration should be given to using multiple year
17 contracting periods.

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

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

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

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

38 (7) Any contract with a managed care organization to provide
39 services to medical assistance enrollees shall require that managed
40 care organizations offer contracts to mental health providers and

1 substance use disorder treatment providers to provide access to
2 primary care services integrated into behavioral health clinical
3 settings, for individuals with behavioral health and medical
4 comorbidities.

5 (8) Managed care organization contracts effective on or after
6 April 1, 2016, shall serve geographic areas that correspond to the
7 regional service areas established in RCW 74.09.870.

8 (9) A managed care organization shall pay a nonparticipating
9 provider that provides a service covered under this chapter or other
10 applicable law to the organization's enrollee no more than the lowest
11 amount paid for that service under the managed care organization's
12 contracts with similar providers in the state if the managed care
13 organization has made good faith efforts to contract with the
14 nonparticipating provider.

15 (10) For services covered under this chapter or other applicable
16 law to medical assistance or medical care services enrollees,
17 nonparticipating providers must accept as payment in full the amount
18 paid by the managed care organization under subsection (9) of this
19 section in addition to any deductible, coinsurance, or copayment that
20 is due from the enrollee for the service provided. An enrollee is not
21 liable to any nonparticipating provider for covered services, except
22 for amounts due for any deductible, coinsurance, or copayment under
23 the terms and conditions set forth in the managed care organization
24 contract to provide services under this section.

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

38 (12) Managed care organization contracts or amendments effective
39 on or after July 1, 2028, shall be required to meet network adequacy
40 requirements established under this chapter for postacute care

1 services, including nursing homes licensed under chapter 18.51 RCW,
2 inpatient rehabilitation facilities licensed under chapter 70.41 RCW,
3 and any other postacute care services the authority determines
4 necessary to increase access to a full continuum of care for medicaid
5 enrollees. The adequacy requirements included in this subsection
6 shall be incorporated into monitoring and reporting requirements
7 under subsection (11) of this section.

8 (13) Payments under RCW 74.60.130 are exempt from this section.

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