ESSB 5927 - H COMM AMD
By Committee on Ways & Means

ADOPTED 05/09/2011

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** (1) The legislature finds that:

(a) There is an increasing level of dispute and uncertainty regarding the amount of payment nonparticipating providers may receive for health care services provided to enrollees of state purchased health care programs designed to serve low-income individuals and families, such as basic health and the medicaid managed care programs;

(b) The dispute has resulted in litigation, including a recent Washington superior court ruling that determined nonparticipating providers were entitled to receive billed charges from a managed health care system for services provided to medicaid and basic health plan enrollees. The decision would allow a nonparticipating provider to demand and receive payment in an amount exceeding the payment managed health care system network providers receive for the same services. Similar provider lawsuits have now been filed in other jurisdictions in the state;

(c) In the biennial operating budget, the legislature has previously indicated its intent that payment to nonparticipating providers for services provided to medicaid managed care enrollees should be limited to amounts paid to medicaid fee-for-service providers. The duration of these provisions is limited to the period during which the operating budget is in effect. A more permanent resolution of these issues is needed; and

(d) Continued failure to resolve this dispute will have adverse impacts on state purchased health care programs serving low-income enrollees, including: (i) Diminished ability for the state to negotiate cost-effective contracts with managed health care systems; (ii) a potential for significant reduction in the willingness of providers to participate in managed health care system provider

networks; (iii) a reduction in providers participating in the managed health care systems; and (iv) increased exposure for program enrollees to balance billing practices by nonparticipating providers. Ultimately, fewer eligible people will get the care they need as state purchased health care programs will operate with less efficiency and reduced access to cost-effective and quality health care coverage for program enrollees.

(2) It is the intent of the legislature to create a legislative solution that reduces the cost borne by the state to provide public health care coverage to low-income enrollees in managed health care systems, protects enrollees and state purchased health care programs from balance billing by nonparticipating providers, provides appropriate payment to health care providers for services provided to enrollees of state purchased health care programs, and limits the risk for managed health care systems that contract with the state programs.

Sec. 2. 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((~~,~~)):

(a) "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~~)) this chapter 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;

(b) "Nonparticipating provider" means a person, health care provider, practitioner, facility, or entity, acting within their scope of practice, that does not have a written contract to participate in a managed health care system's provider network, but provides health care services to enrollees of programs authorized under this chapter whose health care services are provided by the managed health care system.

(2) The department of social and health services shall enter into agreements with managed health care systems to provide health care

services to recipients of temporary assistance for needy families under the following conditions:

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

(b) Agreements in at least one county shall include enrollment of all recipients of temporary assistance for needy families;

(c) To the extent that this provision is consistent with section 1903(m) of Title XIX of the federal social security act or federal 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 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 shall not restrict a recipient's right to terminate enrollment in a system for good cause as established by the department by rule;

(d) To the extent that this provision is consistent with section 1903(m) of Title XIX of the federal social security act, participating managed health care systems shall not enroll a disproportionate number of medical assistance recipients within the total numbers of persons served by the managed health care systems, except as authorized by the department under federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act;

(e) In negotiating with managed health care systems the department shall adopt a uniform procedure to negotiate and enter into contractual arrangements, including standards regarding the quality of services to be provided; and financial integrity of the responding system;

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

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

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

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

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

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

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

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

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

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

(ii) Quality of services provided to enrollees;

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

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

(v) Payment rates; and

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

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

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

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

(f) Procedures for resolution of disputes between the department and contract bidders or the department and contracting carriers related to the award of, or failure to award, a managed care contract must be clearly set out in the procurement document. In designing such procedures, the department shall give strong consideration to the negotiation and dispute resolution processes used by the Washington state health care authority in its managed health care contracting activities.

(6) The department 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.

(7) A managed health care system shall pay a nonparticipating provider that provides a service covered under this chapter to the system's enrollee no more than the lowest amount paid for that service under the managed health care system's contracts with similar providers in the state.

(8) For services covered under this chapter to medical assistance or medical care services enrollees and provided on or after the effective date of this section, nonparticipating providers must accept as payment in full the amount paid by the managed health care system under subsection (7) of this section in addition to any deductible, coinsurance, or copayment that is due from the enrollee for the service provided. An enrollee is not liable to any nonparticipating provider for covered services, except for amounts due for any deductible, coinsurance, or copayment under the terms and conditions set forth in the managed health care system contract to provide services under this section.

