Z-0092.3

SENATE BILL 5700

State of Washington 68th Legislature 2023 Regular Session

By Senators Van De Wege, Cleveland, and Dhingra; by request of Health Care Authority

Read first time 02/03/23. Referred to Committee on Health & Long Term Care.

1 AN ACT Relating to modernization of state health care authority-
2 related laws; amending RCW 41.05.006, 41.05.009, 41.05.011,
3 41.05.013, 41.05.015, 41.05.031, 41.05.035, 41.05.039, 41.05.046,
4 41.05.066, 41.05.068, 41.05.130, 41.05.160, 41.05.220, 41.05.310,
5 41.05.320, 41.05.400, 41.05.413, 41.05.520, 41.05.540, 41.05.550,
6 41.05.601, 41.05.650, 41.05.660, 41.05A.120, 41.05A.160, 41.05A.170,
7 70.320.050, 70.390.020, 71.24.380, 74.09.010, 74.09.171, 74.09.215,
8 74.09.220, 74.09.325, 74.09.328, 74.09.470, 74.09.4701, 74.09.480,
9 74.09.522, 74.09.630, 74.09.634, 74.09.645, 74.09.650, 74.09.653,
10 74.09.655, 74.09.657, and 74.09.860; reenacting and amending RCW
11 41.05.021, 71.24.035, 74.09.053, and 74.09.659; decodifying RCW
12 41.05.033, 41.05.110, 41.05.280, 41.05.680, and 74.09.756; and
13 repealing RCW 41.05.090, 41.05.205, 41.05.240, and 74.09.720.

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

15 **Sec. 1.** RCW 41.05.006 and 2018 c 260 s 2 are each amended to
16 read as follows:
17 (1) The legislature recognizes that (a) the state is a major
18 purchaser of health care services, (b) the increasing costs of such
19 health care services are posing and will continue to pose a great
20 financial burden on the state, (c) it is the state's policy,
21 consistent with the best interests of the state, to provide

comprehensive health care as an employer, to ((~~employees and school~~)) public employees, officials, their dependents, and to those who are dependent on the state for necessary medical care, and (d) it is imperative that the state begin to develop effective and efficient health care delivery systems and strategies for procuring health care services in order for the state to continue to purchase the most comprehensive health care possible.

(2) It is therefore the purpose of this chapter to establish the Washington state health care authority whose purpose shall be to (a) develop health care benefit programs that provide access to at least one comprehensive benefit plan funded to the fullest extent possible by the employer, and a health savings account/high deductible health plan option as defined in section 1201 of the medicare prescription drug improvement and modernization act of 2003, as amended, for eligible ((~~employees and school~~)) public employees, officials, and their dependents, and (b) study all state purchased health care, alternative health care delivery systems, and strategies for the procurement of health care services and make recommendations aimed at minimizing the financial burden which health care poses on the state, ((~~employees and school~~)) public employees, and its charges, while at the same time allowing the state to provide the most comprehensive health care options possible.

Sec. 2. RCW 41.05.009 and 2018 c 260 s 3 are each amended to read as follows:

(1) The authority, or an employing agency at the authority's direction, shall initially determine and periodically review whether ((~~an employee or a school~~)) a public employee is eligible for benefits pursuant to the criteria established under this chapter.

(2) An employing agency shall inform ((~~an employee or a school~~)) a public employee in writing whether or not he or she is eligible for benefits when initially determined and upon any subsequent change, including notice of the ((~~employee's or school~~)) public employee's right to an appeal.

Sec. 3. RCW 41.05.011 and 2019 c 411 s 4 are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Authority" means the Washington state health care authority.

(2) "Board" means the public employees' benefits board established under RCW 41.05.055 and the school employees' benefits board established under RCW 41.05.740.

(3) "Dependent care assistance program" means a benefit plan whereby employees and school employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under this chapter pursuant to 26 U.S.C. Sec. 129 or other sections of the internal revenue code.

(4) "Director" means the director of the authority.

(5) "Emergency service personnel killed in the line of duty" means law enforcement officers and firefighters as defined in RCW 41.26.030, members of the Washington state patrol retirement fund as defined in RCW 43.43.120, and reserve officers and firefighters as defined in RCW 41.24.010 who die as a result of injuries sustained in the course of employment as determined consistent with Title 51 RCW by the department of labor and industries.

(6)(a) "Employee" for the public employees' benefits board program includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (i) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021(1)(g); (ii) employees of employee organizations representing state civil service employees, at the option of each such employee organization; (iii) through December 31, 2019, employees of a school district if the authority agrees to provide any of the school districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (iv) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021(1) (f) and (g); (v) employees of the Washington health

benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021(1) (g) and (n); and (vi) through December 31, 2019, employees of a charter school established under chapter 28A.710 RCW. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; ((~~employees of the Washington state convention and trade center as provided in RCW 41.05.110;~~)) students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under this chapter or by the authority under this chapter.

(b) Effective January 1, 2020, "school employee" for the school employees' benefits board program includes:

(i) All employees of school districts and charter schools established under chapter 28A.710 RCW;

(ii) Represented employees of educational service districts; and

(iii) Effective January 1, 2024, all employees of educational service districts.

(7) "Employee group" means employees of a similar employment type, such as administrative, represented classified, nonrepresented classified excluding such employees in educational service districts until December 31, 2023, confidential, represented certificated, or nonrepresented certificated excluding such employees in educational service districts until December 31, 2023, within a school employees' benefits board organization.

(8)(a) "Employer" for the public employees' benefits board program means the state of Washington.

(b) "Employer" for the school employees' benefits board program means school districts and educational service districts and charter schools established under chapter 28A.710 RCW.

(9) "Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, and employee organizations representing state civil service employees((~~, and through December 31, 2019, school districts, charter schools, and through December 31, 2023, educational service districts~~)) obtaining employee benefits through a contractual agreement with the authority to participate in benefit plans developed by the public employees' benefits board.

1 (10)(a) "Employing agency" for the public employees' benefits
2 board program means a division, department, or separate agency of
3 state government, including an institution of higher education; a
4 county, municipality, or other political subdivision; and a tribal
5 government covered by this chapter.
6 (b) "Employing agency" for the school employees' benefits board
7 program means school districts, educational service districts, and
8 charter schools.
9 (11) "Faculty" means an academic employee of an institution of
10 higher education whose workload is not defined by work hours but
11 whose appointment, workload, and duties directly serve the
12 institution's academic mission, as determined under the authority of
13 its enabling statutes, its governing body, and any applicable
14 collective bargaining agreement.
15 (12) "Flexible benefit plan" means a benefit plan that allows
16 ((~~employees and school~~)) public employees to choose the level of
17 health care coverage provided and the amount of employee or school
18 employee contributions from among a range of choices offered by the
19 authority.
20 (13) "Insuring entity" means an insurer as defined in chapter
21 48.01 RCW, a health care service contractor as defined in chapter
22 48.44 RCW, or a health maintenance organization as defined in chapter
23 48.46 RCW.
24 (14) "((~~Medical flexible~~)) Flexible spending arrangement" means a
25 benefit plan whereby ((~~state and school~~)) public employees may reduce
26 their salary before taxes to pay for medical expenses not reimbursed
27 by insurance as provided in the salary reduction plan under this
28 chapter pursuant to 26 U.S.C. Sec. 125 or other sections of the
29 internal revenue code.
30 (15) "Participant" means an individual who fulfills the
31 eligibility and enrollment requirements under the salary reduction
32 plan.
33 (16) "Plan year" means the time period established by the
34 authority.
35 (17) "Premium payment plan" means a benefit plan whereby public
36 employees may pay their share of group health plan premiums with
37 pretax dollars as provided in the salary reduction plan under this
38 chapter pursuant to 26 U.S.C. Sec. 125 or other sections of the
39 internal revenue code.

(18) "Public employee" has the same meaning as employee and school employee.

