SSB 5394 - H COMM AMD
By Committee on Health Care & Wellness

NOT CONSIDERED 04/07/2011

1 Strike everything after the enacting clause and insert the
2 following:

3 "NEW SECTION. **Sec. 1.** A new section is added to chapter 74.09 RCW
4 to read as follows:
5 The legislature finds that:
6 (1) Health care costs are growing rapidly, exceeding the consumer
7 price index year after year. Consequently, state health programs are
8 capturing a growing share of the state budget, even as state revenues
9 have declined. Sustaining these critical health programs will require
10 actions to effectively contain health care cost increases in the
11 future; and
12 (2) The primary care health home model has been demonstrated to
13 successfully constrain costs, while improving quality of care. Chronic
14 care management, occurring within a primary care health home, has been
15 shown to be especially effective at reducing costs and improving
16 quality. However, broad adoption of these models has been impeded by
17 a fee-for-service system that reimburses volume of services and does
18 not adequately support important primary care health home services,
19 such as case management and patient outreach. Furthermore, successful
20 implementation will require a broad adoption effort by private and
21 public payers, in coordination with providers.
22 Therefore the legislature intends to promote the adoption of
23 primary care health homes for children and adults and, within them,
24 advance the practice of chronic care management to improve health
25 outcomes and reduce unnecessary costs. To facilitate the best
26 coordination and patient care, primary care health homes are encouraged
27 to collaborate with other providers currently outside the medical
28 insurance model. Successful chronic care management for persons
29 receiving long-term care services in addition to medical care will
30 require close coordination between primary care providers, long-term

care workers, and other long-term care service providers, including area agencies on aging. Primary care providers also should consider oral health coordination through collaboration with dental providers and, when possible, delivery of oral health prevention services. The legislature also intends that the methods and approach of the primary care health home become part of basic primary care medical education.

Sec. 2. RCW 74.09.010 and 2010 1st sp.s. c 8 s 28 are each reenacted and amended to read as follows:

((~~As used in this chapter:~~)) The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

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

~~(3)~~)) "Chronic care management" means the health care management within a health home of persons identified with, or at high risk for, one or more chronic conditions. Effective chronic care management:

(a) Actively assists patients to acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability;

(b) Employs evidence-based clinical practices;

(c) Coordinates care across health care settings and providers, including tracking referrals;

(d) Provides ready access to behavioral health services that are, to the extent possible, integrated with primary care; and

(e) Uses appropriate community resources to support individual patients and families in managing chronic conditions.

(3) "Chronic condition" means a prolonged condition and includes, but is not limited to:

(a) A mental health condition;

(b) A substance use disorder;

(c) Asthma;

1 (d) Diabetes;
2 (e) Heart disease; and
3 (f) Being overweight, as evidenced by a body mass index over
4 twenty-five.
5 (4) "County" means the board of county commissioners, county
6 council, county executive, or tribal jurisdiction, or its designee. A
7 combination of two or more county authorities or tribal jurisdictions
8 may enter into joint agreements ((to fulfill the requirements of RCW
9 74.09.415 through 74.09.435)).
10 (((4))) (5) "Department" means the department of social and health
11 services.
12 (((5))) (6) "Department of health" means the Washington state
13 department of health created pursuant to RCW 43.70.020.
14 (((6))) (7) "Full benefit dual eligible beneficiary" means an
15 individual who, for any month: Has coverage for the month under a
16 medicare prescription drug plan or medicare advantage plan with part D
17 coverage; and is determined eligible by the state for full medicaid
18 benefits for the month under any eligibility category in the state's
19 medicaid plan or a section 1115 demonstration waiver that provides
20 pharmacy benefits.
21 (((7))) (8) "Health home" or "primary care health home" means
22 coordinated health care provided by a licensed primary care provider
23 coordinating all medical care services, and a multidisciplinary health
24 care team comprised of clinical and nonclinical staff. The term
25 "coordinating all medical care services" shall not be construed to
26 require prior authorization by a primary care provider in order for a
27 patient to receive treatment for covered services by an optometrist
28 licensed under chapter 18.53 RCW. At a minimum, primary care health
29 home services include:
30 (a) Comprehensive care management including, but not limited to,
31 chronic care treatment and management;
32 (b) Extended hours of service;
33 (c) Multiple ways for patients to communicate with the team,
34 including electronically and by phone;
35 (d) Education of patients on self-care, prevention, and health
36 promotion, including the use of patient decision aids;
37 (e) Coordinating and assuring smooth transitions and follow-up from
38 inpatient to other settings;