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

(10) Subsections (7) through (9) of this section expire July 1, 2016.

Sec. 3. RCW 70.47.020 and 2011 c 205 s 1 are each reenacted and amended to read as follows:

As used in this chapter:

(1) "Administrator" means the Washington basic health plan administrator, who also holds the position of administrator of the Washington state health care authority.

(2) "Health coverage tax credit eligible enrollee" means individual workers and their qualified family members who lose their jobs due to the effects of international trade and are eligible for certain trade adjustment assistance benefits; or are eligible for benefits under the

alternative trade adjustment assistance program; or are people who receive benefits from the pension benefit guaranty corporation and are at least fifty-five years old.

(3) "Health coverage tax credit program" means the program created by the Trade Act of 2002 (P.L. 107-210) that provides a federal tax credit that subsidizes private health insurance coverage for displaced workers certified to receive certain trade adjustment assistance benefits and for individuals receiving benefits from the pension benefit guaranty corporation.

(4) "Managed health care system" means: (a) Any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof, that provides directly or by contract basic health care services, as defined by the administrator and rendered by duly licensed providers, to a defined patient population enrolled in the plan and in the managed health care system; or (b) a self-funded or self-insured method of providing insurance coverage to subsidized enrollees provided under RCW 41.05.140 and subject to the limitations under RCW 70.47.100((~~(7)~~)) (9).

(5) "Nonparticipating provider" means a person, health care provider, practitioner, facility, or entity, acting within their authorized scope of practice or licensure, that does not have a written contract to participate in a managed health care system's provider network, but provides services to plan enrollees who receive coverage through the managed health care system.

(6) "Nonsubsidized enrollee" means an individual, or an individual plus the individual's spouse or dependent children: (a) Who is not eligible for medicare; (b) who is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator; (c) who is accepted for enrollment by the administrator as provided in RCW 48.43.018, either because the potential enrollee cannot be required to complete the standard health questionnaire under RCW 48.43.018, or, based upon the results of the standard health questionnaire, the potential enrollee would not qualify for coverage under the Washington state health insurance pool; (d) who resides in an area of the state served by a managed health care system participating in the plan; (e) who chooses

to obtain basic health care coverage from a particular managed health care system; and (f) who pays or on whose behalf is paid the full costs for participation in the plan, without any subsidy from the plan.

((~~(6)~~)) (7) "Premium" means a periodic payment, which an individual, their employer or another financial sponsor makes to the plan as consideration for enrollment in the plan as a subsidized enrollee, a nonsubsidized enrollee, or a health coverage tax credit eligible enrollee.

((~~(7)~~)) (8) "Rate" means the amount, negotiated by the administrator with and paid to a participating managed health care system, that is based upon the enrollment of subsidized, nonsubsidized, and health coverage tax credit eligible enrollees in the plan and in that system.

((~~(8)~~)) (9) "Subsidy" means the difference between the amount of periodic payment the administrator makes to a managed health care system on behalf of a subsidized enrollee plus the administrative cost to the plan of providing the plan to that subsidized enrollee, and the amount determined to be the subsidized enrollee's responsibility under RCW 70.47.060(2).

((~~(9)~~)) (10) "Subsidized enrollee" means:

(a) An individual, or an individual plus the individual's spouse or dependent children:

(i) Who is not eligible for medicare;

(ii) Who is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator;

(iii) Who is not a full-time student who has received a temporary visa to study in the United States;

(iv) Who resides in an area of the state served by a managed health care system participating in the plan;

(v) Until March 1, 2011, whose gross family income at the time of enrollment 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;

(vi) Who chooses to obtain basic health care coverage from a particular managed health care system in return for periodic payments to the plan;

(vii) Who is not receiving medical assistance administered by the department of social and health services; and

(viii) After February 28, 2011, who is in the basic health transition eligibles population under 1115 medicaid demonstration project number 11-W-00254/10;

(b) An individual who meets the requirements in (a)(i) through (iv), (vi), and (vii) of this subsection and who is a foster parent licensed under chapter 74.15 RCW and whose gross family income at the time of enrollment does not exceed three hundred percent of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services; and

(c) To the extent that state funds are specifically appropriated for this purpose, with a corresponding federal match, an individual, or an individual's spouse or dependent children, who meets the requirements in (a)(i) through (iv), (vi), and (vii) of this subsection and whose gross family income at the time of enrollment is more than two hundred percent, but less than two hundred fifty-one percent, of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services.