(19) "Retired or disabled school employee" means:

(a) Persons who separated from employment with a school district or educational service district and are receiving a retirement allowance under chapter 41.32 or 41.40 RCW as of September 30, 1993;

(b) Persons who separate from employment with a school district, educational service district, or charter school on or after October 1, 1993, and immediately upon separation receive a retirement allowance under chapter 41.32, 41.35, or 41.40 RCW;

(c) Persons who separate from employment with a school district, educational service district, or charter school due to a total and permanent disability, and are eligible to receive a deferred retirement allowance under chapter 41.32, 41.35, or 41.40 RCW.

(20) "Salary" means a ((~~state or school~~)) public employee's monthly salary or wages.

(21) "Salary reduction plan" means a benefit plan whereby public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program, ((~~medical~~)) flexible spending arrangement, or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the internal revenue code.

(22) "School employees' benefits board organization" means a public school district or educational service district or charter school established under chapter 28A.710 RCW that is required to participate in benefit plans provided by the school employees' benefits board.

(23) "School year" means school year as defined in RCW 28A.150.203(11).

(24) "Seasonal employee" means a state employee hired to work during a recurring, annual season with a duration of three months or more, and anticipated to return each season to perform similar work.

(25) "Separated employees" means persons who separate from employment with an employer as defined in:

(a) RCW 41.32.010(17) on or after July 1, 1996; or

(b) RCW 41.35.010 on or after September 1, 2000; or

(c) RCW 41.40.010 on or after March 1, 2002;

and who are at least age fifty-five and have at least ten years of service under the teachers' retirement system plan 3 as defined in RCW 41.32.010(33), the Washington school employees' retirement system

plan 3 as defined in RCW 41.35.010, or the public employees' retirement system plan 3 as defined in RCW 41.40.010.

(26) "State purchased health care" or "health care" means medical and behavioral health care, pharmaceuticals, and medical equipment purchased with state and federal funds by the department of social and health services, the department of health, the basic health plan, the state health care authority, the department of labor and industries, the department of corrections, the department of veterans affairs, and local school districts.

(27) "Tribal government" means an Indian tribal government as defined in section 3(32) of the employee retirement income security act of 1974, as amended, or an agency or instrumentality of the tribal government, that has government offices principally located in this state.

Sec. 4. RCW 41.05.013 and 2006 c 307 s 8 are each amended to read as follows:

(1) The authority shall coordinate state agency efforts to develop and implement uniform policies across state purchased health care programs that will ensure prudent, cost-effective health services purchasing, maximize efficiencies in administration of state purchased health care programs, improve the quality of care provided through state purchased health care programs, and reduce administrative burdens on health care providers participating in state purchased health care programs. The policies adopted should be based, to the extent possible, upon the best available scientific and medical evidence and shall endeavor to address:

(a) Methods of formal assessment, such as a health technology assessment under RCW 70.14.080 through 70.14.130. Consideration of the best available scientific evidence does not preclude consideration of experimental or investigational treatment or services under a clinical investigation approved by an institutional review board;

(b) Monitoring of health outcomes, adverse events, quality, and cost-effectiveness of health services;

(c) Development of a common definition of medical necessity; and

(d) Exploration of common strategies for disease management and demand management programs, including asthma, diabetes, heart disease, and similar common chronic diseases. Strategies to be explored include individual asthma management plans. ((~~On January 1,~~

~~2007, and January 1, 2009, the authority shall issue a status report to the legislature summarizing any results it attains in exploring and coordinating strategies for asthma, diabetes, heart disease, and other chronic diseases.~~))

(2) The ((~~administrator~~)) director may invite health care provider organizations, carriers, other health care purchasers, and consumers to participate in efforts undertaken under this section.

(3) For the purposes of this section "best available scientific and medical evidence" means the best available clinical evidence derived from systematic research.

Sec. 5. RCW 41.05.015 and 2018 c 201 s 7001 are each amended to read as follows:

The director shall designate a medical director who is licensed under chapter 18.57 or 18.71 RCW. The director shall also appoint such professional personnel and other assistants and employees, including professional medical screeners, as may be reasonably necessary to carry out the provisions of this chapter and chapters 74.09, 71.05, 71.24, and 71.34 RCW and other applicable law. The medical screeners must be supervised by one or more physicians whom the director or the director's designee shall appoint.

Sec. 6. RCW 41.05.021 and 2018 c 260 s 6 and 2018 c 201 s 7002 are each reenacted and amended to read as follows:

(1) The Washington state health care authority is created within the executive branch. The authority shall have a director appointed by the governor, with the consent of the senate. The director shall serve at the pleasure of the governor. The director may employ a deputy director, and such assistant directors and special assistants as may be needed to administer the authority, who shall be exempt from chapter 41.06 RCW, and any additional staff members as are necessary to administer this chapter. The director may delegate any power or duty vested in him or her by law, including authority to make final decisions and enter final orders in hearings conducted under chapter 34.05 RCW. The primary duties of the authority shall be to: Administer insurance benefits for employees, retired or disabled state and school employees, and school employees; administer the basic health plan pursuant to chapter 70.47 RCW; administer the children's health program pursuant to chapter 74.09 RCW; study state purchased health care programs in order to maximize cost containment

1 in these programs while ensuring access to quality health care;
2 implement state initiatives, joint purchasing strategies, and
3 techniques for efficient administration that have potential
4 application to all state-purchased health services; and administer
5 grants that further the mission and goals of the authority. The
6 authority's duties include, but are not limited to, the following:
7 (a) To administer health care benefit programs for employees,
8 retired or disabled state and school employees, and school employees
9 as specifically authorized in RCW 41.05.065 and 41.05.740 and in
10 accordance with the methods described in RCW 41.05.075, 41.05.140,
11 and other provisions of this chapter;
12 (b) To analyze state purchased health care programs and to
13 explore options for cost containment and delivery alternatives for
14 those programs that are consistent with the purposes of those
15 programs, including, but not limited to:
16 (i) Creation of economic incentives for the persons for whom the
17 state purchases health care to appropriately utilize and purchase
18 health care services, including the development of flexible benefit
19 plans to offset increases in individual financial responsibility;
20 (ii) Utilization of provider arrangements that encourage cost
21 containment, including but not limited to prepaid delivery systems,
22 utilization review, and prospective payment methods, and that ensure
23 access to quality care, including assuring reasonable access to local
24 providers, especially for employees and school employees residing in
25 rural areas;
26 (iii) Coordination of state agency efforts to purchase drugs
27 effectively as provided in RCW 70.14.050;
28 (iv) Development of recommendations and methods for purchasing
29 medical equipment and supporting services on a volume discount basis;
30 (v) Development of data systems to obtain utilization data from
31 state purchased health care programs in order to identify cost
32 centers, utilization patterns, provider and hospital practice
33 patterns, and procedure costs, utilizing the information obtained
34 pursuant to RCW 41.05.031; and
35 (vi) In collaboration with other state agencies that administer
36 state purchased health care programs, private health care purchasers,
37 health care facilities, providers, and carriers:
38 (A) Use evidence-based medicine principles to develop common
39 performance measures and implement financial incentives in contracts
40 with insuring entities, health care facilities, and providers that:

(I) Reward improvements in health outcomes for individuals with chronic diseases, increased utilization of appropriate preventive health services, and reductions in medical errors; and

(II) Increase, through appropriate incentives to insuring entities, health care facilities, and providers, the adoption and use of information technology that contributes to improved health outcomes, better coordination of care, and decreased medical errors;

(B) Through state health purchasing, reimbursement, or pilot strategies, promote and increase the adoption of health information technology systems, including electronic medical records, by hospitals as defined in RCW 70.41.020, integrated delivery systems, and providers that:

(I) Facilitate diagnosis or treatment;

(II) Reduce unnecessary duplication of medical tests;

(III) Promote efficient electronic physician order entry;

(IV) Increase access to health information for consumers and their providers; and

