Z-1208.1

SENATE BILL 6710

State of Washington 61st Legislature 2010 Regular Session

By Senator Keiser; by request of Governor Gregoire

Read first time 01/22/10. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to administration of the medicaid program; amending RCW 74.09.010, 74.09.015, 74.09.035, 74.09.037, 74.09.050, 74.09.055, 74.09.075, 74.09.080, 74.09.085, 74.09.110, 74.09.120, 74.09.160, 74.09.180, 74.09.185, 74.09.190, 74.09.200, 74.09.210, 74.09.240, 74.09.260, 74.09.280, 74.09.290, 74.09.300, 74.09.470, 74.09.480, 74.09.490, 74.09.500, 74.09.510, 74.09.515, 74.09.520, 74.09.521, 74.09.5221, 74.09.5222, 74.09.5227, 74.09.523, 74.09.530, 74.09.540, 74.09.555, 74.09.565, 74.09.575, 74.09.585, 74.09.595, 74.09.650, 74.09.655, 74.09.658, 74.09.659, 74.09.660, 74.09.700, 74.09.710, 74.09.715, 74.09.725, 74.09.730, 74.09.755, 74.09.790, 74.09.800, 74.09.810, and 74.09.820; and reenacting and amending RCW 74.09.053 and 74.09.522.

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

Sec. 1. RCW 74.09.010 and 2007 c 3 s 2 are each amended to read as follows:

As used in this chapter, unless the context clearly indicates otherwise:

(1) "Agency" means the single state medicaid agency, designated by

the governor and approved by the United States department of health and human services in the state plan covering medicaid.

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

((~~(3)~~)) (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) "Department" means the department of social and health services.~~))

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

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

(7) "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.

(8) "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.

(9) "Medical care services" means the limited scope of care financed by state funds and provided to general assistance recipients, and recipients of alcohol and drug addiction services provided under chapter 74.50 RCW.

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

(11) "Poverty" means the federal poverty level determined annually

by the United States department of health and human services, or successor agency.

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

~~(13)~~)) "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.

Sec. 2. RCW 74.09.015 and 2007 c 259 s 16 are each amended to read as follows:

To the extent that sufficient funding is provided specifically for this purpose, the ((~~department~~)) agency, in collaboration with the health care authority, shall provide all persons receiving services under this chapter with access to a twenty-four hour, seven day a week nurse hotline. The health care authority and the ((~~department of social and health services~~)) agency shall determine the most appropriate way to provide the nurse hotline under RCW 41.05.037 and this section, which may include use of the 211 system established in chapter 43.211 RCW.

Sec. 3. RCW 74.09.035 and 1987 c 406 s 12 are each amended to read as follows:

(1) To the extent of available funds, medical care services may be provided to recipients of general assistance, and recipients of alcohol and drug addiction services provided under chapter 74.50 RCW, in accordance with medical eligibility requirements established by the ((~~department~~)) agency.

(2) Determination of the amount, scope, and duration of medical care services shall be limited to coverage as defined by the ((~~department~~)) agency, except that adult dental, and routine foot care shall not be included unless there is a specific appropriation for these services.

(3) The ((~~department~~)) agency shall establish standards of assistance and resource and income exemptions, which may include deductibles and co-insurance provisions. In addition, the

((~~department~~)) agency may include a prohibition against the voluntary assignment of property or cash for the purpose of qualifying for assistance.

(4) Residents of skilled nursing homes, intermediate care facilities, and intermediate care facilities for the mentally retarded who are eligible for medical care services shall be provided medical services to the same extent as provided to those persons eligible under the medical assistance program.

(5) Payments made by the ((~~department~~)) agency under this program shall be the limit of expenditures for medical care services solely from state funds.

(6) Eligibility for medical care services shall commence with the date of certification for general assistance or the date of eligibility for alcohol and drug addiction services provided under chapter 74.50 RCW.

Sec. 4. RCW 74.09.037 and 2004 c 115 s 3 are each amended to read as follows:

Any card issued after December 31, 2005, by the ((~~department~~)) agency or a managed health care system to a person receiving services under this chapter, that must be presented to providers for purposes of claims processing, may not display an identification number that includes more than a four-digit portion of the person's complete social security number.

Sec. 5. RCW 74.09.050 and 2000 c 5 s 15 are each amended to read as follows:

The ((~~secretary~~)) head of the agency shall appoint such professional personnel and other assistants and employees, including professional medical screeners, as may be reasonably necessary to carry out the provisions of this chapter. The medical screeners shall be supervised by one or more physicians who shall be appointed by the ((~~secretary~~)) head of the agency or his or her designee. The ((~~secretary~~)) head of the agency shall appoint a medical director who is licensed under chapter 18.57 or 18.71 RCW.

Sec. 6. RCW 74.09.053 and 2009 c 568 s 6 and 2009 c 479 s 62 are each reenacted and amended to read as follows:

(1) Beginning in November 2012, the ((~~department of social and health services~~)) agency, in coordination with the health care authority, shall by November 15th of each year report to the legislature:

(a) The number of medical assistance recipients who: (i) Upon enrollment or recertification had reported being employed, and beginning with the 2008 report, the month and year they reported being hired; or (ii) upon enrollment or recertification had reported being the dependent of someone who was employed, and beginning with the 2008 report, the month and year they reported the employed person was hired. For recipients identified under (a)(i) and (ii) of this subsection, the ((~~department~~)) agency shall report the basis for their medical assistance eligibility, including but not limited to family medical coverage, transitional medical assistance, children's medical coverage, aged coverage, or coverage for persons with disabilities; member months; and the total cost to the state for these recipients, expressed as general fund-state and general fund-federal dollars. The information shall be reported by employer size for employers having more than fifty employees as recipients or with dependents as recipients. This information shall be provided for the preceding January and June of that year.

(b) The following aggregated information: (i) The number of employees who are recipients or with dependents as recipients by private and governmental employers; (ii) the number of employees who are recipients or with dependents as recipients by employer size for employers with fifty or fewer employees, fifty-one to one hundred employees, one hundred one to one thousand employees, one thousand one to five thousand employees and more than five thousand employees; and (iii) the number of employees who are recipients or with dependents as recipients by industry type.

(2) For each aggregated classification, the report will include the number of hours worked, the number of ((~~department of social and health services~~)) agency covered lives, and the total cost to the state for these recipients. This information shall be for each quarter of the preceding year.

Sec. 7. RCW 74.09.055 and 2006 c 24 s 1 are each amended to read as follows:

The ((~~department~~)) agency is authorized to establish copayment, deductible, or coinsurance, or other cost-sharing requirements for recipients of any medical programs defined in RCW 74.09.010, except that premiums shall not be imposed on children in households at or below two hundred percent of the federal poverty level.

Sec. 8. RCW 74.09.075 and 1979 c 141 s 337 are each amended to read as follows:

The ((~~department~~)) agency shall provide (a) for evaluation of employability when a person is applying for public assistance representing a medical condition as a basis for need, and (b) for medical reports to be used in the evaluation of total and permanent disability. It shall further provide for medical consultation and assistance in determining the need for special diets, housekeeper and attendant services, and other requirements as found necessary because of the medical condition under the rules promulgated by the ((~~secretary~~)) head of the agency.

Sec. 9. RCW 74.09.080 and 1979 c 141 s 338 are each amended to read as follows:

In carrying out the administrative responsibility of this chapter, the ((~~department~~)) agency may contract with an individual or a group, may utilize existing local state public assistance offices, or establish separate welfare medical care offices on a county or multicounty unit basis as found necessary.

Sec. 10. RCW 74.09.085 and 2005 c 446 s 3 are each amended to read as follows:

The ((~~secretary~~)) head of the agency shall, in collaboration with other state agencies that administer state purchased health care programs, private health care purchasers, health care facilities, providers, and carriers, use evidence-based medicine principles to develop common performance measures and implement financial incentives in contracts with insuring entities, health care facilities, and providers that:

(1) Reward improvements in health outcomes for individuals with chronic diseases, increased utilization of appropriate preventive health services, and reductions in medical errors; and

(2) Increase, through appropriate incentives to insuring entities, health care facilities, and providers, the adoption and use of information technology that contributes to improved health outcomes, better coordination of care, and decreased medical errors.

Sec. 11. RCW 74.09.110 and 1979 c 141 s 339 are each amended to read as follows:

The ((~~department~~)) agency shall employ administrative personnel in both state and local offices and employ the services of professional screeners and consultants as found necessary to carry out the proper administration of the program.

Sec. 12. RCW 74.09.120 and 1998 c 322 s 45 are each amended to read as follows:

The ((~~department~~)) agency shall purchase necessary physician and dentist services by contract or "fee for service." The ((~~department~~)) agency shall purchase nursing home care by contract and payment for the care shall be in accordance with the provisions of chapter 74.46 RCW and rules adopted by the ((~~department~~)) agency under the authority of RCW 74.46.800. No payment shall be made to a nursing home which does not permit inspection by the ((~~department of social and health services~~)) agency of every part of its premises and an examination of all records, including financial records, methods of administration, general and special dietary programs, the disbursement of drugs and methods of supply, and any other records the ((~~department~~)) agency deems relevant to the regulation of nursing home operations, enforcement of standards for resident care, and payment for nursing home services.