(f) Individual and family support including authorized representatives;

(g) The use of information technology to link services, track tests, generate patient registries, and provide clinical data; and

(h) Ongoing performance reporting and quality improvement.

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

((~~(8)~~)) (10) "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.

((~~(9)~~)) (11) "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.

((~~(10)~~)) (12) "Medical care services" means the limited scope of care financed by state funds and provided to disability lifeline benefits recipients, and recipients of alcohol and drug addiction services provided under chapter 74.50 RCW.

((~~(11)~~)) (13) "Multidisciplinary health care team" means an interdisciplinary team of health professionals which may include, but is not limited to, medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers including substance use disorder prevention and treatment providers, doctors of chiropractic, physical therapists, licensed complementary and alternative medicine practitioners, home care and other long-term care providers, and physicians' assistants.

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

((~~(12)~~)) (15) "Poverty" means the federal poverty level determined annually by the United States department of health and human services, or successor agency.

((~~(13)~~)) (16) "Primary care provider" means a general practice physician, family practitioner, internist, pediatrician, osteopath, naturopath, physician assistant, osteopathic physician assistant, and advanced registered nurse practitioner licensed under Title 18 RCW.

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

Sec. 3. RCW 43.70.533 and 2007 c 259 s 5 are each amended to read as follows:

(1) The department shall conduct a program of training and technical assistance regarding care of people with chronic conditions for providers of primary care. The program shall emphasize evidence-based high quality preventive and chronic disease care and shall collaborate with the health care authority to promote the adoption of primary care health homes established under this act. The department may designate one or more chronic conditions to be the subject of the program.

(2) The training and technical assistance program shall include the following elements:

(a) Clinical information systems and sharing and organization of patient data;

(b) Decision support to promote evidence-based care;

(c) Clinical delivery system design;

(d) Support for patients managing their own conditions; and

(e) Identification and use of community resources that are available in the community for patients and their families.

(3) In selecting primary care providers to participate in the program, the department shall consider the number and type of patients with chronic conditions the provider serves, and the provider's participation in the medicaid program, the basic health plan, and health plans offered through the public employees' benefits board.

(4) For the purposes of this section, "health home" and "primary care provider" have the same meaning as in RCW 74.09.010.

Sec. 4. RCW 74.09.522 and 1997 c 59 s 15 and 1997 c 34 s 1 are each reenacted and amended to read as follows:

(1) For the purposes of this section, "managed health care system" means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, health insuring organizations, or any combination thereof, that provides directly or by contract health care services covered under RCW 74.09.520 and rendered by licensed providers, on a prepaid capitated basis and that meets the requirements of section 1903(m)(1)(A) of Title XIX of the federal social security act or

1 federal demonstration waivers granted under section 1115(a) of Title XI
2 of the federal social security act.
3 (2) The department of social and health services shall enter into
4 agreements with managed health care systems to provide health care
5 services to recipients of temporary assistance for needy families under
6 the following conditions:
7 (a) Agreements shall be made for at least thirty thousand
8 recipients statewide;
9 (b) Agreements in at least one county shall include enrollment of
10 all recipients of temporary assistance for needy families;
11 (c) To the extent that this provision is consistent with section
12 1903(m) of Title XIX of the federal social security act or federal
13 demonstration waivers granted under section 1115(a) of Title XI of the
14 federal social security act, recipients shall have a choice of systems
15 in which to enroll and shall have the right to terminate their
16 enrollment in a system: PROVIDED, That the department may limit
17 recipient termination of enrollment without cause to the first month of
18 a period of enrollment, which period shall not exceed twelve months:
19 AND PROVIDED FURTHER, That the department shall not restrict a
20 recipient's right to terminate enrollment in a system for good cause as
21 established by the department by rule;
22 (d) To the extent that this provision is consistent with section
23 1903(m) of Title XIX of the federal social security act, participating
24 managed health care systems shall not enroll a disproportionate number
25 of medical assistance recipients within the total numbers of persons
26 served by the managed health care systems, except as authorized by the
27 department under federal demonstration waivers granted under section
28 1115(a) of Title XI of the federal social security act;
29 (e)(i) In negotiating with managed health care systems the
30 department shall adopt a uniform procedure to ((~~negotiate and~~)) enter
31 into contractual arrangements, to be included in contracts issued or
32 renewed on or after January 1, 2012, including:
33 (A) Standards regarding the quality of services to be provided;
34 ((~~and~~))
35 (B) The financial integrity of the responding system;
36 (C) Provider reimbursement methods that incentivize chronic care
37 management within health homes;