(V) Improve health outcomes;

(C) Coordinate a strategy for the adoption of health information technology systems ((~~using the final health information technology report and recommendations developed under chapter 261, Laws of 2005~~));

(c) To analyze areas of public and private health care interaction;

(d) To provide information and technical and administrative assistance to the board;

(e) To review and approve or deny applications from counties, municipalities, and other political subdivisions of the state to provide state-sponsored insurance or self-insurance programs to their employees in accordance with the provisions of RCW 41.04.205 and (g) of this subsection, setting the premium contribution for approved groups as outlined in RCW 41.05.050;

(f) To review and approve or deny the application when the governing body of a tribal government applies to transfer their employees to an insurance or self-insurance program administered by the public employees' benefits board. In the event of an employee transfer pursuant to this subsection (1)(f), members of the governing body are eligible to be included in such a transfer if the members are authorized by the tribal government to participate in the insurance program being transferred from and subject to payment by

the members of all costs of insurance for the members. The authority shall: (i) Establish the conditions for participation; (ii) have the sole right to reject the application; and (iii) set the premium contribution for approved groups as outlined in RCW 41.05.050. Approval of the application by the authority transfers the employees and dependents involved to the insurance, self-insurance, or health care program administered by the public employees' benefits board;

(g) To ensure the continued status of the employee insurance or self-insurance programs administered under this chapter as a governmental plan under section 3(32) of the employee retirement income security act of 1974, as amended, the authority shall limit the participation of employees of a county, municipal, school district, educational service district, or other political subdivision, the Washington health benefit exchange, or a tribal government, including providing for the participation of those employees whose services are substantially all in the performance of essential governmental functions, but not in the performance of commercial activities. Charter schools established under chapter 28A.710 RCW are employers and are school employees' benefits board organizations unless:

(i) The authority receives guidance from the internal revenue service or the United States department of labor that participation jeopardizes the status of plans offered under this chapter as governmental plans under the federal employees' retirement income security act or the internal revenue code; or

(ii) The charter schools are not in compliance with regulations issued by the internal revenue service and the United States treasury department pertaining to section 414(d) of the federal internal revenue code;

(h) To establish billing procedures and collect funds from school employees' benefits board organizations in a way that minimizes the administrative burden on districts;

(i) Through December 31, 2019, to publish and distribute to nonparticipating school districts and educational service districts by October 1st of each year a description of health care benefit plans available through the authority and the estimated cost if school districts and educational service district employees were enrolled;

(j) To apply for, receive, and accept grants, gifts, and other payments, including property and service, from any governmental or

other public or private entity or person, and make arrangements as to the use of these receipts to implement initiatives and strategies developed under this section;

(k) To issue, distribute, and administer grants that further the mission and goals of the authority;

(l) To adopt rules consistent with this chapter as described in RCW 41.05.160 including, but not limited to:

(i) Setting forth the criteria established by the public employees' benefits board under RCW 41.05.065, and by the school employees' benefits board under RCW 41.05.740, for determining whether ((~~an employee or school~~)) a public employee is eligible for benefits;

(ii) Establishing an appeal process in accordance with chapter 34.05 RCW by which ((~~an employee or school~~)) a public employee may appeal an eligibility determination;

(iii) Establishing a process to assure that the eligibility determinations of an employing agency comply with the criteria under this chapter, including the imposition of penalties as may be authorized by the board;

(m)(i) To administer the medical services programs established under chapter 74.09 RCW as the designated single state agency for purposes of Title XIX of the federal social security act;

(ii) To administer the state children's health insurance program under chapter 74.09 RCW for purposes of Title XXI of the federal social security act;

(iii) To enter into agreements with the department of social and health services for administration of medical care services programs under Titles XIX and XXI of the social security act and programs under chapters 71.05, 71.24, and 71.34 RCW. The agreements shall establish the division of responsibilities between the authority and the department with respect to mental health, ((~~chemical dependency~~)) substance use disorders, and long-term care services, including services for persons with developmental disabilities. The agreements shall be revised as necessary, to comply with the final implementation plan adopted under section 116, chapter 15, Laws of 2011 1st sp. sess.;

(iv) To adopt rules to carry out the purposes of chapter 74.09 RCW;

(v) To appoint such advisory committees or councils as may be required by any federal statute or regulation as a condition to the

receipt of federal funds by the authority. The director may appoint statewide committees or councils in the following subject areas: (A) Health facilities; (B) children and youth services; (C) blind services; (D) medical and health care; (E) drug abuse and alcoholism; (F) rehabilitative services; and (G) such other subject matters as are or come within the authority's responsibilities. The statewide councils shall have representation from both major political parties and shall have substantial consumer representation. Such committees or councils shall be constituted as required by federal law or as the director in his or her discretion may determine. The members of the committees or councils shall hold office for three years except in the case of a vacancy, in which event appointment shall be only for the remainder of the unexpired term for which the vacancy occurs. No member shall serve more than two consecutive terms. Members of such state advisory committees or councils may be paid their travel expenses in accordance with RCW 43.03.050 and 43.03.060 as now existing or hereafter amended;

(n) To review and approve or deny the application from the governing board of the Washington health benefit exchange to provide public employees' benefits board state-sponsored insurance or self-insurance programs to employees of the exchange. The authority shall (i) establish the conditions for participation; (ii) have the sole right to reject an application; and (iii) set the premium contribution for approved groups as outlined in RCW 41.05.050.

(2) The public employees' benefits board and the school employees' benefits board may implement strategies to promote managed competition among employee and school employee health benefit plans. Strategies may include but are not limited to:

(a) Standardizing the benefit package;

(b) Soliciting competitive bids for the benefit package;

(c) Limiting the state's contribution to a percent of the lowest priced qualified plan within a geographical area;

(d) Monitoring the impact of the approach under this subsection with regards to: Efficiencies in health service delivery, cost shifts to subscribers, access to and choice of managed care plans statewide, and quality of health services. The health care authority shall also advise on the value of administering a benchmark employer-managed plan to promote competition among managed care plans.

Sec. 7. RCW 41.05.031 and 1990 c 222 s 4 are each amended to read as follows:

The Washington state health information technology office is located within the authority. The following state agencies are directed to cooperate with the authority to establish appropriate health care information systems in their programs: The department of social and health services, the department of health, the department of labor and industries, the basic health plan, the department of veterans affairs, the department of corrections, the department of children, youth, and families, and the superintendent of public instruction.

The authority, in conjunction with these agencies and in collaboration with the consolidated technology services agency, shall determine:

(1) Definitions of health care services;

(2) Health care data elements common to all agencies;

(3) Health care data elements unique to each agency; and

(4) A mechanism for program and budget review of health care data.

Sec. 8. RCW 41.05.035 and 2007 c 259 s 10 are each amended to read as follows:

(1) The ((~~administrator~~)) director shall design ((~~and pilot~~)), implement, and maintain a consumer-centric health information infrastructure and the ((~~first health record banks~~)) state electronic health record repositories that will facilitate the secure exchange of health information when and where needed and shall:

(a) Complete the plan of initial implementation, including but not limited to determining the technical infrastructure for ((~~health record banks~~)) the state electronic health record repositories and the account locator service, setting criteria and standards for health record ((~~banks~~)) repositories, and determining oversight of the state health ((~~record banks~~)) records service;

(b) Implement the first state health record ((~~banks in pilot sites~~)) repositories as funding allows;

(c) Involve health care consumers in meaningful ways in the design, implementation, oversight, and dissemination of information on the state health record ((~~bank~~)) repositories system; and

(d) Promote adoption of electronic medical records and health information exchange through continuation of the Washington health

information collaborative, and by working with private payors and other organizations in restructuring reimbursement to provide incentives for providers to adopt electronic medical records in their practices.