The ((~~department~~)) agency may purchase nursing home care by contract in veterans' homes operated by the state department of veterans affairs and payment for the care shall be in accordance with the provisions of chapter 74.46 RCW and rules adopted by the ((~~department~~)) agency under the authority of RCW 74.46.800.

The ((~~department~~)) agency may purchase care in institutions for ((~~the mentally retarded~~)) persons with intellectual disabilities, also known as intermediate care facilities for the mentally retarded. The ((~~department~~)) agency shall establish rules for reasonable accounting and reimbursement systems for such care. Institutions for ((~~the~~

~~mentally retarded~~)) persons with intellectual disabilities include licensed nursing homes, public institutions, licensed boarding homes with fifteen beds or less, and hospital facilities certified as intermediate care facilities for the mentally retarded under the federal medicaid program to provide health, habilitative, or rehabilitative services and twenty-four hour supervision for ((~~mentally retarded individuals~~)) persons with intellectual disabilities or persons with related conditions and includes in the program "active treatment" as federally defined.

The ((~~department~~)) agency may purchase care in institutions for mental diseases by contract. The ((~~department~~)) agency shall establish rules for reasonable accounting and reimbursement systems for such care. Institutions for mental diseases are certified under the federal medicaid program and primarily engaged in providing diagnosis, treatment, or care to persons with mental diseases, including medical attention, nursing care, and related services.

The ((~~department~~)) agency may purchase all other services provided under this chapter by contract or at rates established by the ((~~department~~)) agency.

Sec. 13. RCW 74.09.160 and 1991 c 103 s 1 are each amended to read as follows:

Each vendor or group who has a contract and is rendering service to eligible persons as defined in this chapter shall submit such charges as agreed upon between the ((~~department~~)) agency and the individual or group no later than twelve months from the date of service. If the final charges are not presented within the twelve-month period, they shall not be a charge against the state. Said twelve-month period may also be extended by regulation, but only if required by applicable federal law or regulation, and to no more than the extension of time so required. For services rendered prior to July 28, 1991, final charges shall not be a charge against the state unless they are presented within one hundred twenty days from the date of service.

Sec. 14. RCW 74.09.180 and 1997 c 236 s 1 are each amended to read as follows:

(1) The provisions of this chapter shall not apply to recipients whose personal injuries are occasioned by negligence or wrong of

another: PROVIDED, HOWEVER, That the ((~~secretary~~)) head of the agency may furnish assistance, under the provisions of this chapter, for the results of injuries to or illness of a recipient, and the ((~~department~~)) agency shall thereby be subrogated to the recipient's rights against the recovery had from any tort feasor or the tort feasor's insurer, or both, and shall have a lien thereupon to the extent of the value of the assistance furnished by the ((~~department~~)) agency. To secure reimbursement for assistance provided under this section, the ((~~department~~)) agency may pursue its remedies under RCW 43.20B.060.

(2) The rights and remedies provided to the ((~~department~~)) agency in this section to secure reimbursement for assistance, including the ((~~department's~~)) agency's lien and subrogation rights, may be delegated to a managed health care system by contract entered into pursuant to RCW 74.09.522. A managed health care system may enforce all rights and remedies delegated to it by the ((~~department~~)) agency to secure and recover assistance provided under a managed health care system consistent with its agreement with the ((~~department~~)) agency.

Sec. 15. RCW 74.09.185 and 1995 c 34 s 6 are each amended to read as follows:

To the extent that payment for covered expenses has been made under medical assistance for health care items or services furnished to an individual, in any case where a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services. Recovery pursuant to the subrogation rights, assignment, or enforcement of the lien granted to the ((~~department~~)) agency by this section shall not be reduced, prorated, or applied to only a portion of a judgment, award, or settlement, except as provided in RCW 43.20B.050 and 43.20B.060. The doctrine of equitable subrogation shall not apply to defeat, reduce, or prorate recovery by the ((~~department~~)) agency as to its assignment, lien, or subrogation rights.

Sec. 16. RCW 74.09.190 and 1979 c 141 s 342 are each amended to read as follows:

Nothing in this chapter shall be construed as empowering the

((~~secretary~~)) head of the agency to compel any recipient of public assistance and a medical indigent person to undergo any physical examination, surgical operation, or accept any form of medical treatment contrary to the wishes of said person who relies on or is treated by prayer or spiritual means in accordance with the creed and tenets of any well recognized church or religious denomination.

Sec. 17. RCW 74.09.200 and 1979 ex.s. c 152 s 1 are each amended to read as follows:

The legislature finds and declares it to be in the public interest and for the protection of the health and welfare of the residents of the state of Washington that a proper regulatory and inspection program be instituted in connection with the providing of medical, dental, and other health services to recipients of public assistance and medically indigent persons. In order to effectively accomplish such purpose and to assure that the recipient of such services receives such services as are paid for by the state of Washington, the acceptance by the recipient of such services, and by practitioners of reimbursement for performing such services, shall authorize the ((~~secretary of the department of social and health services~~)) head of the agency or his or her designee, to inspect and audit all records in connection with the providing of such services.

Sec. 18. RCW 74.09.210 and 1989 c 175 s 146 are each amended to read as follows:

(1) No person, firm, corporation, partnership, association, agency, institution, or other legal entity, but not including an individual public assistance recipient of health care, shall, on behalf of himself or others, obtain or attempt to obtain benefits or payments under this chapter in a greater amount than that to which entitled by means of:

(a) A willful false statement;

(b) By willful misrepresentation, or by concealment of any material facts; or

(c) By other fraudulent scheme or device, including, but not limited to:

(i) Billing for services, drugs, supplies, or equipment that were unfurnished, of lower quality, or a substitution or misrepresentation of items billed; or

(ii) Repeated billing for purportedly covered items, which were not in fact so covered.

(2) Any person or entity knowingly violating any of the provisions of subsection (1) of this section shall be liable for repayment of any excess benefits or payments received, plus interest at the rate and in the manner provided in RCW 43.20B.695. Such person or other entity shall further, in addition to any other penalties provided by law, be subject to civil penalties. The ((~~secretary~~)) head of the agency may assess civil penalties in an amount not to exceed three times the amount of such excess benefits or payments: PROVIDED, That these civil penalties shall not apply to any acts or omissions occurring prior to September 1, 1979. RCW 43.20A.215 governs notice of a civil fine and provides the right to an adjudicative proceeding.

(3) A criminal action need not be brought against a person for that person to be civilly liable under this section.

(4) In all proceedings under this section, service, adjudicative proceedings, and judicial review of such determinations shall be in accordance with chapter 34.05 RCW, the Administrative Procedure Act.

(5) Civil penalties shall be deposited in the general fund upon their receipt.

Sec. 19. RCW 74.09.240 and 1995 c 319 s 1 are each amended to read as follows:

(1) Any person, including any corporation, that solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind

(a) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this chapter, or

(b) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made in whole or in part under this chapter,

shall be guilty of a class C felony; however, the fine, if imposed, shall not be in an amount more than twenty-five thousand dollars, except as authorized by RCW 9A.20.030.

(2) Any person, including any corporation, that offers or pays any

remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person

(a) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under this chapter, or

(b) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made in whole or in part under this chapter,

shall be guilty of a class C felony; however, the fine, if imposed, shall not be in an amount more than twenty-five thousand dollars, except as authorized by RCW 9A.20.030.

(3)(a) Except as provided in 42 U.S.C. 1395 nn, physicians are prohibited from self-referring any client eligible under this chapter for the following designated health services to a facility in which the physician or an immediate family member has a financial relationship:

(i) Clinical laboratory services;

(ii) Physical therapy services;

(iii) Occupational therapy services;

(iv) Radiology including magnetic resonance imaging, computerized axial tomography, and ultrasound services;

(v) Durable medical equipment and supplies;

(vi) Parenteral and enteral nutrients equipment and supplies;

(vii) Prosthetics, orthotics, and prosthetic devices;

(viii) Home health services;

(ix) Outpatient prescription drugs;

(x) Inpatient and outpatient hospital services;

(xi) Radiation therapy services and supplies.

(b) For purposes of this subsection, "financial relationship" means the relationship between a physician and an entity that includes either:

(i) An ownership or investment interest; or

(ii) A compensation arrangement.

For purposes of this subsection, "compensation arrangement" means an arrangement involving remuneration between a physician, or an immediate family member of a physician, and an entity.

(c) The ((~~department~~)) agency is authorized to adopt by rule amendments to 42 U.S.C. 1395 nn enacted after July 23, 1995.

(d) This section shall not apply in any case covered by a general exception specified in 42 U.S.C. Sec. 1395 nn.

(4) Subsections (1) and (2) of this section shall not apply to

(a) a discount or other reduction in price obtained by a provider of services or other entity under this chapter if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this chapter, and

(b) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(5) Subsections (1) and (2) of this section, if applicable to the conduct involved, shall supersede the criminal provisions of chapter 19.68 RCW, but shall not preclude administrative proceedings authorized by chapter 19.68 RCW.

Sec. 20. RCW 74.09.260 and 1991 sp.s. c 8 s 7 are each amended to read as follows:

Any person, including any corporation, that knowingly:

(1) Charges, for any service provided to a patient under any medical care plan authorized under this chapter, money or other consideration at a rate in excess of the rates established by the ((~~department of social and health services~~)) agency; or

(2) Charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under such plan, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient):

(a) As a precondition of admitting a patient to a hospital or nursing facility; or

(b) As a requirement for the patient's continued stay in such facility,

when the cost of the services provided therein to the patient is paid for, in whole or in part, under such plan, shall be guilty of a class C felony: PROVIDED, That the fine, if imposed, shall not be in an amount more than twenty-five thousand dollars, except as authorized by RCW 9A.20.030.

