H-1151.1

HOUSE BILL 1705

State of Washington 59th Legislature 2005 Regular Session

By Representatives Linville, Ericksen, Morris, Quall, Schual-Berke and Lantz

Read first time 02/02/2005. Referred to Committee on Health Care.

AN ACT Relating to health care; amending RCW 41.05.013; reenacting and amending RCW 74.09.510 and 74.09.522; and creating new sections.

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

NEW SECTION. **Sec. 1.** It is the intent of the legislature to preserve the number of private medical practitioners providing essential safety net care to uninsured and medicaid patients by addressing barriers to private practice participation. Private practitioners are critical to preserving health care access for lower-income patients. The legislature intends to provide targeted economic incentives for private provider participation in safety net care and calls for the streamlining of medicaid administrative procedures and a reduction of the administrative burden on private medical providers.

Sec. 2. RCW 74.09.510 and 2001 2nd sp.s. c 15 s 3 and 2001 1st sp.s. c 4 s 1 are each reenacted and amended to read as follows:

(1) Medical assistance may be provided in accordance with eligibility requirements established by the department, as defined in the social security Title XIX state plan for mandatory categorically needy persons and: ((~~(1)~~)) (a) Individuals who would be eligible for

cash assistance except for their institutional status; ((~~(2)~~)) (b) individuals who are under twenty-one years of age, who would be eligible for medicaid, but do not qualify as dependent children and who are in ((~~(a)~~)) (i) foster care, ((~~(b)~~)) (ii) subsidized adoption, ((~~(c)~~)) (iii) a nursing facility or an intermediate care facility for the mentally retarded, or ((~~(d)~~)) (iv) inpatient psychiatric facilities; ((~~(3)~~)) (c) the aged, blind, and disabled who: ((~~(a)~~)) (i) Receive only a state supplement, or ((~~(b)~~)) (ii) would not be eligible for cash assistance if they were not institutionalized; ((~~(4)~~)) (d) categorically eligible individuals who meet the income and resource requirements of the cash assistance programs; ((~~(5)~~)) (e) individuals who are enrolled in managed health care systems, who have otherwise lost eligibility for medical assistance, but who have not completed a current six-month enrollment in a managed health care system, and who are eligible for federal financial participation under Title XIX of the social security act; ((~~(6)~~)) (f) children and pregnant women allowed by federal statute for whom funding is appropriated; ((~~(7)~~)) (g) working individuals with disabilities authorized under section 1902(a)(10)(A)(ii) of the social security act for whom funding is appropriated; ((~~(8)~~)) (h) other individuals eligible for medical services under RCW 74.09.035 and 74.09.700 for whom federal financial participation is available under Title XIX of the social security act; ((~~(9)~~)) (i) persons allowed by section 1931 of the social security act for whom funding is appropriated; and ((~~(10)~~)) (j) women who: ((~~(a)~~)) (i) Are under sixty-five years of age; ((~~(b)~~)) (ii) have been screened for breast and cervical cancer under the national breast and cervical cancer early detection program administered by the department of health or tribal entity and have been identified as needing treatment for breast or cervical cancer; and ((~~(c)~~)) (iii) are not otherwise covered by health insurance. Medical assistance provided under this subsection is limited to the period during which the woman requires treatment for breast or cervical cancer, and is subject to any conditions or limitations specified in the omnibus appropriations act.

(2) The department shall reverify eligibility for medical assistance on an annual basis.

(3) The department shall not charge copremiums for medical and dental coverage of children.

