ENGROSSED SUBSTITUTE SENATE BILL 5927

State of Washington 62nd Legislature 2011 1st Special Session

By Senate Ways & Means (originally sponsored by Senators Keiser and Pflug; by request of Health Care Authority and Department of Social and Health Services)

READ FIRST TIME 04/18/11.

1 AN ACT Relating to limiting payments for health care services
2 provided to low-income enrollees in state purchased health care
3 programs; amending RCW 70.47.100; reenacting and amending RCW 74.09.522
4 and 70.47.020; adding a new section to chapter 70.47 RCW; creating a
5 new section; and providing expiration dates.

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

7 NEW SECTION. **Sec. 1.** (1) The legislature finds that:
8 (a) There is an increasing level of dispute and uncertainty
9 regarding the amount of payment nonparticipating providers may receive
10 for health care services provided to enrollees of state purchased
11 health care programs designed to serve low-income individuals and
12 families, such as basic health and the medicaid managed care programs;
13 (b) The dispute has resulted in litigation, including a recent
14 Washington superior court ruling that determined nonparticipating
15 providers were entitled to receive billed charges from a managed health
16 care system for services provided to medicaid and basic health plan
17 enrollees. The decision would allow a nonparticipating provider to
18 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, 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 and does not include hospitals or facilities contracted with the managed health care system under this chapter.

(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

1 served by the managed health care systems, except as authorized by the
2 department under federal demonstration waivers granted under section
3 1115(a) of Title XI of the federal social security act;
4 (e) In negotiating with managed health care systems the department
5 shall adopt a uniform procedure to negotiate and enter into contractual
6 arrangements, including standards regarding the quality of services to
7 be provided; and financial integrity of the responding system;
8 (f) The department shall seek waivers from federal requirements as
9 necessary to implement this chapter;
10 (g) The department shall, wherever possible, enter into prepaid
11 capitation contracts that include inpatient care. However, if this is
12 not possible or feasible, the department may enter into prepaid
13 capitation contracts that do not include inpatient care;
14 (h) The department shall define those circumstances under which a
15 managed health care system is responsible for out-of-plan services and
16 assure that recipients shall not be charged for such services; and
17 (i) Nothing in this section prevents the department from entering
18 into similar agreements for other groups of people eligible to receive
19 services under this chapter.
20 (3) The department shall ensure that publicly supported community
21 health centers and providers in rural areas, who show serious intent
22 and apparent capability to participate as managed health care systems
23 are seriously considered as contractors. The department shall
24 coordinate its managed care activities with activities under chapter
25 70.47 RCW.
26 (4) The department shall work jointly with the state of Oregon and
27 other states in this geographical region in order to develop
28 recommendations to be presented to the appropriate federal agencies and
29 the United States congress for improving health care of the poor, while
30 controlling related costs.
31 (5) The legislature finds that competition in the managed health
32 care marketplace is enhanced, in the long term, by the existence of a
33 large number of managed health care system options for medicaid
34 clients. In a managed care delivery system, whose goal is to focus on
35 prevention, primary care, and improved enrollee health status,
36 continuity in care relationships is of substantial importance, and
37 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 negotiate in accordance with community standards for industry with health care providers to assure an adequate network of health care providers within its service areas and within each facility that has a written contract with the managed health care system. To facilitate negotiations with health care providers, a managed health care system shall provide the department documentation indicating that the managed health care system attempted to contract with the nonparticipating provider or provider group on similar terms to other participating providers delivering the same care in the same service area.

(8) If the requirement of subsection (7) of this section is satisfied, for services provided by nonparticipating providers, the managed health care system shall only be obligated to pay an amount determined by establishing the mode reimbursement rate for the same services in the same service area contracted for under this section by the managed health care system.

(9) In any case where a managed health care system must send an enrollee to a nonparticipating provider for contracted services under the circumstances and conditions set forth in subsection (8) of this section, it must notify the department and the provider as to the basis for utilizing the nonparticipating provider's services. Any disagreement between the managed health care system and a provider or provider group regarding whether the managed health care system satisfied the requirements set forth in subsection (7) of this section shall be decided by the department.

(10) 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.

(11) Subsections (7) through (10) of this section expire January 1, 2014.

Sec. 3. RCW 70.47.020 and 2009 c 568 s 2 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))) (8).

(5) "Nonparticipating provider" means a person, health care provider, practitioner, 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 and does not include hospitals or facilities contracted with the managed health care system under this chapter.

(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) 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; and

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

(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) A managed health care system shall negotiate in accordance with community standards for industry with health care providers to assure an adequate network of health care providers within its service areas and within each facility that has a written contract with the managed health care system. To facilitate negotiations with health care providers, a managed health care system shall provide the administrator documentation indicating that the managed health care system attempted to contract with the nonparticipating provider or provider group on similar terms to other participating providers delivering the same care in the same service area.

(b) This subsection (2) expires January 1, 2014.

(3) 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)~~)) (4) 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)~~)) (5) 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)~~)) (6) 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)~~)) (7) 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)~~)) (5) 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)~~)) (8) 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.

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

(1) If the requirements of RCW 70.47.100 are satisfied, for services provided by nonparticipating providers, the managed health care system shall only be obligated to pay an amount determined by establishing the mode reimbursement rate for the same services in the same service area contracted for under this section by the managed health care system.

(2) In any case where a managed health care system must send an enrollee to a nonparticipating provider for contracted services under the circumstances and conditions set forth in subsection (1) of this section, it must notify the administrator and the provider as to the basis for utilizing the nonparticipating provider's services. Any disagreement between the managed health care system and a provider or provider group regarding whether the managed health care system satisfied the requirements set forth in RCW 70.47.100 shall be decided by the administrator pursuant to the requirements set forth in RCW 70.47.100.

(3) This section expires January 1, 2014.

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.

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