Sec. 21. RCW 74.09.280 and 1979 ex.s. c 152 s 9 are each amended to read as follows:

The ((~~secretary of social and health services~~)) head of the agency may by rule require that any application, statement, or form filled out by suppliers of medical care under this chapter shall contain or be verified by a written statement that it is made under the penalties of perjury and such declaration shall be in lieu of any oath otherwise required, and each such paper shall in such event so state. The making or subscribing of any such papers or forms containing any false or misleading information may be prosecuted and punished under chapter 9A.72 RCW.

Sec. 22. RCW 74.09.290 and 1994 sp.s. c 9 s 749 are each amended to read as follows:

The ((~~secretary of the department of social and health services~~)) head of the agency or ((~~his~~)) the head of the agency's authorized representative shall have the authority to:

(1) Conduct audits and investigations of providers of medical and other services furnished pursuant to this chapter, except that the Washington state medical quality assurance commission shall generally serve in an advisory capacity to the ((~~secretary~~)) head of the agency in the conduct of audits or investigations of physicians. Any overpayment discovered as a result of an audit of a provider under this authority shall be offset by any underpayments discovered in that same audit sample. In order to determine the provider's actual, usual, customary, or prevailing charges, the ((~~secretary~~)) head of the agency may examine such random representative records as necessary to show accounts billed and accounts received except that in the conduct of such examinations, patient names, other than public assistance applicants or recipients, shall not be noted, copied, or otherwise made available to the ((~~department~~)) agency. In order to verify costs incurred by the ((~~department~~)) agency for treatment of public assistance applicants or recipients, the ((~~secretary~~)) head of the agency may examine patient records or portions thereof in connection with services to such applicants or recipients rendered by a health care provider, notwithstanding the provisions of RCW 5.60.060, 18.53.200, 18.83.110, or any other statute which may make or purport to make such records privileged or confidential: PROVIDED, That no

original patient records shall be removed from the premises of the health care provider, and that the disclosure of any records or information by the ((~~department of social and health services~~)) agency is prohibited and shall be punishable as a class C felony according to chapter 9A.20 RCW, unless such disclosure is directly connected to the official purpose for which the records or information were obtained: PROVIDED FURTHER, That the disclosure of patient information as required under this section shall not subject any physician or other health services provider to any liability for breach of any confidential relationship between the provider and the patient, but no evidence resulting from such disclosure may be used in any civil, administrative, or criminal proceeding against the patient unless a waiver of the applicable evidentiary privilege is obtained: PROVIDED FURTHER, That the ((~~secretary~~)) head of the agency shall destroy all copies of patient medical records in their possession upon completion of the audit, investigation or proceedings;

(2) Approve or deny applications to participate as a provider of services furnished pursuant to this chapter;

(3) Terminate or suspend eligibility to participate as a provider of services furnished pursuant to this chapter; and

(4) Adopt, promulgate, amend, and repeal administrative rules, in accordance with the Administrative Procedure Act, chapter 34.05 RCW, to carry out the policies and purposes of RCW 74.09.200 through 74.09.290.

Sec. 23. RCW 74.09.300 and 1979 ex.s. c 152 s 11 are each amended to read as follows:

Whenever the ((~~secretary of the department of social and health services~~)) head of the agency imposes a civil penalty under RCW 74.09.210, or terminates or suspends a provider's eligibility under RCW 74.09.290, he shall, if the provider is licensed pursuant to Titles 18, 70, or 71 RCW, give written notice of such imposition, termination, or suspension to the appropriate licensing agency or disciplinary board.

Sec. 24. RCW 74.09.470 and 2009 c 463 s 2 are each amended to read as follows:

(1) Consistent with the goals established in RCW 74.09.402, through the apple health for kids program authorized in this section, the ((~~department~~)) agency shall provide affordable health care coverage to

children under the age of nineteen who reside in Washington state and whose family income at the time of enrollment is not greater than two hundred fifty percent of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services, and effective January 1, 2009, and only to the extent that funds are specifically appropriated therefor, to children whose family income is not greater than three hundred percent of the federal poverty level. In administering the program, the ((~~department~~)) agency shall take such actions as may be necessary to ensure the receipt of federal financial participation under the medical assistance program, as codified at Title XIX of the federal social security act, the state children's health insurance program, as codified at Title XXI of the federal social security act, and any other federal funding sources that are now available or may become available in the future. The ((~~department~~)) agency and the caseload forecast council shall estimate the anticipated caseload and costs of the program established in this section.

(2) The ((~~department~~)) agency shall accept applications for enrollment for children's health care coverage; establish appropriate minimum-enrollment periods, as may be necessary; and determine eligibility based on current family income. The ((~~department~~)) agency shall make eligibility determinations within the time frames for establishing eligibility for children on medical assistance, as defined by RCW 74.09.510. The application and annual renewal processes shall be designed to minimize administrative barriers for applicants and enrolled clients, and to minimize gaps in eligibility for families who are eligible for coverage. If a change in family income results in a change in the source of funding for coverage, the ((~~department~~)) agency shall transfer the family members to the appropriate source of funding and notify the family with respect to any change in premium obligation, without a break in eligibility. The ((~~department~~)) agency shall use the same eligibility redetermination and appeals procedures as those provided for children on medical assistance programs. The ((~~department~~)) agency shall modify its eligibility renewal procedures to lower the percentage of children failing to annually renew. The ((~~department~~)) agency shall manage its outreach, application, and renewal procedures with the goals of: (a) Achieving year by year improvements in enrollment, enrollment rates, renewals, and renewal

rates; (b) maximizing the use of existing program databases to obtain information related to earned and unearned income for purposes of eligibility determination and renewals, including, but not limited to, the basic food program, the child care subsidy program, federal social security administration programs, and the employment security department wage database; (c) streamlining renewal processes to rely primarily upon data matches, online submissions, and telephone interviews; and (d) implementing any other eligibility determination and renewal processes to allow the state to receive an enhanced federal matching rate and additional federal outreach funding available through the federal children's health insurance program reauthorization act of 2009 by January 2010. The ((~~department~~)) agency shall advise the governor and the legislature regarding the status of these efforts by September 30, 2009. The information provided should include the status of the ((~~department's~~)) agency's efforts, the anticipated impact of those efforts on enrollment, and the costs associated with that enrollment.

(3) To ensure continuity of care and ease of understanding for families and health care providers, and to maximize the efficiency of the program, the amount, scope, and duration of health care services provided to children under this section shall be the same as that provided to children under medical assistance, as defined in RCW 74.09.520.

(4) The primary mechanism for purchasing health care coverage under this section shall be through contracts with managed health care systems as defined in RCW 74.09.522, subject to conditions, limitations, and appropriations provided in the biennial appropriations act. However, the ((~~department~~)) agency shall make every effort within available resources to purchase health care coverage for uninsured children whose families have access to dependent coverage through an employer-sponsored health plan or another source when it is cost-effective for the state to do so, and the purchase is consistent with requirements of Title XIX and Title XXI of the federal social security act. To the extent allowable under federal law, the ((~~department~~)) agency shall require families to enroll in available employer-sponsored coverage, as a condition of participating in the program established under this section, when it is cost-effective for the state to do so.

Families who enroll in available employer-sponsored coverage under this section shall be accounted for separately in the annual report required by RCW 74.09.053.

(5)(a) To reflect appropriate parental responsibility, the ((~~department~~)) agency shall develop and implement a schedule of premiums for children's health care coverage due to the ((~~department~~)) agency from families with income greater than two hundred percent of the federal poverty level. For families with income greater than two hundred fifty percent of the federal poverty level, the premiums shall be established in consultation with the senate majority and minority leaders and the speaker and minority leader of the house of representatives. Premiums shall be set at a reasonable level that does not pose a barrier to enrollment. The amount of the premium shall be based upon family income and shall not exceed the premium limitations in Title XXI of the federal social security act. Premiums shall not be imposed on children in households at or below two hundred percent of the federal poverty level as articulated in RCW 74.09.055.

(b) Beginning no later than January 1, 2010, the ((~~department~~)) agency shall offer families whose income is greater than three hundred percent of the federal poverty level the opportunity to purchase health care coverage for their children through the programs administered under this section without an explicit premium subsidy from the state. The design of the health benefit package offered to these children should provide a benefit package substantially similar to that offered in the apple health for kids program, and may differ with respect to cost-sharing, and other appropriate elements from that provided to children under subsection (3) of this section including, but not limited to, application of preexisting conditions, waiting periods, and other design changes needed to offer affordable coverage. The amount paid by the family shall be in an amount equal to the rate paid by the state to the managed health care system for coverage of the child, including any associated and administrative costs to the state of providing coverage for the child. Any pooling of the program enrollees that results in state fiscal impact must be identified and brought to the legislature for consideration.