(2) The ((~~administrator~~)) director may establish an advisory board, a stakeholder committee, and subcommittees to assist in carrying out the duties under this section. The ((~~administrator~~)) director may reappoint health information infrastructure advisory board members to assure continuity and shall appoint any additional representatives that may be required for their expertise and experience.

(a) The ((~~administrator~~)) director shall appoint the chair of the advisory board, chairs, and cochairs of the stakeholder committee, if formed;

(b) Meetings of the board, stakeholder committee, and any advisory group are subject to chapter 42.30 RCW, the open public meetings act, including RCW 42.30.110(1)(l), which authorizes an executive session during a regular or special meeting to consider proprietary or confidential nonpublished information; and

(c) The members of the board, stakeholder committee, and any advisory group:

(i) Shall agree to the terms and conditions imposed by the ((~~administrator~~)) director regarding conflicts of interest as a condition of appointment;

(ii) Are immune from civil liability for any official acts performed in good faith as members of the board, stakeholder committee, or any advisory group.

(3) Members of the board may be compensated for participation in accordance with a personal services contract to be executed after appointment and before commencement of activities related to the work of the board. Members of the stakeholder committee shall not receive compensation but shall be reimbursed under RCW 43.03.050 and 43.03.060.

(4) The ((~~administrator~~)) director may work with public and private entities to develop and encourage the use of personal health records which are portable, interoperable, secure, and respectful of patients' privacy.

(5) The ((~~administrator~~)) director may enter into contracts to issue, distribute, and administer grants that are necessary or proper to carry out this section.

Sec. 9. RCW 41.05.039 and 2009 c 300 s 3 are each amended to read as follows:

(1) By August 1, 2009, the ((~~administrator~~)) director shall designate one or more lead organizations to coordinate development of processes, guidelines, and standards to:

(a) Improve patient access to and control of their own health care information and thereby enable their active participation in their own care; and

(b) Implement methods for the secure exchange of clinical data as a means to promote:

(i) Continuity of care;

(ii) Quality of care;

(iii) Patient safety; and

(iv) Efficiency in medical practices.

(2) The lead organization designated by the ((~~administrator~~)) director under this section shall:

(a) Be representative of health care privacy advocates, providers, and payors across the state;

(b) Have expertise and knowledge in the major disciplines related to the secure exchange of health data;

(c) Be able to support the costs of its work without recourse to state funding. The ((~~administrator~~)) director and the lead organization are authorized and encouraged to seek federal funds, including funds from the federal American recovery and reinvestment act, as well as solicit, receive, contract for, collect, and hold grants, donations, and gifts to support the implementation of this section and RCW 41.05.042;

(d) In collaboration with the ((~~administrator~~)) director, identify and convene work groups, as needed, to accomplish the goals of this section and RCW 41.05.042;

(e) Conduct outreach and communication efforts to maximize the adoption of the guidelines, standards, and processes developed by the lead organization;

(f) Submit regular updates to the ((~~administrator~~)) director on the progress implementing the requirements of this section and RCW 41.05.042; and

(g) With the ((~~administrator~~)) director, report to the legislature December 1, 2009, and on December 1st of each year through December 1, 2012, on progress made, the time necessary for

completing tasks, and identification of future tasks that should be prioritized for the next improvement cycle.

(3) Within available funds as specified in subsection (2)(c) of this section, the ((~~administrator~~)) director shall:

(a) Participate in and review the work and progress of the lead organization, including the establishment and operation of work groups for this section and RCW 41.05.042; and

(b) Consult with the office of the attorney general to determine whether:

(i) An antitrust safe harbor is necessary to enable licensed carriers and providers to develop common rules and standards; and, if necessary, take steps, such as implementing rules or requesting legislation, to establish a safe harbor; and

(ii) Legislation is needed to limit provider liability if their health records are missing health information despite their participation in the exchange of health information.

(4) The lead organization or organizations shall take steps to minimize the costs that implementation of the processes, guidelines, and standards may have on participating entities, including providers.

Sec. 10. RCW 41.05.046 and 2009 c 300 s 5 are each amended to read as follows:

If any provision in RCW 41.05.036, 41.05.039, and 41.05.042 conflicts with existing or new federal requirements, the ((~~administrator~~)) director shall recommend modifications, as needed, to assure compliance with the aims of RCW 41.05.036, 41.05.039, and 41.05.042 and federal requirements.

Sec. 11. RCW 41.05.066 and 2018 c 260 s 13 are each amended to read as follows:

A certificate of domestic partnership qualified under the provisions of RCW 26.60.030 shall be recognized as evidence of a ((~~qualified~~)) state registered domestic partnership fulfilling all necessary eligibility criteria for the partner of the ((~~employee or school~~)) public employee to receive benefits. Nothing in this section affects the requirements of domestic partners to complete documentation related to federal tax status that may currently be required by the board for ((~~employees or school~~)) public employees choosing to make premium payments on a pretax basis.

Sec. 12. RCW 41.05.068 and 2009 c 479 s 25 are each amended to read as follows:

The authority may participate as an employer-sponsored program established in section 1860D-22 of the medicare prescription drug, improvement, and modernization act of 2003, P.L. 108-173 et seq., to receive federal employer subsidy funds for continuing to provide retired employee health coverage, including a pharmacy benefit. The ((~~administrator~~)) director, in consultation with the office of financial management, shall evaluate participation in the employer incentive program, including but not limited to any necessary program changes to meet the eligibility requirements that employer-sponsored retiree health coverage provide prescription drug coverage at least equal to the actuarial value of standard prescription drug coverage under medicare part D. Any employer subsidy moneys received from participation in the federal employer incentive program shall be deposited in the state general fund.

Sec. 13. RCW 41.05.130 and 2017 3rd sp.s. c 13 s 810 are each amended to read as follows:

(1) The state health care authority administrative account is hereby created in the state treasury. Moneys in the account, including unanticipated revenues under RCW 43.79.270, may be spent only after appropriation by statute, and may be used only for operating expenses of the authority((~~, and during the 2013-2015 fiscal biennium, for health care related analysis provided to the legislature by the office of the state actuary. During the 2017-2019 and 2019-2021 fiscal biennia, moneys in the account may be used for the initial operating expenses of the authority associated with chapter 13, Laws of 2017 3rd sp. sess. All funds so used shall be reimbursed from the school employees' insurance administrative account following the start of benefit provision by the school employees' benefits board on January 1, 2020~~)).

(2) The school employees' insurance administrative account is hereby created in the state treasury. Moneys in the account may be used for operating, contracting, and other administrative expenses of the authority in administration of the school employees insurance program, including reimbursement of the state health care authority administrative account for initial operating expenses of the authority associated with chapter 13, Laws of 2017 3rd sp. sess.

Sec. 14. RCW 41.05.160 and 1988 c 107 s 15 are each amended to read as follows:

The ((~~administrator~~)) director may promulgate and adopt rules consistent with this chapter to carry out the purposes of this chapter. All rules shall be adopted in accordance with chapter 34.05 RCW.

Sec. 15. RCW 41.05.220 and 1998 c 245 s 38 are each amended to read as follows:

(1) State general funds appropriated to the department of health for the purposes of funding community health centers to provide primary health and dental care services, migrant health services, and maternity health care services shall be transferred to the state health care authority. Any related administrative funds expended by the department of health for this purpose shall also be transferred to the health care authority. The health care authority shall exclusively expend these funds through contracts with community health centers to provide primary health and dental care services, migrant health services, and maternity health care services. The ((~~administrator~~)) director of the health care authority shall establish requirements necessary to assure community health centers provide quality health care services that are appropriate and effective and are delivered in a cost-efficient manner. The ((~~administrator~~)) director shall further assure that community health centers have appropriate referral arrangements for acute care and medical specialty services not provided by the community health centers.

(2) The authority, in consultation with the department of health, shall work with community and migrant health clinics and other providers of care to underserved populations, to ensure that the number of people of color and underserved people receiving access to managed care is expanded in proportion to need, based upon demographic data.

