H-1289.1

HOUSE BILL 1854

State of Washington 65th Legislature 2017 Regular Session

By Representatives Cody, Schmick, and Tharinger

Read first time 02/01/17. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to the transition of medicaid enrollees to
2 skilled nursing facility care; amending RCW 74.09.522; and adding a
3 new section to chapter 74.09 RCW.

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

5 **Sec. 1.** RCW 74.09.522 and 2015 c 256 s 1 are each amended to
6 read as follows:
7 (1) For the purposes of this section:
8 (a) "Managed health care system" means any health care
9 organization, including health care providers, insurers, health care
10 service contractors, health maintenance organizations, health
11 insuring organizations, or any combination thereof, that provides
12 directly or by contract health care services covered under this
13 chapter and rendered by licensed providers, on a prepaid capitated
14 basis and that meets the requirements of section 1903(m)(1)(A) of
15 Title XIX of the federal social security act or federal demonstration
16 waivers granted under section 1115(a) of Title XI of the federal
17 social security act;
18 (b) "Nonparticipating provider" means a person, health care
19 provider, practitioner, facility, or entity, acting within their
20 scope of practice, that does not have a written contract to
21 participate in a managed health care system's provider network, but

1 provides health care services to enrollees of programs authorized
2 under this chapter whose health care services are provided by the
3 managed health care system.

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

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

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

12 (c) To the extent that this provision is consistent with section
13 1903(m) of Title XIX of the federal social security act or federal
14 demonstration waivers granted under section 1115(a) of Title XI of
15 the federal social security act, recipients shall have a choice of
16 systems in which to enroll and shall have the right to terminate
17 their enrollment in a system: PROVIDED, That the authority may limit
18 recipient termination of enrollment without cause to the first month
19 of a period of enrollment, which period shall not exceed twelve
20 months: AND PROVIDED FURTHER, That the authority shall not restrict a
21 recipient's right to terminate enrollment in a system for good cause
22 as established by the authority by rule;

23 (d) To the extent that this provision is consistent with section
24 1903(m) of Title XIX of the federal social security act,
25 participating managed health care systems shall not enroll a
26 disproportionate number of medical assistance recipients within the
27 total numbers of persons served by the managed health care systems,
28 except as authorized by the authority under federal demonstration
29 waivers granted under section 1115(a) of Title XI of the federal
30 social security act;

31 (e)(i) In negotiating with managed health care systems the
32 authority shall adopt a uniform procedure to enter into contractual
33 arrangements, to be included in contracts issued or renewed on or
34 after January 1, 2015, including:

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

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

37 (C) Provider reimbursement methods that incentivize chronic care
38 management within health homes, including comprehensive medication
39 management services for patients with multiple chronic conditions
40 consistent with the findings and goals established in RCW 74.09.5223;

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

(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;

(F) Provider reimbursement methods within the medical billing processes that incentivize pharmacists or other qualified providers licensed in Washington state to provide comprehensive medication management services consistent with the findings and goals established in RCW 74.09.5223;

(G) Evaluation and reporting on the impact of comprehensive medication management services on patient clinical outcomes and total health care costs, including reductions in emergency department utilization, hospitalization, and drug costs; and

(H) Established consistent processes to incentivize integration of behavioral health services in the primary care setting, promoting care that is integrated, collaborative, colocated, and preventive.

(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 (G) 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

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

4 (3) The authority shall ensure that publicly supported community
5 health centers and providers in rural areas, who show serious intent
6 and apparent capability to participate as managed health care systems
7 are seriously considered as contractors. The authority shall
8 coordinate its managed care activities with activities under chapter
9 70.47 RCW.

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

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

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

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

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

36 (ii) Quality of services provided to enrollees;

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

39 (iv) Demonstrated capability to perform contracted services,
40 including ability to supply an adequate provider network<u>, and</u>

including a demonstrated capability to appropriately transition enrollees in a timely manner to skilled nursing facility care when it is determined to be more appropriate than acute hospital care;

(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.

(g) The authority shall actively monitor and enforce contractors' responsibility to coordinate the timely and appropriate transition of enrollees to skilled nursing facility care when it is determined to be more appropriate than acute hospital care. The authority shall incentivize timely and appropriate transition of enrollees to skilled nursing facility care by levying an overstay fee if an enrollee is not placed in a skilled nursing facility within a reasonable time period. The overstay fee is calculated based on the administrative day rate established by rule by the authority. Following notice by an acute care hospital to the contractor that an enrollee is ready for transition to skilled nursing facility care, if the enrollee remains ready for transition to skilled nursing facility care and in the acute care hospital longer than ten days, the overstay fee will equal one-third of the administrative day rate per day for days eleven

through twenty. If the enrollee remains ready for transition to skilled nursing facility care and in the acute care hospital longer than twenty days, the overstay fee will equal two-thirds of the administrative day rate for days twenty-one through thirty. If the enrollee remains ready for transition to skilled nursing facility care and in the acute care hospital longer than thirty days, the overstay fee will equal twice the administrative day rate for each additional day. Any overstay fees owed by the contractor will be paid to the authority for deposit in the state general fund.

(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) By April 1, 2016, any contract with a managed health care system to provide services to medical assistance enrollees shall require that managed health care systems offer contracts to behavioral health organizations, mental health providers, or chemical dependency treatment providers to provide access to primary care services integrated into behavioral health clinical settings, for individuals with behavioral health and medical comorbidities.

(8) Managed health care system contracts effective on or after April 1, 2016, shall serve geographic areas that correspond to the regional service areas established in RCW 43.20A.893.

(9) 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 if the managed health care system has made good faith efforts to contract with the nonparticipating provider.

(10) 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 (9) 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.

(11) 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.

(12) Payments under RCW 74.60.130 are exempt from this section.

(13) Subsections (9) through (11) of this section expire July 1, 2021.

NEW SECTION. **Sec. 2.** A new section is added to chapter 74.09 RCW to read as follows:

The authority must conduct a survey of skilled nursing facilities licensed under chapter 18.51 RCW to identify barriers in skilled nursing facilities accepting and admitting enrollees from acute care hospitals in a timely and appropriate manner. The survey must include questions to identify what additional resources are needed to accept enrollees, including those with complex needs. The authority must create a report on the survey results, including identifying steps to improve timely and appropriate transfer of enrollees from acute care hospitals. The report must also include information on the number and trend in administrative days, by facility and contractor. The survey results and the authority's report must be publicly available, including posted on the agency's web site.

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