(6) The ((~~department~~)) agency shall undertake and continue a proactive, targeted outreach and education effort with the goal of enrolling children in health coverage and improving the health literacy

of youth and parents. The ((~~department~~)) agency shall collaborate with the department of health, local public health jurisdictions, the office of the superintendent of public instruction, the department of early learning, health educators, health care providers, health carriers, community-based organizations, and parents in the design and development of this effort. The outreach and education effort shall include the following components:

(a) Broad dissemination of information about the availability of coverage, including media campaigns;

(b) Assistance with completing applications, and community-based outreach efforts to help people apply for coverage. Community-based outreach efforts should be targeted to the populations least likely to be covered;

(c) Use of existing systems, such as enrollment information from the free and reduced-price lunch program, the department of early learning child care subsidy program, the department of health's women, infants, and children program, and the early childhood education and assistance program, to identify children who may be eligible but not enrolled in coverage;

(d) Contracting with community-based organizations and government entities to support community-based outreach efforts to help families apply for coverage. These efforts should be targeted to the populations least likely to be covered. The ((~~department~~)) agency shall provide informational materials for use by government entities and community-based organizations in their outreach activities, and should identify any available federal matching funds to support these efforts;

(e) Development and dissemination of materials to engage and inform parents and families statewide on issues such as: The benefits of health insurance coverage; the appropriate use of health services, including primary care provided by health care practitioners licensed under chapters 18.71, 18.57, 18.36A, and 18.79 RCW, and emergency services; the value of a medical home, well-child services and immunization, and other preventive health services with linkages to department of health child profile efforts; identifying and managing chronic conditions such as asthma and diabetes; and the value of good nutrition and physical activity;

(f) An evaluation of the outreach and education efforts, based upon clear, cost-effective outcome measures that are included in contracts with entities that undertake components of the outreach and education effort;

(g) An implementation plan to develop online application capability that is integrated with the ((~~department's~~)) agency's automated client eligibility system, and to develop data linkages with the office of the superintendent of public instruction for free and reduced-price lunch enrollment information and the department of early learning for child care subsidy program enrollment information.

(7) The ((~~department~~)) agency shall take action to increase the number of primary care physicians providing dental disease preventive services including oral health screenings, risk assessment, family education, the application of fluoride varnish, and referral to a dentist as needed.

(8) The ((~~department~~)) agency shall monitor the rates of substitution between private-sector health care coverage and the coverage provided under this section and shall report to appropriate committees of the legislature by December 2010.

Sec. 25. RCW 74.09.480 and 2009 c 463 s 4 are each amended to read as follows:

(1) The ((~~department~~)) agency, in collaboration with the department of health, health carriers, local public health jurisdictions, children's health care providers including pediatricians, family practitioners, and pediatric subspecialists, community and migrant health centers, parents, and other purchasers, shall establish a concise set of explicit performance measures that can indicate whether children enrolled in the program are receiving health care through an established and effective medical home, and whether the overall health of enrolled children is improving. Such indicators may include, but are not limited to:

(a) Childhood immunization rates;

(b) Well child care utilization rates, including the use of behavioral and oral health screening, and validated, structured developmental screens using tools, that are consistent with nationally accepted pediatric guidelines and recommended administration schedule, once funding is specifically appropriated for this purpose;

(c) Care management for children with chronic illnesses;

(d) Emergency room utilization;

(e) Visual acuity and eye health;

(f) Preventive oral health service utilization; and

(g) Children's mental health status. In defining these measures the ((~~department~~)) agency shall be guided by the measures provided in RCW 71.36.025.

Performance measures and targets for each performance measure must be established and monitored each biennium, with a goal of achieving measurable, improved health outcomes for the children of Washington state each biennium.

(2) Beginning in calendar year 2009, targeted provider rate increases shall be linked to quality improvement measures established under this section. The ((~~department~~)) agency, in conjunction with those groups identified in subsection (1) of this section, shall develop parameters for determining criteria for increased payment, alternative payment methodologies, or other incentives for those practices and health plans that incorporate evidence-based practice and improve and achieve sustained improvement with respect to the measures.

(3) The ((~~department~~)) agency shall provide a report to the governor and the legislature related to provider performance on these measures, beginning in September 2010 for 2007 through 2009 and biennially thereafter. The ((~~department~~)) agency shall advise the legislature as to its progress towards developing this biennial reporting system by September 30, 2009.

Sec. 26. RCW 74.09.490 and 2007 c 359 s 5 are each amended to read as follows:

(1)(a) The ((~~department~~)) agency, in consultation with the evidence-based practice institute established in RCW 71.24.061, shall develop and implement policies to improve prescribing practices for treatment of emotional or behavioral disturbances in children, improve the quality of children's mental health therapy through increased use of evidence-based and research-based practices and reduced variation in practice, improve communication and care coordination between primary care and mental health providers, and prioritize care in the family home or care which integrates the family where out-of-home placement is required.

(b) The ((~~department~~)) agency shall identify those children with emotional or behavioral disturbances who may be at high risk due to off-label use of prescription medication, use of multiple medications, high medication dosage, or lack of coordination among multiple prescribing providers, and establish one or more mechanisms to evaluate the appropriateness of the medication these children are using, including but not limited to obtaining second opinions from experts in child psychiatry.

(c) The ((~~department~~)) agency shall review the psychotropic medications of all children under five and establish one or more mechanisms to evaluate the appropriateness of the medication these children are using, including but not limited to obtaining second opinions from experts in child psychiatry.

(d) The ((~~department~~)) agency shall track prescriptive practices with respect to psychotropic medications with the goal of reducing the use of medication.

(e) The ((~~department~~)) agency shall encourage the use of cognitive behavioral therapies and other treatments which are empirically supported or evidence-based, in addition to or in the place of prescription medication where appropriate.

(2) The ((~~department~~)) agency shall convene a representative group of regional support networks, community mental health centers, and managed health care systems contracting with the ((~~department~~)) agency under RCW 74.09.522 to:

(a) Establish mechanisms and develop contract language that ensures increased coordination of and access to medicaid mental health benefits available to children and their families, including ensuring access to services that are identified as a result of a developmental screen administered through early periodic screening, diagnosis, and treatment;

(b) Define managed health care system and regional support network contractual performance standards that track access to and utilization of services; and

(c) Set standards for reducing the number of children that are prescribed antipsychotic drugs and receive no outpatient mental health services with their medication.

(3) The ((~~department~~)) agency shall submit a report on progress and any findings under this section to the legislature by January 1, 2009.

Sec. 27. RCW 74.09.500 and 1979 c 141 s 343 are each amended to read as follows:

There is hereby established a new program of federal-aid assistance to be known as medical assistance to be administered by the ((~~state department of social and health services~~)) agency. The ((~~department of social and health services~~)) agency is authorized to comply with the federal requirements for the medical assistance program provided in the Social Security Act and particularly Title XIX of Public Law (89-97) in order to secure federal matching funds for such program.

Sec. 28. RCW 74.09.510 and 2007 c 315 s 1 are each amended to read as follows:

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

(1) Individuals who would be eligible for cash assistance except for their institutional status;

(2) 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) foster care, (b) subsidized adoption, (c) a nursing facility or an intermediate care facility for persons who are mentally retarded, or (d) inpatient psychiatric facilities;

(3) Individuals who:

(a) Are under twenty-one years of age;

(b) On or after July 22, 2007, were in foster care under the legal responsibility of the department of social and health services or a federally recognized tribe located within the state; and

(c) On their eighteenth birthday, were in foster care under the legal responsibility of the department of social and health services or a federally recognized tribe located within the state;

(4) Persons who are aged, blind, or disabled who: (a) Receive only a state supplement, or (b) would not be eligible for cash assistance if they were not institutionalized;

(5) Categorically eligible individuals who meet the income and resource requirements of the cash assistance programs;

(6) 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;

(7) Children and pregnant women allowed by federal statute for whom funding is appropriated;

(8) Working individuals with disabilities authorized under section 1902(a)(10)(A)(ii) of the social security act for whom funding is appropriated;

(9) 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;

(10) Persons allowed by section 1931 of the social security act for whom funding is appropriated; and

(11) Women who: (a) Are under sixty-five years of age; (b) 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) 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.

Sec. 29. RCW 74.09.515 and 2007 c 359 s 8 are each amended to read as follows:

(1) The department <u>of social and health services</u> shall adopt rules and policies providing that when youth who were enrolled in a medical assistance program immediately prior to confinement are released from confinement, their medical assistance coverage will be fully reinstated on the day of their release, subject to any expedited review of their continued eligibility for medical assistance coverage that is required under federal or state law.

(2) The department <u>of social and health services</u>, in collaboration with county juvenile court administrators and regional support networks, shall establish procedures for coordination between department <u>of social and health services</u> field offices, juvenile rehabilitation administration institutions, and county juvenile courts that result in prompt reinstatement of eligibility and speedy

eligibility determinations for youth who are likely to be eligible for medical assistance services upon release from confinement. Procedures developed under this subsection must address:

(a) Mechanisms for receiving medical assistance services' applications on behalf of confined youth in anticipation of their release from confinement;

(b) Expeditious review of applications filed by or on behalf of confined youth and, to the extent practicable, completion of the review before the youth is released; and

(c) Mechanisms for providing medical assistance services' identity cards to youth eligible for medical assistance services immediately upon their release from confinement.

(3) For purposes of this section, "confined" or "confinement" means detained in a facility operated by or under contract with the department of social and health services, juvenile rehabilitation administration, or detained in a juvenile detention facility operated under chapter 13.04 RCW.

(4) The department of social and health services shall adopt standardized statewide screening and application practices and forms designed to facilitate the application of a confined youth who is likely to be eligible for a medical assistance program.

