S-1057.1

SENATE BILL 5631

State of Washington 63rd Legislature 2013 Regular Session

By Senator Becker

Read first time 02/06/13. Referred to Committee on Health Care .

AN ACT Relating to modifying the expiration dates that limit payments for health care services provided to low-income enrollees in state purchased health care programs by aligning them with the start of medicaid expansion; amending RCW 70.47.230; reenacting and amending RCW 74.09.522 and 70.47.100; and providing expiration dates.

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

Sec. 1. RCW 74.09.522 and 2011 1st sp.s. c 15 s 29, 2011 1st sp.s. c 9 s 2, and 2011 c 316 s 4 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 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 authority 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 authority 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 authority shall not restrict a recipient's right to terminate enrollment in a system for good cause as established by the authority 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 authority under federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act;

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

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

(B) The financial integrity of the responding system;

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

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

(E) 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.

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

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

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

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

(h) The authority 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;

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

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

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

(4) The authority 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 authority in its healthy options managed health care purchasing efforts:

(a) All managed health care systems should have an opportunity to contract with the authority to the extent that minimum contracting requirements defined by the authority are met, at payment rates that enable the authority 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 authority, 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 authority 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 Washington state health care authority 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 authority and contract bidders or the authority 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.

(6) The authority 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 August 24, 2011, 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~~)) health care authority, including hospital-based physician services. The ((~~department~~)) health care 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 ((~~department~~)) health care authority 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~~)) 2014.

Sec. 2. RCW 70.47.100 and 2011 1st sp.s. c 9 s 4 and 2011 c 316 s 5 are each reenacted and amended to read as follows:

(1) A managed health care system participating in the plan shall do so by contract with the ((~~administrator~~)) director 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~~)) director as long as payments from the ((~~administrator~~)) director 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~~)) director 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~~)) director 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~~)) director 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~~)) director 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.

(5) Prior to negotiating with any managed health care system, the ((~~administrator~~)) director 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.

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

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

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

(d) The ((~~administrator~~)) director 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.

(7)(a) The ((~~administrator~~)) director 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.

(8) The ((~~administrator~~)) director 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 (6) of this section, upon a determination by the ((~~administrator~~)) director that it is necessary to provide access, as defined in the request for proposal documents, to covered basic health care services for enrollees.

(9) The ((~~administrator~~)) director 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~~)) director 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~~)) director. If implementing a self-funded or self-insured method, the ((~~administrator~~)) director 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~~)) 2014.

Sec. 3. RCW 70.47.230 and 2011 1st sp.s. c 9 s 5 are each amended to read as follows:

(1) For services provided to plan enrollees on or after August 24, 2011, 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~~)) director. 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~~)) director.

(2) This section expires July 1, ((~~2016~~)) 2014.

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