Sec. 16. RCW 41.05.310 and 2008 c 229 s 4 are each amended to read as follows:

The authority shall have responsibility for the formulation and adoption of a plan, policies, and procedures designed to guide, direct, and administer the salary reduction plan. For the plan year beginning January 1, 1996, the ((~~administrator~~)) director may

establish a premium only plan. Expansion of the salary reduction plan or cafeteria plan during subsequent plan years shall be subject to approval by the director of the office of financial management.

(1) A plan document describing the benefits offered under the salary reduction plan shall be adopted and administered by the authority. The authority shall represent the state in all matters concerning the administration of the plan. The state, through the authority, may engage the services of a professional consultant or administrator on a contractual basis to serve as an agent to assist the authority or perform the administrative functions necessary in carrying out the purposes of RCW 41.05.123, 41.05.300 through 41.05.350, and 41.05.295.

(2) The authority shall formulate and establish policies and procedures for the administration of the salary reduction plan that are consistent with existing state law, the internal revenue code, and the regulations adopted by the internal revenue service as they may apply to the benefits offered to participants under the plan.

(3) Every action taken by the authority in administering RCW 41.05.123, 41.05.300 through 41.05.350, and 41.05.295 shall be presumed to be a fair and reasonable exercise of the authority vested in or the duties imposed upon it. The authority shall be presumed to have exercised reasonable care, diligence, and prudence and to have acted impartially as to all persons interested unless the contrary be proved by clear and convincing affirmative evidence.

Sec. 17. RCW 41.05.320 and 2018 c 260 s 20 are each amended to read as follows:

(1) Elected officials and permanent employees and school employees are eligible to participate in the salary reduction plan and reduce their salary by agreement with the authority. The authority may adopt rules to: (a) Limit the participation of employing agencies and their employees in the plan; and (b) permit participation in the plan by temporary employees and school employees.

(2) Persons eligible under subsection (1) of this section may enter into salary reduction agreements with the state.

(3)(a) An eligible person may become a participant of the salary reduction plan for a full plan year with annual benefit plan selection for each new plan year made before the beginning of the plan year, as determined by the authority, or upon becoming eligible.

(b) Once an eligible person elects to participate in the salary reduction plan and determines the amount his or her gross salary shall be reduced and the benefit plan for which the funds are to be used during the plan year, the agreement shall be irrevocable and may not be amended during the plan year except as provided in (c) of this subsection. Prior to making an election to participate in the salary reduction plan, the eligible person shall be informed in writing of all the benefits and reductions that will occur as a result of such election.

(c) The authority shall provide in the salary reduction plan that a participant may enroll, terminate, or change his or her election after the plan year has begun if there is a significant change in a participant's status, as provided by 26 U.S.C. Sec. 125 and the regulations adopted under that section and defined by the authority.

(4) The authority shall establish as part of the salary reduction plan the procedures for and effect of withdrawal from the plan by reason of retirement, death, leave of absence, or termination of employment. To the extent possible under federal law, the authority shall protect participants from forfeiture of rights under the plan.

(5) Any reduction of salary under the salary reduction plan shall not reduce the reportable compensation for the purpose of computing the state retirement and pension benefits earned by the ((~~employee or school~~)) public employee pursuant to chapters 41.26, 41.32, 41.35, 41.37, 41.40, and 43.43 RCW.

Sec. 18. RCW 41.05.400 and 2000 c 80 s 7 are each amended to read as follows:

(1) The ((~~administrator~~)) director shall design and offer a plan of health care coverage as described in subsection (2) of this section, for any person eligible under subsection (3) of this section. The health care coverage shall be designed and offered only to the extent that state funds are specifically appropriated for this purpose.

(2) The plan of health care coverage shall have the following components:

(a) Services covered more limited in scope than those contained in RCW 48.41.110(3);

(b) Enrollee cost-sharing that may include but not be limited to point-of-service cost-sharing for covered services;

(c) Deductibles of three thousand dollars on a per person per calendar year basis, and four thousand dollars on a per family per calendar year basis. The deductible shall be applied to the first three thousand dollars, or four thousand dollars, of eligible expenses incurred by the covered person or family, respectively, except that the deductible shall not be applied to clinical preventive services as recommended by the United States public health service. Enrollee out-of-pocket expenses required to be paid under the plan for cost-sharing and deductibles shall not exceed five thousand dollars per person, or six thousand dollars per family;

(d) Payment methodologies for network providers may include but are not limited to resource-based relative value fee schedules, capitation payments, diagnostic related group fee schedules, and other similar strategies including risk-sharing arrangements; and

(e) Other appropriate care management and cost-containment measures determined appropriate by the ((~~administrator~~)) director, including but not limited to care coordination, provider network limitations, preadmission certification, and utilization review.

(3) Any person is eligible for coverage in the plan who resides in a county of the state where no carrier, as defined in RCW 48.43.005, or insurer regulated under chapter 48.15 RCW offers to the public an individual health benefit plan as defined in RCW 48.43.005 other than a catastrophic health plan as defined in RCW 48.43.005 at the time of application to the ((~~administrator~~)) director. Such eligibility may terminate pursuant to subsection (8) of this section.

(4) The ((~~administrator~~)) director may not reject an individual for coverage based upon preexisting conditions of the individual or deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions; except that it shall impose a nine-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months before the effective date of coverage. The preexisting condition waiting period shall not apply to prenatal care services. Credit against the waiting period shall be provided pursuant to subsections (5) and (6) of this section.

(5) Except for persons to whom subsection (6) of this section applies, the ((~~administrator~~)) director shall credit any preexisting condition waiting period in the plan for a person who was enrolled at

any time during the sixty-three day period immediately preceding the date of application for the plan in a group health benefit plan or an individual health benefit plan other than a catastrophic health plan. The ((~~administrator~~)) director must credit the period of coverage the person was continuously covered under the immediately preceding health plan toward the waiting period of the new health plan. For the purposes of this subsection, a preceding health plan includes an employer-provided self-funded health plan.

(6) The ((~~administrator~~)) director shall waive any preexisting condition waiting period in the plan for a person who is an eligible individual as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. 300gg-41(b)).

(7) The ((~~administrator~~)) director shall set the rates to be charged plan enrollees.

(8) When a carrier, as defined in RCW 48.43.005, or an insurer regulated under chapter 48.15 RCW, begins to offer an individual health benefit plan as defined in RCW 48.43.005 in a county where no carrier or insurer had been offering an individual health benefit plan:

(a) If the health benefit plan offered is other than a catastrophic health plan as defined in RCW 48.43.005, any person enrolled in the plan under subsection (3) of this section in that county shall no longer be eligible;

(b) The ((~~administrator~~)) director shall provide written notice to any person who is no longer eligible for coverage under the plan within thirty days of the ((~~administrator's~~)) director's determination that the person is no longer eligible. The notice shall: (i) Indicate that coverage under the plan will cease ninety days from the date that the notice is dated; (ii) describe any other coverage options available to the person; and (iii) describe the enrollment process for the available options.

Sec. 19. RCW 41.05.413 and 2019 c 364 s 4 are each amended to read as follows:

The director may, in his or her sole discretion, waive the requirements of RCW 41.05.410(2)(g)((~~(i)~~)) if he or she finds that:

(1) A health carrier offering a qualified health plan under RCW 41.05.410 is unable to form a provider network that meets the network

access standards adopted by the insurance commissioner due to the requirements of RCW 41.05.410(2)(g)((~~(i)~~)); and

(2) The health carrier is able to achieve actuarially sound premiums that are ten percent lower than the previous plan year through other means.