Sec. 30. RCW 74.09.520 and 2007 c 3 s 1 are each amended to read as follows:

(1) The term "medical assistance" may include the following care and services: (a) Inpatient hospital services; (b) outpatient hospital services; (c) other laboratory and X-ray services; (d) nursing facility services; (e) physicians' services, which shall include prescribed medication and instruction on birth control devices; (f) medical care, or any other type of remedial care as may be established by the ((~~secretary~~)) agency; (g) home health care services; (h) private duty nursing services; (i) dental services; (j) physical and occupational therapy and related services; (k) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select; (l) personal care services, as provided in this section; (m) hospice services; (n) other diagnostic, screening, preventive, and rehabilitative services; and (o) like services when furnished to a

child by a school district in a manner consistent with the requirements of this chapter. For the purposes of this section, the ((~~department~~)) agency may not cut off any prescription medications, oxygen supplies, respiratory services, or other life-sustaining medical services or supplies.

"Medical assistance," notwithstanding any other provision of law, shall not include routine foot care, or dental services delivered by any health care provider, that are not mandated by Title XIX of the social security act unless there is a specific appropriation for these services.

(2) The ((~~department~~)) agency shall amend the state plan for medical assistance under Title XIX of the federal social security act to include personal care services, as defined in 42 C.F.R. 440.170(f), in the categorically needy program.

(3) The ((~~department~~)) agency shall adopt, amend, or rescind such administrative rules as are necessary to ensure that Title XIX personal care services are provided to eligible persons in conformance with federal regulations.

(a) These administrative rules shall include financial eligibility indexed according to the requirements of the social security act providing for medicaid eligibility.

(b) The rules shall require clients be assessed as having a medical condition requiring assistance with personal care tasks. Plans of care for clients requiring health-related consultation for assessment and service planning may be reviewed by a nurse.

(c) The ((~~department~~)) agency shall determine by rule which clients have a health-related assessment or service planning need requiring registered nurse consultation or review. This definition may include clients that meet indicators or protocols for review, consultation, or visit.

(4) The ((~~department~~)) agency shall design and implement a means to assess the level of functional disability of persons eligible for personal care services under this section. The personal care services benefit shall be provided to the extent funding is available according to the assessed level of functional disability. Any reductions in services made necessary for funding reasons should be accomplished in a manner that assures that priority for maintaining services is given

to persons with the greatest need as determined by the assessment of functional disability.

(5) Effective July 1, 1989, the ((~~department~~)) agency shall offer hospice services in accordance with available funds.

(6) For Title XIX personal care services administered by ((~~aging and disability services administration of the department~~)) the agency, the ((~~department~~)) agency shall contract with area agencies on aging:

(a) To provide case management services to individuals receiving Title XIX personal care services in their own home; and

(b) To reassess and reauthorize Title XIX personal care services or other home and community services as defined in RCW 74.39A.009 in home or in other settings for individuals consistent with the intent of this section:

(i) Who have been initially authorized by the ((~~department~~)) agency to receive Title XIX personal care services or other home and community services as defined in RCW 74.39A.009; and

(ii) Who, at the time of reassessment and reauthorization, are receiving such services in their own home.

(7) In the event that an area agency on aging is unwilling to enter into or satisfactorily fulfill a contract or an individual consumer's need for case management services will be met through an alternative delivery system, the ((~~department~~)) agency is authorized to:

(a) Obtain the services through competitive bid; and

(b) Provide the services directly until a qualified contractor can be found.

(8) Subject to the availability of amounts appropriated for this specific purpose, effective July 1, 2007, the ((~~department~~)) agency may offer medicare part D prescription drug copayment coverage to full benefit dual eligible beneficiaries.

Sec. 31. RCW 74.09.521 and 2009 c 388 s 1 are each amended to read as follows:

(1) To the extent that funds are specifically appropriated for this purpose the ((~~department~~)) agency shall revise its medicaid healthy options managed care and fee-for-service program standards under medicaid, Title XIX of the federal social security act to improve access to mental health services for children who do not meet the regional support network access to care standards. Effective July 1,

2008, the program standards shall be revised to allow outpatient therapy services to be provided by licensed mental health professionals, as defined in RCW 71.34.020, or by a mental health professional regulated under Title 18 RCW who is under the direct supervision of a licensed mental health professional, and up to twenty outpatient therapy hours per calendar year, including family therapy visits integral to a child's treatment. This section shall be administered in a manner consistent with federal early periodic screening, diagnosis, and treatment requirements related to the receipt of medically necessary services when a child's need for such services is identified through developmental screening.

(2) The ((~~department~~)) agency and the children's mental health evidence-based practice institute established in RCW 71.24.061 shall collaborate to encourage and develop incentives for the use of prescribing practices and evidence-based and research-based treatment practices developed under RCW 74.09.490 by mental health professionals serving children under this section.

Sec. 32. 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~~)) agency 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~~)) agency 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~~)) agency shall not restrict a recipient's right to terminate enrollment in a system for good cause as established by the ((~~department~~)) agency 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~~)) agency 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~~)) agency 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~~)) agency shall seek waivers from federal requirements as necessary to implement this chapter;

(g) The ((~~department~~)) agency shall, wherever possible, enter into prepaid capitation contracts that include inpatient care. However, if this is not possible or feasible, the ((~~department~~)) agency may enter into prepaid capitation contracts that do not include inpatient care;

(h) The ((~~department~~)) agency 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~~)) agency from entering into similar agreements for other groups of people eligible to receive services under this chapter.

(3) The ((~~department~~)) agency 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~~)) agency shall coordinate its managed care activities with activities under chapter 70.47 RCW.

(4) The ((~~department~~)) agency 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~~)) agency in its healthy options managed health care purchasing efforts:

(a) All managed health care systems should have an opportunity to contract with the ((~~department~~)) agency to the extent that minimum contracting requirements defined by the ((~~department~~)) agency are met, at payment rates that enable the ((~~department~~)) agency 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~~)) agency, 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~~)) agency 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~~)) agency 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~~)) agency and contract bidders or the ((~~department~~)) agency 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~~)) agency 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~~)) agency 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. 33. RCW 74.09.5221 and 1997 c 231 s 112 are each amended to read as follows:

To the extent that federal statutes or regulations, or provisions of waivers granted to the ((~~department of social and health services~~)) agency by the federal department of health and human services, include standards that differ from the minimums stated in sections 101 through 106, 109, and 111 of this act, those sections do not apply to contracts with health carriers awarded pursuant to RCW 74.09.522.

Sec. 34. RCW 74.09.5222 and 2009 c 545 s 4 are each amended to read as follows:

(1) The ((~~department~~)) agency shall submit a section 1115 demonstration waiver request to the federal department of health and human services to expand and revise the medical assistance program as codified in Title XIX of the federal social security act. The waiver request should be designed to ensure the broadest federal financial participation under Title XIX and XXI of the federal social security act. To the extent permitted under federal law, the waiver request should include the following components:

(a) Establishment of a single eligibility standard for low-income persons, including expansion of categorical eligibility to include childless adults. The ((~~department~~)) agency shall request that the single eligibility standard be phased in such that incremental steps are taken to cover additional low-income parents and individuals over time, with the goal of offering coverage to persons with household income at or below two hundred percent of the federal poverty level;

(b) Establishment of a single seamless application and eligibility determination system for all state low-income medical programs included in the waiver. Applications may be electronic and may include an electronic signature for verification and authentication. Eligibility determinations should maximize federal financing where possible;

(c) The delivery of all low-income coverage programs as a single program, with a common core benefit package that may be similar to the basic health benefit package or an alternative benefit package approved by the secretary of the federal department of health and human services, including the option of supplemental coverage for select categorical groups, such as children, and individuals who are aged, blind, and disabled;

(d) A program design to include creative and innovative approaches such as: Coverage for preventive services with incentives to use appropriate preventive care; enhanced medical home reimbursement and bundled payment methodologies; cost-sharing options; use of care management and care coordination programs to improve coordination of medical and behavioral health services; application of an innovative predictive risk model to better target care management services; and mandatory enrollment in managed care, as may be necessary;

(e) The ability to impose enrollment limits or benefit design changes for eligibility groups that were not eligible under the Title XIX state plan in effect on the date of submission of the waiver application;

(f) A premium assistance program whereby employers can participate in coverage options for employees and dependents of employees otherwise eligible under the waiver. The waiver should make every effort to maximize enrollment in employer-sponsored health insurance when it is cost-effective for the state to do so, and the purchase is consistent with the requirements of Titles XIX and XXI of the federal social security act. To the extent allowable under federal law, the ((~~department~~)) agency shall require enrollment in available employer-sponsored coverage as a condition of eligibility for coverage under the waiver; and

(g) The ability to share savings that might accrue to the federal medicare program, Title XVIII of the federal social security act, from improved care management for persons who are eligible for both medicare and medicaid. Through the waiver application process, the ((~~department~~)) agency shall determine whether the state could serve, directly or by contract, as a medicare special needs plan for persons eligible for both medicare and medicaid.

(2) The ((~~department~~)) agency shall hold ongoing stakeholder discussions as it is developing the waiver request, and provide opportunities for public review and comment as the request is being developed.

(3) The ((~~department~~)) agency and the health care authority shall identify statutory changes that may be necessary to ensure successful and timely implementation of the waiver request as submitted to the federal department of health and human services as the apple health program for adults.