1 (D) Provider reimbursement methods that reward health homes that, 2 by using chronic care management, reduce emergency department and 3 inpatient use; and

4 (E) Promoting provider participation in the program of training and 5 technical assistance regarding care of people with chronic conditions 6 described in RCW 43.70.533, including allocation of funds to support 7 provider participation in the training, unless the managed care system 8 is an integrated health delivery system that has programs in place for 9 chronic care management.

10 (ii)(A) Health home services contracted for under this subsection 11 may be prioritized to enrollees with complex, high cost, or multiple 12 chronic conditions.

13 (B) Contracts that include the items in (e)(i)(C) through (E) of 14 this subsection must not exceed the rates that would be paid in the 15 absence of these provisions;

16 (f) The department shall seek waivers from federal requirements as 17 necessary to implement this chapter;

18 (g) The department shall, wherever possible, enter into prepaid 19 capitation contracts that include inpatient care. However, if this is 20 not possible or feasible, the department may enter into prepaid 21 capitation contracts that do not include inpatient care;

22 (h) The department shall define those circumstances under which a 23 managed health care system is responsible for out-of-plan services and 24 assure that recipients shall not be charged for such services; ((~~and~~))

25 (i) Nothing in this section prevents the department from entering 26 into similar agreements for other groups of people eligible to receive 27 services under this chapter; and

28 (j) The department must consult with the federal center for 29 medicare and medicaid innovation and seek funding opportunities to 30 support health homes.

31 (3) The department shall ensure that publicly supported community 32 health centers and providers in rural areas, who show serious intent 33 and apparent capability to participate as managed health care systems 34 are seriously considered as contractors. The department shall 35 coordinate its managed care activities with activities under chapter 36 70.47 RCW.

37 (4) The department shall work jointly with the state of Oregon and 38 other states in this geographical region in order to develop

1 recommendations to be presented to the appropriate federal agencies and
2 the United States congress for improving health care of the poor, while
3 controlling related costs.

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

14 (a) All managed health care systems should have an opportunity to
15 contract with the department to the extent that minimum contracting
16 requirements defined by the department are met, at payment rates that
17 enable the department to operate as far below appropriated spending
18 levels as possible, consistent with the principles established in this
19 section.

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

23 (i) Demonstrated commitment to or experience in serving low-income
24 populations;

25 (ii) Quality of services provided to enrollees;

26 (iii) Accessibility, including appropriate utilization, of services
27 offered to enrollees;

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

30 (v) Payment rates; and

31 (vi) The ability to meet other specifically defined contract
32 requirements established by the department, including consideration of
33 past and current performance and participation in other state or
34 federal health programs as a contractor.

35 (c) Consideration should be given to using multiple year
36 contracting periods.