Sec. 20. RCW 41.05.520 and 2003 1st sp.s. c 29 s 7 are each amended to read as follows:

(1) The ((~~administrator~~)) director shall establish and advertise a pharmacy connection program through which health care providers and members of the public can obtain information about manufacturer-sponsored prescription drug assistance programs. The ((~~administrator~~)) director shall ensure that the program has staff available who can assist persons in procuring free or discounted medications from manufacturer-sponsored prescription drug assistance programs by:

(a) Determining whether an assistance program is offered for the needed drug or drugs;

(b) Evaluating the likelihood of a person obtaining drugs from an assistance program under the guidelines formulated;

(c) Assisting persons with the application and enrollment in an assistance program;

(d) Coordinating and assisting physicians and others authorized to prescribe medications with communications, including applications, made on behalf of a person to a participating manufacturer to obtain approval of the person in an assistance program; and

(e) Working with participating manufacturers to simplify the system whereby eligible persons access drug assistance programs, including development of a single application form and uniform enrollment process.

(2) Notice regarding the pharmacy connection program shall initially target senior citizens, but the program shall be available to anyone, and shall include a toll-free telephone number, available during regular business hours, that may be used to obtain information.

(3) The ((~~administrator~~)) director may apply for and accept grants or gifts and may enter into interagency agreements or contracts with other state agencies or private organizations to assist with the implementation of this program including, but not

limited to, contracts, gifts, or grants from pharmaceutical manufacturers to assist with the direct costs of the program.

(4) The ((~~administrator~~)) director shall notify pharmaceutical companies doing business in Washington of the pharmacy connection program. Any pharmaceutical company that does business in this state and that offers a pharmaceutical assistance program shall notify the ((~~administrator~~)) director of the existence of the program, the drugs covered by the program, and all information necessary to apply for assistance under the program.

(5) For purposes of this section, "manufacturer-sponsored prescription drug assistance program" means a program offered by a pharmaceutical company through which the company provides a drug or drugs to eligible persons at no charge or at a reduced cost. The term does not include the provision of a drug as part of a clinical trial.

Sec. 21. RCW 41.05.540 and 2007 c 259 s 40 are each amended to read as follows:

(1) The health care authority, in coordination with the department of health, health plans participating in public employees' benefits board programs, and the University of Washington's center for health promotion, shall establish and maintain a state employee health program focused on reducing the health risks and improving the health status of state employees, dependents, and retirees enrolled in the public employees' benefits board. The program shall use public and private sector best practices to achieve goals of measurable health outcomes, measurable productivity improvements, positive impact on the cost of medical care, and positive return on investment. The program shall establish standards for health promotion and disease prevention activities, and develop a mechanism to update standards as evidence-based research brings new information and best practices forward.

(2) The state employee health program shall:

(a) Provide technical assistance and other services as needed to wellness staff in all state agencies and institutions of higher education;

(b) Develop effective communication tools and ongoing training for wellness staff;

(c) Contract with outside vendors for evaluation of program goals;

1 (d) Strongly encourage the widespread completion of online health
2 assessment tools for all state employees, dependents, and retirees.
3 The health assessment tool must be voluntary and confidential. Health
4 assessment data and claims data shall be used to:
5 (i) Engage state agencies and institutions of higher education in
6 providing evidence-based programs targeted at reducing identified
7 health risks;
8 (ii) Guide contracting with third-party vendors to implement
9 behavior change tools for targeted high-risk populations; and
10 (iii) Guide the benefit structure for state employees,
11 dependents, and retirees to include covered services and medications
12 known to manage and reduce health risks.
13 ((~~(3) The health care authority shall report to the legislature~~
14 ~~in December 2008 and December 2010 on outcome goals for the employee~~
15 ~~health program.~~))

16 **Sec. 22.** RCW 41.05.550 and 2015 c 161 s 1 are each amended to
17 read as follows:
18 (1) The definitions in this subsection apply throughout this
19 section unless the context clearly requires otherwise.
20 (a) "Federal poverty level" means the official poverty level
21 based on family size established and adjusted under section 673(2) of
22 the omnibus budget reconciliation act of 1981 (P.L. 97-35; 42 U.S.C.
23 Sec. 9902(2), as amended).
24 (b) "Foundation" means the prescription drug assistance
25 foundation established in this section, a nonprofit corporation
26 organized under the laws of this state to provide assistance in
27 accessing prescription drugs to qualified uninsured individuals.
28 (c) "Health insurance coverage including prescription drugs"
29 means prescription drug coverage under a private insurance plan,
30 including a plan offered through the health benefit exchange under
31 chapter 43.71 RCW, the medicaid program, the state children's health
32 insurance program ("SCHIP"), the medicare program, the basic health
33 plan, or any employer-sponsored health plan that includes a
34 prescription drug benefit.
35 (d) "Qualified uninsured individual" means an uninsured person or
36 an underinsured person who is a resident of this state and whose
37 income meets financial criteria established by the foundation.

(e) "Underinsured" means an individual who has health insurance coverage including prescription drugs, but for whom the prescription drug coverage is inadequate for their needs.

(f) "Uninsured" means an individual who lacks health insurance coverage including prescription drugs.

(2)(a) The ((~~administrator~~)) director shall establish the foundation as a nonprofit corporation, organized under the laws of this state. The foundation shall assist qualified uninsured individuals in obtaining prescription drugs at little or no cost.

(b) The foundation shall be administered in a manner that:

(i) Begins providing assistance to qualified uninsured individuals by January 1, 2006;

(ii) Defines the population that may receive assistance in accordance with this section; and

(iii) Complies with the eligibility requirements necessary to obtain and maintain tax-exempt status under federal law.

(c) The board of directors of the foundation consists of up to eleven with a minimum of five members appointed by the governor to staggered terms of three years. The governor shall select as members of the board individuals who (i) will represent the interests of persons who lack prescription drug coverage; and (ii) have demonstrated expertise in business management and in the administration of a not-for-profit organization.

(d) The foundation shall apply for and comply with all federal requirements necessary to obtain and maintain tax-exempt status with respect to the federal tax obligations of the foundation's donors.

(e) The foundation is authorized, subject to the direction and ratification of the board, to receive, solicit, contract for, collect, and hold in trust for the purposes of this section, donations, gifts, grants, and bequests in the form of money paid or promised, services, materials, equipment, or other things tangible or intangible that may be useful for helping the foundation to achieve its purpose. The foundation may use all sources of public and private financing to support foundation activities. No general fund-state funds shall be used for the ongoing operation of the foundation.

(f) No liability on the part of, and no cause of action of any nature, shall arise against any member of the board of directors of the foundation or against an employee or agent of the foundation for any lawful action taken by them in the performance of their administrative powers and duties under this section.

1 **Sec. 23.** RCW 41.05.601 and 2005 c 6 s 12 are each amended to
2 read as follows:
3 The ((~~administrator~~)) <u>director</u> may adopt rules to implement RCW
4 41.05.600.

5 **Sec. 24.** RCW 41.05.650 and 2009 c 299 s 1 are each amended to
6 read as follows:
7 (1) The community health care collaborative grant program is
8 established to further the efforts of community-based coalitions to
9 increase access to appropriate, affordable health care for Washington
10 residents, particularly employed low-income persons and children in
11 school who are uninsured and underinsured, through local programs
12 addressing one or more of the following: (a) Access to medical
13 treatment; (b) the efficient use of health care resources; and (c)
14 quality of care.
15 (2) Consistent with funds appropriated for community health care
16 collaborative grants specifically for this purpose, two-year grants
17 may be awarded pursuant to RCW 41.05.660 by the ((~~administrator~~))
18 <u>director</u> of the health care authority.
19 (3) The health care authority shall provide administrative
20 support for the program. Administrative support activities may
21 include health care authority facilitation of statewide discussions
22 regarding best practices and standardized performance measures among
23 grantees, or subcontracting for such discussions.
24 (4) Eligibility for community health care collaborative grants
25 shall be limited to nonprofit organizations established to serve a
26 defined geographic region or organizations with public agency status
27 under the jurisdiction of a local, county, or tribal government. To
28 be eligible, such entities must have a formal collaborative
29 governance structure and decision-making process that includes
30 representation by the following health care providers: Hospitals,
31 public health, behavioral health, community health centers, rural
32 health clinics, and private practitioners that serve low-income
33 persons in the region, unless there are no such providers within the
34 region, or providers decline or refuse to participate or place
35 unreasonable conditions on their participation. The nature and format
36 of the application, and the application procedure, shall be
37 determined by the ((~~administrator~~)) <u>director</u> of the health care
38 authority. At a minimum, each application shall: (a) Identify the
39 geographic region served by the organization; (b) show how the

structure and operation of the organization reflects the interests of, and is accountable to, this region and members providing care within this region; (c) indicate the size of the grant being requested, and how the money will be spent; and (d) include sufficient information for an evaluation of the application based on the criteria established in RCW 41.05.660.