(4) The legislature must authorize implementation of any waiver approved by the federal department of health and human services under this section.

Sec. 35. RCW 74.09.5227 and 2001 2nd sp.s. c 2 s 3 are each amended to read as follows:

The ((~~department~~)) agency shall implement the program created in

RCW 74.09.5225 within sixty days of September 20, 2001, regardless of the beneficiary's managed care status.

Sec. 36. RCW 74.09.523 and 2001 c 191 s 2 are each amended to read as follows:

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "PACE" means the program of all-inclusive care for the elderly, a managed care medicare/medicaid program authorized under sections 1894, 1905(a), and 1934 of the social security act and administered by the ((~~department~~)) agency.

(b) "PACE program agreement" means an agreement between a PACE organization, the health care financing administration, and the ((~~department~~)) agency.

(2) A PACE program may operate in the state only in accordance with a PACE program agreement with the ((~~department~~)) agency.

(3) A PACE program shall at the time of entering into the initial PACE program agreement, and at each renewal thereof, demonstrate cash reserves to cover expenses in the event of insolvency.

(a) The cash reserves at a minimum shall equal the sum of:

(i) One month's total capitation revenue; and

(ii) One month's average payment to subcontractors.

(b) The program may demonstrate cash reserves to cover expenses of insolvency with one or more of the following: Reasonable and sufficient net worth, insolvency insurance, or parental guarantees.

(4) A PACE program must provide full disclosure regarding the terms of enrollment and the option to disenroll at any time to all persons who seek to participate or who are participants in the program.

Sec. 37. RCW 74.09.530 and 2007 c 315 s 2 are each amended to read as follows:

(1) The amount and nature of medical assistance and the determination of eligibility of recipients for medical assistance shall be the responsibility of the ((~~department of social and health services~~)) agency. The ((~~department~~)) agency shall establish reasonable standards of assistance and resource and income exemptions which shall be consistent with the provisions of the Social Security Act and with the regulations of the secretary of health, education and

welfare for determining eligibility of individuals for medical assistance and the extent of such assistance to the extent that funds are available from the state and federal government. The ((~~department~~)) agency shall not consider resources in determining continuing eligibility for recipients eligible under section 1931 of the social security act.

(2) Individuals eligible for medical assistance under RCW 74.09.510(3) shall be transitioned into coverage under that subsection immediately upon their termination from coverage under RCW 74.09.510(2)(a). The ((~~department~~)) agency shall use income eligibility standards and eligibility determinations applicable to children placed in foster care. The ((~~department~~)) agency, in consultation with the health care authority, shall provide information regarding basic health plan enrollment and shall offer assistance with the application and enrollment process to individuals covered under RCW 74.09.510(3) who are approaching their twenty-first birthday.

Sec. 38. RCW 74.09.540 and 2001 2nd sp.s. c 15 s 2 are each amended to read as follows:

(1) It is the intent of the legislature to remove barriers to employment for individuals with disabilities by providing medical assistance to ((~~the~~)) working ((~~disabled~~)) persons with disabilities through a buy-in program in accordance with section 1902(a)(10)(A)(ii) of the social security act and eligibility and cost-sharing requirements established by the ((~~department~~)) agency.

(2) The ((~~department~~)) agency shall establish income, resource, and cost-sharing requirements for the buy-in program in accordance with federal law and any conditions or limitations specified in the omnibus appropriations act. The ((~~department~~)) agency shall establish and modify eligibility and cost-sharing requirements in order to administer the program within available funds. The ((~~department~~)) agency shall make every effort to coordinate benefits with employer-sponsored coverage available to the working disabled receiving benefits under this chapter.

Sec. 39. RCW 74.09.555 and 2005 c 503 s 12 are each amended to read as follows:

(1) The ((~~department~~)) agency shall adopt rules and policies

providing that when persons with a mental disorder, who were enrolled in medical assistance immediately prior to confinement, are released from confinement, their medical assistance coverage will be fully reinstated on the day of their release, subject to any expedited review of their continued eligibility for medical assistance coverage that is required under federal or state law.

(2) The ((~~department~~)) agency, in collaboration with the Washington association of sheriffs and police chiefs, the department of corrections, and the regional support networks, shall establish procedures for coordination between ((~~department~~)) agency field offices, institutions for mental disease, and correctional institutions, as defined in RCW 9.94.049, that result in prompt reinstatement of eligibility and speedy eligibility determinations for persons who are likely to be eligible for medical assistance services upon release from confinement. Procedures developed under this subsection must address:

(a) Mechanisms for receiving medical assistance services applications on behalf of confined persons in anticipation of their release from confinement;

(b) Expeditious review of applications filed by or on behalf of confined persons and, to the extent practicable, completion of the review before the person is released;

(c) Mechanisms for providing medical assistance services identity cards to persons eligible for medical assistance services immediately upon their release from confinement; and

(d) Coordination with the federal social security administration, through interagency agreements or otherwise, to expedite processing of applications for federal supplemental security income or social security disability benefits, including federal acceptance of applications on behalf of confined persons.

(3) Where medical or psychiatric examinations during a person's confinement indicate that the person is disabled, the correctional institution or institution for mental diseases shall provide the ((~~department~~)) agency with that information for purposes of making medical assistance eligibility and enrollment determinations prior to the person's release from confinement. The ((~~department~~)) agency shall, to the maximum extent permitted by federal law, use the

examination in making its determination whether the person is disabled and eligible for medical assistance.

(4) For purposes of this section, "confined" or "confinement" means incarcerated in a correctional institution, as defined in RCW 9.94.049, or admitted to an institute for mental disease, as defined in 42 C.F.R. part 435, Sec. 1009 on July 24, 2005.

(5) For purposes of this section, "likely to be eligible" means that a person:

(a) Was enrolled in medicaid or supplemental security income or general assistance immediately before he or she was confined and his or her enrollment was terminated during his or her confinement; or

(b) Was enrolled in medicaid or supplemental security income or general assistance at any time during the five years before his or her confinement, and medical or psychiatric examinations during the person's confinement indicate that the person continues to be disabled and the disability is likely to last at least twelve months following release.

(6) The economic services administration shall adopt standardized statewide screening and application practices and forms designed to facilitate the application of a confined person who is likely to be eligible for medicaid.

Sec. 40. RCW 74.09.565 and 1989 c 87 s 4 are each amended to read as follows:

(1) An agreement between spouses transferring or assigning rights to future income from one spouse to the other shall be invalid for purposes of determining eligibility for medical assistance or the limited casualty program for the medically needy, but this subsection does not affect agreements between spouses transferring or assigning resources, and income produced by transferred or assigned resources shall continue to be recognized as the separate income of the transferee.

(2) In determining eligibility for medical assistance or the limited casualty program for the medically needy for a married person in need of institutional care, or care under home and community-based waivers as defined in Title XIX of the social security act, if the community income received in the name of the nonapplicant spouse

exceeds the community income received in the name of the applicant spouse, the applicant's interest in that excess shall be considered unavailable to the applicant.

(3) The ((~~department~~)) agency shall adopt rules consistent with the provisions of section 1924 of the social security act entitled "Treatment of Income and Resources for Certain Institutionalized Spouses," in determining the allocation of income between an institutionalized and community spouse.

(4) The ((~~department~~)) agency shall establish the monthly maintenance needs allowance for the community spouse up to the maximum amount allowed by state appropriation or within available funds and permitted in section 1924 of the social security act. The total monthly needs allowance shall not exceed one thousand five hundred dollars, subject to adjustment provided in section 1924 of the social security act.

Sec. 41. RCW 74.09.575 and 2003 1st sp.s. c 28 s 1 are each amended to read as follows:

(1) The ((~~department~~)) agency shall promulgate rules consistent with the treatment of resources provisions of section 1924 of the social security act entitled "Treatment of Income and Resources for Certain Institutionalized Spouses," in determining the allocation of resources between the institutionalized and community spouse.

(2) In the interest of supporting the community spouse the ((~~department~~)) agency shall allow the maximum resource allowance amount permissible under the social security act for the community spouse for persons institutionalized before August 1, 2003.

(3) For persons institutionalized on or after August 1, 2003, the ((~~department~~)) agency, in the interest of supporting the community spouse, shall allow up to a maximum of forty thousand dollars in resources for the community spouse. For the fiscal biennium beginning July 1, 2005, and each fiscal biennium thereafter, the maximum resource allowance amount for the community spouse shall be adjusted for economic trends and conditions by increasing the amount allowable by the consumer price index as published by the federal bureau of labor statistics. However, in no case shall the amount allowable exceed the maximum resource allowance permissible under the social security act.

Sec. 42. RCW 74.09.585 and 1995 1st sp.s. c 18 s 81 are each amended to read as follows:

(1) The ((~~department~~)) agency shall establish standards consistent with section 1917 of the social security act in determining the period of ineligibility for medical assistance due to the transfer of resources.

(2) There shall be no penalty imposed for the transfer of assets that are excluded in a determination of the individual's eligibility for medicaid to the extent such assets are protected by the long-term care insurance policy or contract pursuant to chapter 48.85 RCW.

(3) The ((~~department~~)) agency may waive a period of ineligibility if the ((~~department~~)) agency determines that denial of eligibility would work an undue hardship.