37 (d) Quality, accessibility, and demonstrated commitment to serving

1 low-income populations shall be given significant weight in the
2 contracting, evaluation, and assignment process.
3 (e) All contractors that are regulated health carriers must meet
4 state minimum net worth requirements as defined in applicable state
5 laws. The department shall adopt rules establishing the minimum net
6 worth requirements for contractors that are not regulated health
7 carriers. This subsection does not limit the authority of the
8 department to take action under a contract upon finding that a
9 contractor's financial status seriously jeopardizes the contractor's
10 ability to meet its contract obligations.
11 (f) Procedures for resolution of disputes between the department
12 and contract bidders or the department and contracting carriers related
13 to the award of, or failure to award, a managed care contract must be
14 clearly set out in the procurement document. In designing such
15 procedures, the department shall give strong consideration to the
16 negotiation and dispute resolution processes used by the Washington
17 state health care authority in its managed health care contracting
18 activities.
19 (6) The department may apply the principles set forth in subsection
20 (5) of this section to its managed health care purchasing efforts on
21 behalf of clients receiving supplemental security income benefits to
22 the extent appropriate.

23 **Sec. 5.** RCW 70.47.100 and 2009 c 568 s 5 are each amended to read
24 as follows:
25 (1) A managed health care system participating in the plan shall do
26 so by contract with the administrator and shall provide, directly or by
27 contract with other health care providers, covered basic health care
28 services to each enrollee covered by its contract with the
29 administrator as long as payments from the administrator on behalf of
30 the enrollee are current. A participating managed health care system
31 may offer, without additional cost, health care benefits or services
32 not included in the schedule of covered services under the plan. A
33 participating managed health care system shall not give preference in
34 enrollment to enrollees who accept such additional health care benefits
35 or services. Managed health care systems participating in the plan
36 shall not discriminate against any potential or current enrollee based
37 upon health status, sex, race, ethnicity, or religion. The

1 administrator may receive and act upon complaints from enrollees
2 regarding failure to provide covered services or efforts to obtain
3 payment, other than authorized copayments, for covered services
4 directly from enrollees, but nothing in this chapter empowers the
5 administrator to impose any sanctions under Title 18 RCW or any other
6 professional or facility licensing statute.
7 (2) The plan shall allow, at least annually, an opportunity for
8 enrollees to transfer their enrollments among participating managed
9 health care systems serving their respective areas. The administrator
10 shall establish a period of at least twenty days in a given year when
11 this opportunity is afforded enrollees, and in those areas served by
12 more than one participating managed health care system the
13 administrator shall endeavor to establish a uniform period for such
14 opportunity. The plan shall allow enrollees to transfer their
15 enrollment to another participating managed health care system at any
16 time upon a showing of good cause for the transfer.
17 (3) Prior to negotiating with any managed health care system, the
18 administrator shall determine, on an actuarially sound basis, the
19 reasonable cost of providing the schedule of basic health care
20 services, expressed in terms of upper and lower limits, and recognizing
21 variations in the cost of providing the services through the various
22 systems and in different areas of the state.
23 (4) In negotiating with managed health care systems for
24 participation in the plan, the administrator shall adopt a uniform
25 procedure that includes at least the following:
26 (a) The administrator shall issue a request for proposals,
27 including standards regarding the quality of services to be provided;
28 financial integrity of the responding systems; and responsiveness to
29 the unmet health care needs of the local communities or populations
30 that may be served;
31 (b) The administrator shall then review responsive proposals and
32 may negotiate with respondents to the extent necessary to refine any
33 proposals;
34 (c) The administrator may then select one or more systems to
35 provide the covered services within a local area; and
36 (d) The administrator may adopt a policy that gives preference to
37 respondents, such as nonprofit community health clinics, that have a

history of providing quality health care services to low-income persons.

(5)(a) The administrator may contract with a managed health care system to provide covered basic health care services to subsidized enrollees, nonsubsidized enrollees, health coverage tax credit eligible enrollees, or any combination thereof. At a minimum, such contracts issued on or after January 1, 2012, must include:

(i) Provider reimbursement methods that incentivize chronic care management within health homes;

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

(iii) Promoting provider participation in the program of training and technical assistance regarding care of people with chronic conditions described in RCW 43.70.533, including allocation of funds to support provider participation in the training unless the managed care system is an integrated health delivery system that has programs in place for chronic care management.

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

(c) For the purposes of this subsection, "chronic care management," "chronic condition," and "health home" have the same meaning as in RCW 74.09.010.