((~~(10)~~)) (11) "Washington basic health plan" or "plan" means the system of enrollment and payment for basic health care services, administered by the plan administrator through participating managed health care systems, created by this chapter.

Sec. 4. RCW 70.47.100 and 2009 c 568 s 5 are each amended to read as follows:

(1) A managed health care system participating in the plan shall do so by contract with the administrator and shall provide, directly or by contract with other health care providers, covered basic health care services to each enrollee covered by its contract with the administrator as long as payments from the administrator on behalf of the enrollee are current. A participating managed health care system may offer, without additional cost, health care benefits or services not included in the schedule of covered services under the plan. A participating managed health care system shall not give preference in enrollment to enrollees who accept such additional health care benefits or services. Managed health care systems participating in the plan shall not discriminate against any potential or current enrollee based

upon health status, sex, race, ethnicity, or religion. The administrator may receive and act upon complaints from enrollees regarding failure to provide covered services or efforts to obtain payment, other than authorized copayments, for covered services directly from enrollees, but nothing in this chapter empowers the administrator to impose any sanctions under Title 18 RCW or any other professional or facility licensing statute.

(2) A managed health care system shall pay a nonparticipating provider that provides a service covered under this chapter to the system's enrollee no more than the lowest amount paid for that service under the managed health care system's contracts with similar providers in the state.

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

(4) The plan shall allow, at least annually, an opportunity for enrollees to transfer their enrollments among participating managed health care systems serving their respective areas. The administrator shall establish a period of at least twenty days in a given year when this opportunity is afforded enrollees, and in those areas served by more than one participating managed health care system the administrator shall endeavor to establish a uniform period for such opportunity. The plan shall allow enrollees to transfer their enrollment to another participating managed health care system at any time upon a showing of good cause for the transfer.

((~~(3)~~)) (5) Prior to negotiating with any managed health care system, the administrator shall determine, on an actuarially sound basis, the reasonable cost of providing the schedule of basic health

care services, expressed in terms of upper and lower limits, and recognizing variations in the cost of providing the services through the various systems and in different areas of the state.

((~~(4)~~)) (6) In negotiating with managed health care systems for participation in the plan, the administrator shall adopt a uniform procedure that includes at least the following:

(a) The administrator shall issue a request for proposals, including standards regarding the quality of services to be provided; financial integrity of the responding systems; and responsiveness to the unmet health care needs of the local communities or populations that may be served;

(b) The administrator shall then review responsive proposals and may negotiate with respondents to the extent necessary to refine any proposals;

(c) The administrator may then select one or more systems to provide the covered services within a local area; and

(d) The administrator may adopt a policy that gives preference to respondents, such as nonprofit community health clinics, that have a history of providing quality health care services to low-income persons.

((~~(5)~~)) (7) 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.

((~~(6)~~)) (8) 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)~~)) (6) 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)~~)) (9) 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 sufficient for the self-funded or self-insured risk assumed, or expected to be assumed, by the administrator. If implementing a self-

funded or self-insured method, the administrator may request funds to be moved from the basic health plan trust account or the basic health plan subscription account to the basic health plan self-insurance reserve account established in RCW 41.05.140.

(10) Subsections (2) and (3) of this section expire July 1, 2016.

NEW SECTION. **Sec. 5.** A new section is added to chapter 70.47 RCW to read as follows:

(1) For services provided to plan enrollees on or after the effective date of this section, nonparticipating providers must accept as payment in full the amount paid by the managed health care system under RCW 70.47.100(2) in addition to any deductible, coinsurance, or copayment that is due from the enrollee under the terms and conditions set forth in the managed health care system contract with the administrator. A plan enrollee is not liable to any nonparticipating provider for covered services, except for amounts due for any deductible, coinsurance, or copayment under the terms and conditions set forth in the managed health care system contract with the administrator.

(2) This section expires July 1, 2016.

NEW SECTION. **Sec. 6.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected."

Correct the title.

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