Sec. 43. RCW 74.09.595 and 1989 c 87 s 8 are each amended to read as follows:

The ((~~department~~)) agency shall in compliance with section 1924 of the social security act adopt procedures which provide due process for institutionalized or community spouses who request a fair hearing as to the valuation of resources, the amount of the community spouse resource allowance, or the monthly maintenance needs allowance.

Sec. 44. RCW 74.09.650 and 2003 1st sp.s. c 29 s 2 are each amended to read as follows:

(1) To the extent funds are appropriated specifically for this purpose, and subject to any conditions placed on appropriations made for this purpose, the ((~~department~~)) agency shall design a medicaid prescription drug assistance program. Neither the benefits of, nor eligibility for, the program is considered to be an entitlement.

(2) The ((~~department~~)) agency shall request any federal waiver necessary to implement this program. Consistent with federal waiver conditions, the ((~~department~~)) agency may charge enrollment fees, premiums, or point-of-service cost-sharing to program enrollees.

(3) Eligibility for this program is limited to persons:

(a) Who are eligible for medicare or age sixty-five and older;

(b) Whose family income does not exceed two hundred percent of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services;

(c) Who lack insurance that provides prescription drug coverage; and

(d) Who are not otherwise eligible under Title XIX of the federal social security act.

(4) The ((~~department~~)) agency shall use a cost-effective prescription drug benefit design. Consistent with federal waiver conditions, this benefit design may be different than the benefit design offered under the medical assistance program. The benefit design may include a deductible benefit that provides coverage when enrollees incur higher prescription drug costs as defined by the ((~~department~~)) agency. The ((~~department~~)) agency also may offer more than one benefit design.

(5) The ((~~department~~)) agency shall limit enrollment of persons who qualify for the program so as to prevent an overexpenditure of appropriations for this program or to assure necessary compliance with federal waiver budget neutrality requirements. The ((~~department~~)) agency may not reduce existing medical assistance program eligibility or benefits to assure compliance with federal waiver budget neutrality requirements.

(6) Premiums paid by medicaid enrollees not in the medicaid prescription drug assistance program may not be used to finance the medicaid prescription drug assistance program.

(7) This program will be terminated within twelve months after implementation of a prescription drug benefit under Title XVIII of the federal social security act.

(8) The ((~~department~~)) agency shall provide recommendations to the appropriate committees of the senate and house of representatives by November 15, 2003, on financing options available to support the medicaid prescription drug assistance program. In recommending financing options, the ((~~department~~)) agency shall explore every opportunity to maximize federal funding to support the program.

Sec. 45. RCW 74.09.655 and 2008 c 245 s 1 are each amended to read as follows:

The ((~~department~~)) agency shall provide coverage under this chapter for smoking cessation counseling services, as well as prescription and nonprescription agents when used to promote smoking cessation, so long as such agents otherwise meet the definition of "covered outpatient

drug" in 42 U.S.C. Sec. 1396r-8(k). However, the ((~~department~~)) agency may initiate an individualized inquiry and determine and implement by rule appropriate coverage limitations as may be required to encourage the use of effective, evidence-based services and prescription and nonprescription agents. The ((~~department~~)) agency shall track per-capita expenditures for a cohort of clients that receive smoking cessation benefits, and submit a cost-benefit analysis to the legislature on or before January 1, 2012.

Sec. 46. RCW 74.09.658 and 2009 c 326 s 1 are each amended to read as follows:

(1) The home health program shall require registered nurse oversight and intervention, as appropriate. In-person contact between a home health care registered nurse and a patient is not required under the state's medical assistance program for home health services that are: (a) Delivered with the assistance of telemedicine and (b) otherwise eligible for reimbursement as a medically necessary skilled home health nursing visit under the program.

(2) The ((~~department~~)) agency in consultation with home health care service providers shall develop reimbursement rules and, in rule, define the requirements that must be met for a reimbursable skilled nursing visit when services are rendered without a face-to-face visit and are assisted by telemedicine.

(3)(a) The ((~~department~~)) agency shall establish the reimbursement rate for skilled home health nursing services delivered with the assistance of telemedicine that meet the requirements of a reimbursable visit as defined by the ((~~department~~)) agency.

(b) Reimbursement is not provided for purchase or lease of telemedicine equipment.

(4) Any home health agency licensed under chapter 70.127 RCW and eligible for reimbursement under the medical programs authorized under this chapter may be reimbursed for services under this section if the service meets the requirements for a reimbursable skilled nursing visit as defined by the ((~~department~~)) agency.

(5) Nothing in this section shall be construed to alter the scope of practice of any home health care services provider or authorizes the delivery of home health care services in a setting or manner not otherwise authorized by law.

(6) The use of telemedicine is not intended to replace registered nurse health care ((~~visit[s]~~)) visits when necessary.

(7) For the purposes of this section, "telemedicine" means the use of telemonitoring to enhance the delivery of certain home health medical services through:

(a) The provision of certain education related to health care services using audio, video, or data communication instead of a face-to-face visit; or

(b) The collection of clinical data and the transmission of such data between a patient at a distant location and the home health provider through electronic processing technologies. Objective clinical data that may be transmitted includes, but is not limited to, weight, blood pressure, pulse, respirations, blood glucose, and pulse oximetry.

Sec. 47. RCW 74.09.659 and 2009 c 545 s 5 are each amended to read as follows:

(1) The ((~~department~~)) agency shall continue to submit applications for the family planning waiver program.

(2) The ((~~department~~)) agency shall submit a request to the federal department of health and human services to amend the current family planning waiver program as follows:

(a) Provide coverage for sexually transmitted disease testing and treatment;

(b) Return to the eligibility standards used in 2005 including, but not limited to, citizenship determination based on declaration or matching with federal social security databases, insurance eligibility standards comparable to 2005, and confidential service availability for minors and survivors of domestic and sexual violence; and

(c) Within available funds, increase income eligibility to two hundred fifty percent of the federal poverty level, to correspond with income eligibility for publicly funded maternity care services.

Sec. 48. RCW 74.09.660 and 2003 1st sp.s. c 29 s 8 are each amended to read as follows:

Each of the state's area agencies on aging shall implement a program intended to inform and train persons sixty-five years of age and older in the safe and appropriate use of prescription and

nonprescription medications. To further this purpose, the ((~~department~~)) agency shall award development grants averaging up to twenty-five thousand dollars to each of the agencies upon a showing that:

(1) The area agency on aging has the ability to effectively administer such a program, including an understanding of the relevant issues and appropriate outreach and follow-up;

(2) The area agency on aging can bring resources to the program in addition to those funded by the grant; and

(3) The program will be a collaborative effort between the agency and other health care programs and providers in the location to be served, including doctors, pharmacists, and long-term care providers.

Sec. 49. RCW 74.09.700 and 2001 c 269 s 1 are each amended to read as follows:

(1) To the extent of available funds and subject to any conditions placed on appropriations made for this purpose, medical care may be provided under the limited casualty program to persons not otherwise eligible for medical assistance or medical care services who are medically needy as defined in the social security Title XIX state plan and medical indigents in accordance with eligibility requirements established by the ((~~department~~)) agency. The eligibility requirements may include minimum levels of incurred medical expenses. This includes residents of nursing facilities, residents of intermediate care facilities for the mentally retarded, and individuals who are otherwise eligible for section 1915(c) of the federal social security act home and community-based waiver services, administered by the department of social and health services aging and adult services administration, who are aged, blind, or disabled as defined in Title XVI of the federal social security act and whose income exceeds three hundred percent of the federal supplement security income benefit level.

(2) Determination of the amount, scope, and duration of medical coverage under the limited casualty program shall be the responsibility of the ((~~department~~)) agency, subject to the following:

(a) Only the following services may be covered:

(i) For persons who are medically needy as defined in the social security Title XIX state plan: Inpatient and outpatient hospital services, and home and community-based waiver services;

(ii) For persons who are medically needy as defined in the social security Title XIX state plan, and for persons who are medical indigents under the eligibility requirements established by the ((~~department~~)) agency: Rural health clinic services; physicians' and clinic services; prescribed drugs, dentures, prosthetic devices, and eyeglasses; nursing facility services; and intermediate care facility services for the mentally retarded; home health services; hospice services; other laboratory and X-ray services; rehabilitative services, including occupational therapy; medically necessary transportation; and other services for which funds are specifically provided in the omnibus appropriations act;

(b) Medical care services provided to the medically indigent and received no more than seven days prior to the date of application shall be retroactively certified and approved for payment on behalf of a person who was otherwise eligible at the time the medical services were furnished: PROVIDED, That eligible persons who fail to apply within the seven-day time period for medical reasons or other good cause may be retroactively certified and approved for payment.

(3) The ((~~department~~)) agency shall establish standards of assistance and resource and income exemptions. All nonexempt income and resources of limited casualty program recipients shall be applied against the cost of their medical care services.

Sec. 50. RCW 74.09.710 and 2007 c 259 s 4 are each amended to read as follows:

(1) The ((~~department of social and health services~~)) agency, in collaboration with the department of health, shall:

(a) Design and implement medical homes for its aged, blind, and disabled clients in conjunction with chronic care management programs to improve health outcomes, access, and cost-effectiveness. Programs must be evidence based, facilitating the use of information technology to improve quality of care, must acknowledge the role of primary care providers and include financial and other supports to enable these providers to effectively carry out their role in chronic care management, and must improve coordination of primary, acute, and long-term care for those clients with multiple chronic conditions. The ((~~department~~)) agency shall consider expansion of existing medical home and chronic care management programs and build on the Washington state

collaborative initiative. The ((~~department~~)) agency shall use best practices in identifying those clients best served under a chronic care management model using predictive modeling through claims or other health risk information; and

(b) Evaluate the effectiveness of current chronic care management efforts in the health and recovery services administration and the aging and disability services administration, comparison to best practices, and recommendations for future efforts and organizational structure to improve chronic care management.