(d) Contracts that include the items in (a)(i) through (iii) of this subsection must not exceed the rates that would be paid in the absence of these provisions.

(6) The administrator may establish procedures and policies to further negotiate and contract with managed health care systems following completion of the request for proposal process in subsection (4) of this section, upon a determination by the administrator that it is necessary to provide access, as defined in the request for proposal documents, to covered basic health care services for enrollees.

(7) The administrator may implement a self-funded or self-insured method of providing insurance coverage to subsidized enrollees, as provided under RCW 41.05.140. Prior to implementing a self-funded or self-insured method, the administrator shall ensure that funding available in the basic health plan self-insurance reserve account is

1 sufficient for the self-funded or self-insured risk assumed, or
2 expected to be assumed, by the administrator. If implementing a self-
3 funded or self-insured method, the administrator may request funds to
4 be moved from the basic health plan trust account or the basic health
5 plan subscription account to the basic health plan self-insurance
6 reserve account established in RCW 41.05.140.

7 **Sec. 6.** RCW 41.05.021 and 2009 c 537 s 4 are each amended to read
8 as follows:
9 (1) The Washington state health care authority is created within
10 the executive branch. The authority shall have an administrator
11 appointed by the governor, with the consent of the senate. The
12 administrator shall serve at the pleasure of the governor. The
13 administrator may employ up to seven staff members, who shall be exempt
14 from chapter 41.06 RCW, and any additional staff members as are
15 necessary to administer this chapter. The administrator may delegate
16 any power or duty vested in him or her by this chapter, including
17 authority to make final decisions and enter final orders in hearings
18 conducted under chapter 34.05 RCW. The primary duties of the authority
19 shall be to: Administer state employees' insurance benefits and
20 retired or disabled school employees' insurance benefits; administer
21 the basic health plan pursuant to chapter 70.47 RCW; study state-
22 purchased health care programs in order to maximize cost containment in
23 these programs while ensuring access to quality health care; implement
24 state initiatives, joint purchasing strategies, and techniques for
25 efficient administration that have potential application to all state-
26 purchased health services; and administer grants that further the
27 mission and goals of the authority. The authority's duties include,
28 but are not limited to, the following:
29 (a) To administer health care benefit programs for employees and
30 retired or disabled school employees as specifically authorized in RCW
31 41.05.065 and in accordance with the methods described in RCW
32 41.05.075, 41.05.140, and other provisions of this chapter;
33 (b) To analyze state-purchased health care programs and to explore
34 options for cost containment and delivery alternatives for those
35 programs that are consistent with the purposes of those programs,
36 including, but not limited to:

(i) Creation of economic incentives for the persons for whom the state purchases health care to appropriately utilize and purchase health care services, including the development of flexible benefit plans to offset increases in individual financial responsibility;

(ii) Utilization of provider arrangements that encourage cost containment, including but not limited to prepaid delivery systems, utilization review, and prospective payment methods, and that ensure access to quality care, including assuring reasonable access to local providers, especially for employees residing in rural areas;

(iii) Coordination of state agency efforts to purchase drugs effectively as provided in RCW 70.14.050;

(iv) Development of recommendations and methods for purchasing medical equipment and supporting services on a volume discount basis;

(v) Development of data systems to obtain utilization data from state-purchased health care programs in order to identify cost centers, utilization patterns, provider and hospital practice patterns, and procedure costs, utilizing the information obtained pursuant to RCW 41.05.031; and

(vi) In collaboration with other state agencies that administer state purchased health care programs, private health care purchasers, health care facilities, providers, and carriers:

(A) 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:

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

(II) 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;

(B) Through state health purchasing, reimbursement, or pilot strategies, promote and increase the adoption of health information technology systems, including electronic medical records, by hospitals as defined in RCW 70.41.020(4), integrated delivery systems, and providers that:

(I) Facilitate diagnosis or treatment;

(II) Reduce unnecessary duplication of medical tests;

