
HOUSE BILL 1637

State of Washington

63rd Legislature

2013 Regular Session

By Representatives Morrell, Short, Cody, Rodne, Harris, Green, Angel, Jinkins, Moeller, Ryu, Moscoso, and Pollet

Read first time 02/04/13. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to prescription review for medicaid managed care
2 enrollees; and reenacting and amending RCW 74.09.522.

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

4 **Sec. 1.** RCW 74.09.522 and 2011 1st sp.s. c 15 s 29, 2011 1st sp.s.
5 c 9 s 2, and 2011 c 316 s 4 are each reenacted and amended to read as
6 follows:

7 (1) For the purposes of this section:

8 (a) "Comprehensive medication management process" means the
9 provision of the following services utilizing the professional practice
10 of pharmaceutical care by a licensed pharmacist for patients taking
11 five or more medications for two or more chronic medical conditions:

12 (i) Assessment of the patient's health status including the
13 personal medication experience and use patterns of all prescribed and
14 over-the-counter medications;

15 (ii) Documentation of the patient's current clinical status and
16 clinical goals of therapy;

17 (iii) Assessment of each medication for appropriateness,
18 effectiveness, safety, and adherence focusing on achievement of desired
19 clinical goals;

1 (iv) Identification of all drug therapy problems including
2 additions or deletions in medications or changes in dosage needed to
3 meet desired clinical goals;

4 (v) Development of a comprehensive medication therapy plan for the
5 patient in consultation with the prescribing practitioner; and

6 (vi) Documentation and follow up of the effects of recommended drug
7 therapy changes on the patient's clinical status and outcomes;

8 (b) "Managed health care system" means any health care
9 organization, including health care providers, insurers, health care
10 service contractors, health maintenance organizations, health insuring
11 organizations, or any combination thereof, that provides directly or by
12 contract health care services covered under this chapter and rendered
13 by licensed providers, on a prepaid capitated basis and that meets the
14 requirements of section 1903(m)(1)(A) of Title XIX of the federal
15 social security act or federal demonstration waivers granted under
16 section 1115(a) of Title XI of the federal social security act;

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

23 (2) The authority shall enter into agreements with managed health
24 care systems to provide health care services to recipients of temporary
25 assistance for needy families under the following conditions:

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

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

30 (c) To the extent that this provision is consistent with section
31 1903(m) of Title XIX of the federal social security act or federal
32 demonstration waivers granted under section 1115(a) of Title XI of the
33 federal social security act, recipients shall have a choice of systems
34 in which to enroll and shall have the right to terminate their
35 enrollment in a system: PROVIDED, That the authority may limit
36 recipient termination of enrollment without cause to the first month of
37 a period of enrollment, which period shall not exceed twelve months:

1 AND PROVIDED FURTHER, That the authority shall not restrict a
2 recipient's right to terminate enrollment in a system for good cause as
3 established by the authority by rule;

4 (d) To the extent that this provision is consistent with section
5 1903(m) of Title XIX of the federal social security act, participating
6 managed health care systems shall not enroll a disproportionate number
7 of medical assistance recipients within the total numbers of persons
8 served by the managed health care systems, except as authorized by the
9 authority under federal demonstration waivers granted under section
10 1115(a) of Title XI of the federal social security act;

11 (e)(i) In negotiating with managed health care systems the
12 authority shall adopt a uniform procedure to enter into contractual
13 arrangements, to be included in contracts issued or renewed on or after
14 January 1, 2012, including:

15 (A) Standards regarding the quality of services to be provided;

16 (B) The financial integrity of the responding system;

17 (C) Provider reimbursement methods that incentivize chronic care
18 management and comprehensive medication management services within
19 health homes;

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

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

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

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

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

37 (g) The authority shall, wherever possible, enter into prepaid

1 capitation contracts that include inpatient care. However, if this is
2 not possible or feasible, the authority may enter into prepaid
3 capitation contracts that do not include inpatient care;

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

7 (i) Nothing in this section prevents the authority from entering
8 into similar agreements for other groups of people eligible to receive
9 services under this chapter; and

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

13 (3) The authority shall ensure that publicly supported community
14 health centers and providers in rural areas, who show serious intent
15 and apparent capability to participate as managed health care systems
16 are seriously considered as contractors. The authority shall
17 coordinate its managed care activities with activities under chapter
18 70.47 RCW.

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

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

34 (a) All managed health care systems should have an opportunity to
35 contract with the authority to the extent that minimum contracting
36 requirements defined by the authority are met, at payment rates that
37 enable the authority to operate as far below appropriated spending

1 levels as possible, consistent with the principles established in this
2 section.

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

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

8 (ii) Quality of services provided to enrollees;

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

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

13 (v) Payment rates; and

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

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

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

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

31 (f) Procedures for resolution of disputes between the authority and
32 contract bidders or the authority and contracting carriers related to
33 the award of, or failure to award, a managed care contract must be
34 clearly set out in the procurement document.

35 (6) The authority may apply the principles set forth in subsection
36 (5) of this section to its managed health care purchasing efforts on
37 behalf of clients receiving supplemental security income benefits to
38 the extent appropriate.

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

6 (8) For services covered under this chapter to medical assistance
7 or medical care services enrollees and provided on or after August 24,
8 2011, nonparticipating providers must accept as payment in full the
9 amount paid by the managed health care system under subsection (7) of
10 this section in addition to any deductible, coinsurance, or copayment
11 that is due from the enrollee for the service provided. An enrollee is
12 not liable to any nonparticipating provider for covered services,
13 except for amounts due for any deductible, coinsurance, or copayment
14 under the terms and conditions set forth in the managed health care
15 system contract to provide services under this section.

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

29 (10) Subsections (7) through (9) of this section expire July 1,
30 2016.

31 (11) By January 1, 2014, contracts with managed care plans must
32 include a requirement that any patient with five or more medications
33 for two or more chronic medical conditions be placed in a comprehensive
34 medication management process with the primary care provider or
35 Washington state licensed pharmacist to verify that all the
36 prescriptions are medically appropriate and to review for drug

1 interactions and opportunities to improve clinical outcomes and reduce
2 emergency care.

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