S-1775.3

SUBSTITUTE SENATE BILL 5703

State of Washington 59th Legislature 2005 Regular Session

By Senate Committee on Health & Long-Term Care (originally sponsored by Senators Brandland, Spanel and Brown)

READ FIRST TIME 03/02/05.

1 AN ACT Relating to health care; amending RCW 74.09.055 and
2 41.05.013; reenacting and amending RCW 74.09.522; adding a new section
3 to chapter 74.09 RCW; and creating new sections.

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

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

14 **Sec. 2.** RCW 74.09.055 and 2003 1st sp.s. c 14 s 1 are each amended
15 to read as follows:
16 (1) Except to the extent provided in subsection (2) of this
17 section, the department is authorized to establish copayment,

deductible, coinsurance, or other cost-sharing requirements for recipients of any medical programs defined in RCW 74.09.010.

(2) The department shall not establish premium requirements for children or pregnant women eligible for medical assistance as defined in RCW 74.09.510 or the children's health program as defined in RCW 74.09.415.

NEW SECTION. **Sec. 3.** A new section is added to chapter 74.09 RCW to read as follows:

Eligibility review periods for children and pregnant women eligible for medical assistance as defined in RCW 74.09.510, children eligible for the children's health program as defined in RCW 74.09.415, and children eligible for the children's health insurance program as defined in RCW 74.09.450 shall be no more frequent than every twelve months.

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

1 demonstration waivers granted under section 1115(a) of Title XI of the
2 federal social security act, recipients shall have a choice of systems
3 in which to enroll and shall have the right to terminate their
4 enrollment in a system: PROVIDED, That the department may limit
5 recipient termination of enrollment without cause to the first month of
6 a period of enrollment, which period shall not exceed twelve months:
7 AND PROVIDED FURTHER, That the department shall not restrict a
8 recipient's right to terminate enrollment in a system for good cause as
9 established by the department by rule;
10 (d) To the extent that this provision is consistent with section
11 1903(m) of Title XIX of the federal social security act, participating
12 managed health care systems shall not enroll a disproportionate number
13 of medical assistance recipients within the total numbers of persons
14 served by the managed health care systems, except as authorized by the
15 department under federal demonstration waivers granted under section
16 1115(a) of Title XI of the federal social security act;
17 (e) In negotiating with managed health care systems the department
18 shall adopt a uniform procedure to negotiate and enter into contractual
19 arrangements, including standards regarding the quality of services to
20 be provided; and financial integrity of the responding system;
21 (f) The department shall seek waivers from federal requirements as
22 necessary to implement this chapter;
23 (g) The department shall, wherever possible, enter into prepaid
24 capitation contracts that include inpatient care. However, if this is
25 not possible or feasible, the department may enter into prepaid
26 capitation contracts that do not include inpatient care;
27 (h) The department shall define those circumstances under which a
28 managed health care system is responsible for out-of-plan services and
29 assure that recipients shall not be charged for such services; and
30 (i) Nothing in this section prevents the department from entering
31 into similar agreements for other groups of people eligible to receive
32 services under this chapter.
33 (3) <u>The department shall require that plans have up-to-date</u>
34 <u>eligibility information, including plan and primary care provider</u>
35 <u>status, accessible to providers at all times. Payments and</u>
36 <u>authorizations shall be made based on this information.</u>
37 <u>(4) The department shall require health care contractors to have</u>
38 <u>primary care and specialty care networks in place within the geographic</u>

service area and that the contractors verify that those networks are up-to-date and that the information is accessible to primary care providers.

(5) The department shall require health care contractors to develop policies and practices to support collaborative efforts to promote a new model of chronic disease management.

(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. 5. 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. 6.** The department of revenue shall develop, in consultation with the department of health, the department of social and health services, and the health care authority, a program to provide business and occupation tax credits for physicians who serve uninsured or state-purchased low-income health care patients in a

1 private practice and shall submit proposed legislation to the
2 legislature by December 15, 2005.

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