(III) Promote efficient electronic physician order entry;
(IV) Increase access to health information for consumers and their providers; and
(V) Improve health outcomes;
(C) Coordinate a strategy for the adoption of health information technology systems using the final health information technology report and recommendations developed under chapter 261, Laws of 2005;
(c) To analyze areas of public and private health care interaction;
(d) To provide information and technical and administrative assistance to the board;
(e) To review and approve or deny applications from counties, municipalities, and other political subdivisions of the state to provide state-sponsored insurance or self-insurance programs to their employees in accordance with the provisions of RCW 41.04.205 and (g) of this subsection, setting the premium contribution for approved groups as outlined in RCW 41.05.050;
(f) To review and approve or deny the application when the governing body of a tribal government applies to transfer their employees to an insurance or self-insurance program administered under this chapter. In the event of an employee transfer pursuant to this subsection (1)(f), members of the governing body are eligible to be included in such a transfer if the members are authorized by the tribal government to participate in the insurance program being transferred from and subject to payment by the members of all costs of insurance for the members. The authority shall: (i) Establish the conditions for participation; (ii) have the sole right to reject the application; and (iii) set the premium contribution for approved groups as outlined in RCW 41.05.050. Approval of the application by the authority transfers the employees and dependents involved to the insurance, self-insurance, or health care program approved by the authority;
(g) To ensure the continued status of the employee insurance or self-insurance programs administered under this chapter as a governmental plan under section 3(32) of the employee retirement income security act of 1974, as amended, the authority shall limit the participation of employees of a county, municipal, school district, educational service district, or other political subdivision, or a tribal government, including providing for the participation of those

1 employees whose services are substantially all in the performance of
2 essential governmental functions, but not in the performance of
3 commercial activities;

4 (h) To establish billing procedures and collect funds from school
5 districts in a way that minimizes the administrative burden on
6 districts;

7 (i) To publish and distribute to nonparticipating school districts
8 and educational service districts by October 1st of each year a
9 description of health care benefit plans available through the
10 authority and the estimated cost if school districts and educational
11 service district employees were enrolled;

12 (j) To apply for, receive, and accept grants, gifts, and other
13 payments, including property and service, from any governmental or
14 other public or private entity or person, and make arrangements as to
15 the use of these receipts to implement initiatives and strategies
16 developed under this section;

17 (k) To issue, distribute, and administer grants that further the
18 mission and goals of the authority;

19 (l) To adopt rules consistent with this chapter as described in RCW
20 41.05.160 including, but not limited to:

21 (i) Setting forth the criteria established by the board under RCW
22 41.05.065 for determining whether an employee is eligible for benefits;

23 (ii) Establishing an appeal process in accordance with chapter
24 34.05 RCW by which an employee may appeal an eligibility determination;

25 (iii) Establishing a process to assure that the eligibility
26 determinations of an employing agency comply with the criteria under
27 this chapter, including the imposition of penalties as may be
28 authorized by the board.

29 (2) On and after January 1, 1996, the public employees' benefits
30 board may implement strategies to promote managed competition among
31 employee health benefit plans. Strategies may include but are not
32 limited to:

33 (a) Standardizing the benefit package;

34 (b) Soliciting competitive bids for the benefit package;

35 (c) Limiting the state's contribution to a percent of the lowest
36 priced qualified plan within a geographical area;

37 (d) Monitoring the impact of the approach under this subsection
38 with regards to: Efficiencies in health service delivery, cost shifts

1 to subscribers, access to and choice of managed care plans statewide,
2 and quality of health services. The health care authority shall also
3 advise on the value of administering a benchmark employer-managed plan
4 to promote competition among managed care plans.

5 (3)(a) The authority must enter into contracts with all the managed
6 care plans and for the self-insured plan or plans, to be implemented as
7 soon as possible but no later than 2013, that include:

8 (i) Provider reimbursement methods that incentivize chronic care
9 management within health homes;

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

13 (iii) Promoting provider participation in the program of training
14 and technical assistance regarding care of people with chronic
15 conditions described in RCW 43.70.533, including allocating funds for
16 provider participation in the training unless the managed care system
17 is an integrated health delivery system that has programs in place for
18 chronic care management.

19 (b) Health home services contracted for under this subsection may
20 be prioritized to enrollees with complex, high cost, or multiple
21 chronic conditions.