Sec. 25. RCW 41.05.660 and 2009 c 299 s 2 are each amended to read as follows:

(1) The community health care collaborative grants shall be awarded on a competitive basis based on a determination of which applicant organization will best serve the purposes of the grant program established in RCW 41.05.650. In making this determination, priority for funding shall be given to the applicants that demonstrate:

(a) The initiatives to be supported by the community health care collaborative grant are likely to address, in a measurable fashion, documented health care access and quality improvement goals aligned with state health policy priorities and needs within the region to be served;

(b) The applicant organization must document formal, active collaboration among key community partners that includes local governments, school districts, large and small businesses, nonprofit organizations, tribal governments, carriers, private health care providers, public health agencies, and community public health and safety networks((~~, as defined in RCW 70.190.010~~));

(c) The applicant organization will match the community health care collaborative grant with funds from other sources. The health care authority may award grants solely to organizations providing at least two dollars in matching funds for each community health care collaborative grant dollar awarded;

(d) The community health care collaborative grant will enhance the long-term capacity of the applicant organization and its members to serve the region's documented health care access needs, including the sustainability of the programs to be supported by the community health care collaborative grant;

(e) The initiatives to be supported by the community health care collaborative grant reflect creative, innovative approaches which complement and enhance existing efforts to address the needs of the

uninsured and underinsured and, if successful, could be replicated in other areas of the state; and

(f) The programs to be supported by the community health care collaborative grant make efficient and cost-effective use of available funds through administrative simplification and improvements in the structure and operation of the health care delivery system.

(2) The ((~~administrator~~)) director of the health care authority shall endeavor to disburse community health care collaborative grant funds throughout the state, supporting collaborative initiatives of differing sizes and scales, serving at-risk populations.

(3) Grants shall be disbursed over a two-year cycle, provided the grant recipient consistently provides timely reports that demonstrate the program is satisfactorily meeting the purposes of the grant and the objectives identified in the organization's application. The requirements for the performance reports shall be determined by the health care authority ((~~administrator~~)) director. The performance measures shall be aligned with the community health care collaborative grant program goals and, where possible, shall be consistent with statewide policy trends and outcome measures required by other public and private grant funders.

Sec. 26. RCW 41.05A.120 and 2011 1st sp.s. c 15 s 99 are each amended to read as follows:

(1) After service of a notice of debt for an overpayment as provided for in RCW 41.05A.110 or 41.05A.170, stating the debt accrued, the director may issue to any person, firm, corporation, association, political subdivision, or department of the state an order to withhold and deliver property of any kind including, but not restricted to, earnings which are due, owing, or belonging to the debtor, when the director has reason to believe that there is in the possession of such person, firm, corporation, association, political subdivision, or department of the state property which is due, owing, or belonging to the debtor. The order to withhold and deliver must state the amount of the debt, and must state in summary the terms of this section, RCW 6.27.150 and 6.27.160, chapters 6.13 and 6.15 RCW, 15 U.S.C. Sec. 1673, and other state or federal exemption laws applicable generally to debtors. The order to withhold and deliver must be served in the manner prescribed for the service of a summons in a civil action or by certified mail, with return receipt

((~~requested~~)) service. Any person, firm, corporation, association, political subdivision, or department of the state upon whom service has been made shall answer the order to withhold and deliver within twenty days, exclusive of the day of service, under oath and in writing, and shall make true answers to the matters inquired of therein. The director may require further and additional answers to be completed by the person, firm, corporation, association, political subdivision, or department of the state. If any such person, firm, corporation, association, political subdivision, or department of the state possesses any property which may be subject to the claim of the authority, such property must be withheld immediately upon receipt of the order to withhold and deliver and must, after the twenty-day period, upon demand, be delivered forthwith to the director. The director shall hold the property in trust for application on the indebtedness involved or for return, without interest, in accordance with final determination of liability or nonliability. In the alternative, there may be furnished to the director a good and sufficient bond, satisfactory to the director, conditioned upon final determination of liability. Where money is due and owing under any contract of employment, express or implied, or is held by any person, firm, corporation, association, political subdivision, or department of the state subject to withdrawal by the debtor, such money must be delivered by remittance payable to the order of the director. Delivery to the director, subject to the exemptions under RCW 6.27.150 and 6.27.160, chapters 6.13 and 6.15 RCW, 15 U.S.C. Sec. 1673, and other state or federal law applicable generally to debtors, of the money or other property held or claimed satisfies the requirement of the order to withhold and deliver. Delivery to the director serves as full acquittance, and the state warrants and represents that it shall defend and hold harmless for such actions persons delivering money or property to the director pursuant to this chapter. The state also warrants and represents that it shall defend and hold harmless for such actions persons withholding money or property pursuant to this chapter.

(2) The director shall also, on or before the date of service of the order to withhold and deliver, mail or cause to be mailed by certified mail a copy of the order to withhold and deliver to the debtor at the debtor's last known post office address or, in the alternative, a copy of the order to withhold and deliver must be served on the debtor in the same manner as a summons in a civil

action on or before the date of service of the order or within two days thereafter. The copy of the order must be mailed or served together with a concise explanation of the right to petition for a hearing on any issue related to the collection. This requirement is not jurisdictional, but, if the copy is not mailed or served as provided in this section, or if any irregularity appears with respect to the mailing or service, the superior court, on its discretion on motion of the debtor promptly made and supported by affidavit showing that the debtor has suffered substantial injury due to the failure to mail the copy, may set aside the order to withhold and deliver and award to the debtor an amount equal to the damages resulting from the director's failure to serve on or mail to the debtor the copy.

Sec. 27. RCW 41.05A.160 and 2011 1st sp.s. c 15 s 103 are each amended to read as follows:

When the authority provides assistance to persons who possess excess real property under RCW 74.04.005((~~(11)~~)) (13)(g), the authority may file a lien against or otherwise perfect its interest in such real property as a condition of granting such assistance, and the authority has the status of a secured creditor.

Sec. 28. RCW 41.05A.170 and 2011 1st sp.s. c 15 s 104 are each amended to read as follows:

(1) When the authority determines that a vendor was overpaid by the authority for either goods or services, or both, provided to authority clients, except nursing homes under chapter 74.46 RCW, the authority shall give written notice to the vendor. The notice must include the amount of the overpayment, the basis for the claim, and the rights of the vendor under this section.

(2) The notice may be served upon the vendor in the manner prescribed for the service of a summons in civil action or be mailed to the vendor at the last known address by certified mail, return receipt requested, demanding payment within twenty days of the date of receipt.

(3) The vendor has the right to an adjudicative proceeding governed by the administrative procedure act, chapter 34.05 RCW, and the rules of the authority. The vendor's application for an adjudicative proceeding must be in writing, state the basis for contesting the overpayment notice, and include a copy of the authority's notice. The application must be served on and received by

the authority within twenty-eight days of the vendor's receipt of the notice of overpayment. The vendor must serve the authority in a manner providing proof of receipt.

(4) Where an adjudicative proceeding has been requested, the presiding or reviewing ((~~office [officer]~~)) <u>officer</u> shall determine the amount, if any, of the overpayment received by the vendor.