(2) For purposes of this section:

(a) "Medical home" means a site of care that provides comprehensive preventive and coordinated care centered on the patient needs and assures high quality, accessible, and efficient care.

(b) "Chronic care management" means the ((~~department's~~)) agency's program that provides care management and coordination activities for medical assistance clients determined to be at risk for high medical costs. "Chronic care management" provides education and training and/or coordination that assist program participants in improving self-management skills to improve health outcomes and reduce medical costs by educating clients to better utilize services.

Sec. 51. RCW 74.09.715 and 2008 c 146 s 13 are each amended to read as follows:

Within funds appropriated for this purpose, the ((~~department~~)) agency shall establish two dental access projects to serve seniors and other adults who are categorically needy blind or disabled. The projects shall provide:

(1) Enhanced reimbursement rates for certified dentists for specific procedures, to begin no sooner than July 1, 2009;

(2) Reimbursement for trained medical providers for preventive oral health services, to begin no sooner than July 1, 2009;

(3) Training, development, and implementation through a partnership with the University of Washington school of dentistry;

(4) Local program coordination including outreach and case management; and

(5) An evaluation that measures the change in utilization rates and cost savings.

Sec. 52. RCW 74.09.725 and 2006 c 367 s 8 are each amended to read as follows:

The ((~~department~~)) agency shall provide coverage for prostate cancer screening under this chapter, provided that the screening is delivered upon the recommendation of the patient's physician, advanced registered nurse practitioner, or physician assistant.

Sec. 53. RCW 74.09.730 and 2009 c 538 s 1 are each amended to read as follows:

In establishing Title XIX payments for inpatient hospital services:

(1) To the extent funds are appropriated specifically for this purpose, and subject to any conditions placed on appropriations made for this purpose, the ((~~department of social and health services~~)) agency shall provide a disproportionate share hospital adjustment considering the following components:

(a) A low-income care component based on a hospital's medicaid utilization rate, its low-income utilization rate, its provision of obstetric services, and other factors authorized by federal law;

(b) A medical indigency care component based on a hospital's services to persons who are medically indigent; and

(c) A state-only component, to be paid from available state funds to hospitals that do not qualify for federal payments under (b) of this subsection, based on a hospital's services to persons who are medically indigent;

(2) The payment methodology for disproportionate share hospitals shall be specified by the ((~~department~~)) agency in regulation.

Sec. 54. RCW 74.09.755 and 1989 c 427 s 12 are each amended to read as follows:

The ((~~department~~)) agency shall prepare and request a waiver under section 1915(c) of the federal social security act to provide community based long-term care services to persons with AIDS or AIDS-related conditions who qualify for the medical assistance program under RCW 74.09.510 or the limited casualty program for the medically needy under RCW 74.09.700. Respite services shall be included as a service available under the waiver.

Sec. 55. RCW 74.09.790 and 1993 c 407 s 9 are each amended to read as follows:

Unless the context clearly requires otherwise, the definitions in this section apply throughout RCW 74.09.760 through 74.09.820 and 74.09.510:

(1) "At-risk eligible person" means an eligible person determined by the ((~~department~~)) agency to need special assistance in applying for and obtaining maternity care, including pregnant women who are substance abusers, pregnant and parenting adolescents, pregnant minority women, and other eligible persons who need special assistance in gaining access to the maternity care system.

(2) "County authority" means the board of county commissioners, county council, or county executive having the authority to participate in the maternity care access program or its designee. Two or more county authorities may enter into joint agreements to fulfill the requirements of this chapter.

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

~~(4)~~)) "Eligible person" means a woman in need of maternity care or a child, who is eligible for medical assistance pursuant to this chapter or the prenatal care program administered by the ((~~department~~)) agency.

((~~(5)~~)) (4) "Maternity care services" means inpatient and outpatient medical care, case management, and support services necessary during prenatal, delivery, and postpartum periods.

((~~(6)~~)) (5) "Support services" means, at least, public health nursing assessment and follow-up, health and childbirth education, psychological assessment and counseling, outreach services, nutritional assessment and counseling, needed vitamin and nonprescriptive drugs, transportation, family planning services, and child care. Support services may include alcohol and substance abuse treatment for pregnant women who are addicted or at risk of being addicted to alcohol or drugs to the extent funds are made available for that purpose.

((~~(7)~~)) (6) "Family planning services" means planning the number of one's children by use of contraceptive techniques.

Sec. 56. RCW 74.09.800 and 1993 c 407 s 10 are each amended to read as follows:

The ((~~department~~)) agency shall, consistent with the state budget act, develop a maternity care access program designed to ensure healthy birth outcomes as follows:

(1) Provide maternity care services to low-income pregnant women and health care services to children in poverty to the maximum extent allowable under the medical assistance program, Title XIX of the federal social security act;

(2) Provide maternity care services to low-income women who are not eligible to receive such services under the medical assistance program, Title XIX of the federal social security act;

(3) By January 1, 1990, have the following procedures in place to improve access to maternity care services and eligibility determinations for pregnant women applying for maternity care services under the medical assistance program, Title XIX of the federal social security act:

(a) Use of a shortened and simplified application form;

(b) Outstationing ((~~department~~)) agency staff to make eligibility determinations;

(c) Establishing local plans at the county and regional level, coordinated by the ((~~department~~)) agency; and

(d) Conducting an interview for the purpose of determining medical assistance eligibility within five working days of the date of an application by a pregnant woman and making an eligibility determination within fifteen working days of the date of application by a pregnant woman;

(4) Establish a maternity care case management system that shall assist at-risk eligible persons with obtaining medical assistance benefits and receiving maternity care services, including transportation and child care services;

(5) Within available resources, establish appropriate reimbursement levels for maternity care providers;

(6) Implement a broad-based public education program that stresses the importance of obtaining maternity care early during pregnancy;

(7) Refer persons eligible for maternity care services under the program established by this section to persons, agencies, or organizations with maternity care service practices that primarily emphasize healthy birth outcomes;

(8) Provide family planning services including information about the synthetic progestin capsule implant form of contraception, for twelve months immediately following a pregnancy to women who were eligible for medical assistance under the maternity care access program during that pregnancy or who were eligible only for emergency labor and delivery services during that pregnancy; and

(9) Within available resources, provide family planning services to women who meet the financial eligibility requirements for services under subsections (1) and (2) of this section.

Sec. 57. RCW 74.09.810 and 1989 1st ex.s. c 10 s 6 are each amended to read as follows:

(1) The ((~~department~~)) agency shall establish an alternative maternity care service delivery system, if it determines that a county or a group of counties is a maternity care distressed area. A maternity care distressed area shall be defined by the ((~~department~~)) agency, in rule, as a county or a group of counties where eligible women are unable to obtain adequate maternity care. The ((~~department~~)) agency shall include the following factors in its determination:

(a) Higher than average percentage of eligible persons in the distressed area who receive late or no prenatal care;

(b) Higher than average percentage of eligible persons in the distressed area who go out of the area to receive maternity care;

(c) Lower than average percentage of obstetrical care providers in the distressed area who provide care to eligible persons;

(d) Higher than average percentage of infants born to eligible persons per obstetrical care provider in the distressed area; and

(e) Higher than average percentage of infants that are of low birth weight, five and one-half pounds or two thousand five hundred grams, born to eligible persons in the distressed area.

(2) If the ((~~department~~)) agency determines that a maternity care distressed area exists, it shall notify the relevant county authority. The county authority shall, within one hundred twenty days, submit a brief report to the ((~~department~~)) agency recommending remedial action. The report shall be prepared in consultation with the ((~~department~~)) agency and its local community service offices, the local public health officer, community health clinics, health care providers, hospitals, the business community, labor representatives, and low-income advocates

in the distressed area. A county authority may contract with a local nonprofit entity to develop the report. If the county authority is unwilling or unable to develop the report, it shall notify the ((~~department~~)) agency within thirty days, and the ((~~department~~)) agency shall develop the report for the distressed area.

(3) The ((~~department~~)) agency shall review the report and use it, to the extent possible, in developing strategies to improve maternity care access in the distressed area. The ((~~department~~)) agency may contract with or directly employ qualified maternity care health providers to provide maternity care services, if access to such providers in the distressed area is not possible by other means. In such cases, the ((~~department~~)) agency is authorized to pay that portion of the health care providers' malpractice liability insurance that represents the percentage of maternity care provided to eligible persons by that provider through increased medical assistance payments.

Sec. 58. RCW 74.09.820 and 1989 1st ex.s. c 10 s 7 are each amended to read as follows:

To the extent that federal matching funds are available, the ((~~department~~)) agency or the department of health ((~~if one is created~~)) shall establish, in consultation with the health science programs of the state's colleges and universities, and community health clinics, a loan repayment program that will encourage maternity care providers to practice in medically underserved areas in exchange for repayment of part or all of their health education loans.

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