1 <u>(4) The department shall upgrade the medicaid management</u>
2 <u>information system and participate in a single secure eligibility</u>
3 <u>verification system used by carriers and health care providers.</u>
4 <u>(5) The department shall require health care contractors to develop</u>
5 <u>policies and practices to support collaborative efforts to promote a</u>
6 <u>new model of chronic disease management.</u>

7 **Sec. 3.** RCW 74.09.522 and 1997 c 59 s 15 and 1997 c 34 s 1 are
8 each reenacted and amended to read as follows:
9 (1) For the purposes of this section, "managed health care system"
10 means any health care organization, including health care providers,
11 insurers, health care service contractors, health maintenance
12 organizations, health insuring organizations, or any combination
13 thereof, that provides directly or by contract health care services
14 covered under RCW 74.09.520 and rendered by licensed providers, on a
15 prepaid capitated basis and that meets the requirements of section
16 1903(m)(1)(A) of Title XIX of the federal social security act or
17 federal demonstration waivers granted under section 1115(a) of Title XI
18 of the federal social security act.
19 (2) The department of social and health services shall enter into
20 agreements with managed health care systems to provide health care
21 services to recipients of temporary assistance for needy families under
22 the following conditions:
23 (a) Agreements shall be made for at least thirty thousand
24 recipients statewide;
25 (b) Agreements in at least one county shall include enrollment of
26 all recipients of temporary assistance for needy families;
27 (c) To the extent that this provision is consistent with section
28 1903(m) of Title XIX of the federal social security act or federal
29 demonstration waivers granted under section 1115(a) of Title XI of the
30 federal social security act, recipients shall have a choice of systems
31 in which to enroll and shall have the right to terminate their
32 enrollment in a system: PROVIDED, That the department may limit
33 recipient termination of enrollment without cause to the first month of
34 a period of enrollment, which period shall not exceed twelve months:
35 AND PROVIDED FURTHER, That the department shall not restrict a
36 recipient's right to terminate enrollment in a system for good cause as
37 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) In negotiating with managed health care systems the department shall adopt a uniform procedure to negotiate and enter into contractual arrangements, including standards regarding the quality of services to be provided; and financial integrity of the responding system;

(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.

(3) The department shall provide retroactive payment to health care providers when patient medicaid eligibility and health contractor verification is not available at the time of service.

(4) The department shall require health care contractors to have primary care and specialty care networks in place and shall verify the integrity of their primary care and specialty care networks, that those networks are geographically within the service area, and that the providers are actually open to accepting referrals before the department signs or extends contracts. If an out-of-county specialist is needed for a medicaid client because of an inadequate specialist network within the county, written documentation is not required.

(5) The department shall develop a grant program to reimburse providers who serve individuals who are medically indigent.

(6) 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)~~)) (7) 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)~~)) (8) 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)~~)) (9) The department may apply the principles set forth in subsection ((~~(5)~~)) (8) of this section to its managed health care purchasing efforts on behalf of clients receiving supplemental security income benefits to the extent appropriate.

Sec. 4. RCW 41.05.013 and 2003 c 276 s 1 are each amended to read as follows:

(1) The authority shall coordinate state agency efforts to develop and implement uniform policies across state purchased health care programs that will ensure prudent, cost-effective health services purchasing, maximize efficiencies in administration of state purchased health care programs, improve the quality of care provided through state purchased health care programs, and reduce administrative burdens on health care providers participating in state purchased health care

programs. The policies adopted should be based, to the extent possible, upon the best available scientific and medical evidence and shall endeavor to address:

(a) Methods of formal assessment, such as health technology assessment. Consideration of the best available scientific evidence does not preclude consideration of experimental or investigational treatment or services under a clinical investigation approved by an institutional review board;

(b) Monitoring of health outcomes, adverse events, quality, and cost-effectiveness of health services;

(c) Development of a common definition of medical necessity; ((~~and~~))

(d) Exploration of common strategies for disease management and demand management programs; and

(e) Implementation of administrative simplification procedures relating to claims processing, referrals and prospective review, and practitioner credentialing.

(2) The administrator may invite health care provider organizations, carriers, other health care purchasers, and consumers to participate in efforts undertaken under this section.

(3) For the purposes of this section "best available scientific and medical evidence" means the best available external clinical evidence derived from systematic research.

NEW SECTION. **Sec. 5.** The department of health shall develop, in consultation with the department of revenue, a program to provide business and occupation tax credits for physicians who serve uninsured and medicaid patients in a private practice or a reduced fee access program for the uninsured and shall submit proposed legislation to the legislature by December 15, 2005.

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