22 (c) For the purposes of this subsection, "chronic care management,"
23 and "health home" have the same meaning as in RCW 74.09.010.

24 (d) Contracts with fully insured plans that include the items in
25 (a)(i) through (iii) of this subsection must be funded within the
26 resources provided by employer funding rates provided for employee
27 health benefits in the omnibus appropriations act.

28 (e) Funding for the items in (a)(i) through (iii) of this
29 subsection in self-insured plans must not increase the resources
30 provided by employer funding rates provided for employee health
31 benefits in the omnibus appropriations act in the absence of these
32 provisions.

33 (f) Nothing in this section shall require contracted third-party
34 health plans administering the self-insured contract to expend
35 resources to implement items in (a)(i) through (iii) of this subsection
36 beyond the resources provided by employer funding rates provided for
37 employee health benefits in the omnibus appropriations act or from
38 other sources in the absence of these provisions.

1 NEW SECTION. **Sec. 7.** A new section is added to chapter 41.05 RCW
2 to read as follows:
3 (1) The legislature finds that collaboration among public payers,
4 private health carriers, third-party payers, and providers to identify
5 appropriate reimbursement methods to align incentives in support of
6 patient centered health homes is necessary to implement the
7 requirements of this act. The legislature therefore declares its
8 intent to exempt from state antitrust laws, and to provide immunity
9 from federal antitrust laws, through the state action doctrine, the
10 collaborative and associated payment reforms designed and implemented
11 under this section that might otherwise be constrained by such laws.
12 The legislature does not authorize any person or entity to engage in
13 activities or to conspire to engage in activities that would constitute
14 per se violations of state or federal antitrust laws including, but not
15 limited to, agreements among competing health care providers or health
16 carriers as to the prices of specific levels of reimbursement for
17 health care services.
18 (2) The legislature recognizes that many Washingtonians are covered
19 by health plans regulated by the federal government, including self-
20 insured and Taft-Hartley plans. While such plans are largely outside
21 the state's purview, they share with the state an interest in
22 containing health care costs and promoting quality of care. The
23 legislature recognizes that the participation of such plans in the
24 state's efforts to promote health homes and reform payment methods
25 would greatly increase the likelihood of success of such efforts.
26 (3) The administrator shall establish a collaborative work group
27 process to encourage input from and participation by such plans to work
28 with the state and carriers to promote health homes and to learn from
29 the experience of the health care authority for successful
30 implementation of health homes for employees with chronic and multiple
31 conditions.
32 (4) Beginning December 1, 2012, the administrator must report to
33 the legislature annually on the efforts of the collaborative work group
34 to broadly implement health homes. The report must also document the
35 efforts to integrate health homes in the publicly purchased programs
36 administered under this chapter and chapters 74.09 and 70.47 RCW.
37 (5) The administrator may write rules to establish the information

1 that insurance carriers must submit for inclusion in the annual report
2 to the legislature.
3 (6) For the purposes of this section, "chronic condition" and
4 "health home" have the same meaning as in RCW 74.09.010.

5 NEW SECTION. **Sec. 8.** A new section is added to chapter 48.43 RCW
6 to read as follows:
7 Each carrier licensed under this title and providing a
8 comprehensive health plan in the state shall participate in the
9 collaborative work group established in section 7 of this act and
10 submit information the health care authority requires for the annual
11 report to the legislature."

12 Correct the title.

EFFECT: Adds physician assistants and osteopathic physician assistants to the definition of "primary care provider." Adds home care and other long-term care providers to the definition of "multidisciplinary health care team."

Authorizes health home services to be limited to those Medicaid, Basic Health Plan, and PEBB enrollees with complex, high cost, or multiple chronic conditions.

Excludes the third-party health plan administering the public employee's health plan from having to expend any resource, beyond appropriated levels, to fund the health homes and chronic care management programs.

Adds legislative findings regarding the need for primary care providers to coordinate with long-term care providers and providers of oral health services.

Specifies that the coordinated care provided by a primary care provider in a health home does not mean that prior authorization is required for a patient to receive treatment for optometry services.

Changes terminology.

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