(5) If the vendor fails to attend or participate in the adjudicative proceeding, upon a showing of valid service, the presiding or reviewing officer may enter an administrative order declaring the amount claimed in the notice to be assessed against the vendor and subject to collection action by the authority.

(6) Failure to make an application for an adjudicative proceeding within twenty-eight days of the date of notice results in the establishment of a final debt against the vendor in the amount asserted by the authority and that amount is subject to collection action. The authority may also charge the vendor with any costs associated with the collection of any final overpayment or debt established against the vendor.

(7) The authority may enforce a final overpayment or debt through lien and foreclosure, distraint, seizure and sale, order to withhold and deliver, or other collection action available to the authority to satisfy the debt due.

(8) Debts determined under this chapter are subject to collection action without further necessity of action by a presiding or reviewing officer. The authority may collect the debt in accordance with RCW 41.05A.120, 41.05A.130, and 41.05A.180. In addition, a vendor lien may be subject to distraint and seizure and sale in the same manner as prescribed for support liens in RCW 74.20A.130.

(9) Chapter 66, Laws of 1998 applies to overpayments for goods or services provided on or after July 1, 1998.

(10) The authority may adopt rules consistent with this section.

Sec. 29. RCW 70.320.050 and 2015 c 209 s 3 are each amended to read as follows:

(1) By December 1, 2014, the department and the authority shall report jointly to the legislature on the expected outcomes and the performance measures. The report must identify the performance measures and the expected outcomes established for each program, the relationship between the performance measures and expected improvements in client outcomes, mechanisms for reporting outcomes

1 and measuring performance, and options for applying the performance
2 measures and expected outcomes development process to other health
3 and social service programs.

4 (2) By December 1, 2016, and annually thereafter, the department
5 and the authority shall report to the legislature on the
6 incorporation of the performance measures into contracts with service
7 coordination organizations and progress toward achieving the
8 identified outcomes. The report shall include:

9 (a) The number of medicaid clients enrolled over the previous
10 year;

11 (b) The number of enrollees who received a baseline health
12 assessment over the previous year;

13 (c) An analysis of trends in health improvement for medicaid
14 enrollees in accordance with the measure set established under RCW
15 ((~~41.05.065~~)) <u>41.05.690</u>; and

16 (d) Recommendations for improving the health of medicaid
17 enrollees.

18 **Sec. 30.** RCW 70.390.020 and 2020 c 340 s 2 are each amended to
19 read as follows:

20 The authority shall establish a board to be known as the health
21 care cost transparency board. The board is responsible for the
22 analysis of total health care expenditures in Washington, identifying
23 trends in health care cost growth, and establishing a health care
24 cost growth benchmark. The board shall provide analysis of the
25 factors impacting these trends in health care cost growth and, after
26 review and consultation with identified entities, shall identify
27 those health care providers and payers that are exceeding the health
28 care cost growth benchmark. <u>The authority may create rules needed to</u>
29 <u>implement this chapter.</u>

30 **Sec. 31.** RCW 71.24.035 and 2021 c 263 s 16 and 2021 c 263 s 8
31 are each reenacted and amended to read as follows:

32 (1) The authority is designated as the state behavioral health
33 authority which includes recognition as the single state authority
34 for substance use disorders<u>, state opioid treatment authority,</u> and
35 state mental health authority.

36 (2) The director shall provide for public, client, tribal, and
37 licensed or certified behavioral health agency participation in
38 developing the state behavioral health program, developing related

1 contracts, and any waiver request to the federal government under
2 medicaid.
3 (3) The director shall provide for participation in developing
4 the state behavioral health program for children and other
5 underserved populations, by including representatives on any
6 committee established to provide oversight to the state behavioral
7 health program.
8 (4) The authority shall be designated as the behavioral health
9 administrative services organization for a regional service area if a
10 behavioral health administrative services organization fails to meet
11 the authority's contracting requirements or refuses to exercise the
12 responsibilities under its contract or state law, until such time as
13 a new behavioral health administrative services organization is
14 designated.
15 (5) The director shall:
16 (a) Assure that any behavioral health administrative services
17 organization, managed care organization, or community behavioral
18 health program provides medically necessary services to medicaid
19 recipients consistent with the state's medicaid state plan or federal
20 waiver authorities, and nonmedicaid services consistent with
21 priorities established by the authority;
22 (b) Develop contracts in a manner to ensure an adequate network
23 of inpatient services, evaluation and treatment services, and
24 facilities under chapter 71.05 RCW to ensure access to treatment,
25 resource management services, and community support services;
26 (c) Make contracts necessary or incidental to the performance of
27 its duties and the execution of its powers, including managed care
28 contracts for behavioral health services, contracts entered into
29 under RCW 74.09.522, and contracts with public and private agencies,
30 organizations, and individuals to pay them for behavioral health
31 services;
32 (d) Define administrative costs and ensure that the behavioral
33 health administrative services organization does not exceed an
34 administrative cost of ten percent of available funds;
35 (e) Establish, to the extent possible, a standardized auditing
36 procedure which is designed to assure compliance with contractual
37 agreements authorized by this chapter and minimizes paperwork
38 requirements. The audit procedure shall focus on the outcomes of
39 service as provided in RCW 71.24.435, 70.320.020, and 71.36.025;

(f) Develop and maintain an information system to be used by the state and behavioral health administrative services organizations and managed care organizations that includes a tracking method which allows the authority to identify behavioral health clients' participation in any behavioral health service or public program on an immediate basis. The information system shall not include individual patient's case history files. Confidentiality of client information and records shall be maintained as provided in this chapter and chapter 70.02 RCW;

(g) Monitor and audit behavioral health administrative services organizations as needed to assure compliance with contractual agreements authorized by this chapter;

(h) Monitor and audit access to behavioral health services for individuals eligible for medicaid who are not enrolled in a managed care organization;

(i) Adopt such rules as are necessary to implement the authority's responsibilities under this chapter;

(j) Administer or supervise the administration of the provisions relating to persons with substance use disorders and intoxicated persons of any state plan submitted for federal funding pursuant to federal health, welfare, or treatment legislation;

(k) Require the behavioral health administrative services organizations and the managed care organizations to develop agreements with tribal, city, and county jails and the department of corrections to accept referrals for enrollment on behalf of a confined person, prior to the person's release;

(l) Require behavioral health administrative services organizations and managed care organizations, as applicable, to provide services as identified in RCW 71.05.585 and 10.77.175 to individuals committed for involuntary treatment under less restrictive alternative court orders when:

(i) The individual is enrolled in the medicaid program; or

(ii) The individual is not enrolled in medicaid and does not have other insurance which can pay for the services; and

(m) Coordinate with the centers for medicare and medicaid services to provide that behavioral health aide services are eligible for federal funding of up to one hundred percent.

(6) The director shall use available resources only for behavioral health administrative services organizations and managed care organizations, except:

1 (a) To the extent authorized, and in accordance with any
2 priorities or conditions specified, in the biennial appropriations
3 act; or
4 (b) To incentivize improved performance with respect to the
5 client outcomes established in RCW 71.24.435, 70.320.020, and
6 71.36.025, integration of behavioral health and medical services at
7 the clinical level, and improved care coordination for individuals
8 with complex care needs.
9 (7) Each behavioral health administrative services organization,
10 managed care organization, and licensed or certified behavioral
11 health agency shall file with the secretary of the department of
12 health or the director, on request, such data, statistics, schedules,
13 and information as the secretary of the department of health or the
14 director reasonably requires. A behavioral health administrative
15 services organization, managed care organization, or licensed or
16 certified behavioral health agency which, without good cause, fails
17 to furnish any data, statistics, schedules, or information as
18 requested, or files fraudulent reports thereof, may be subject to the
19 contractual remedies in RCW 74.09.871 or may have its service
20 provider certification or license revoked or suspended.
21 (8) The superior court may restrain any behavioral health
22 administrative services organization, managed care organization, or
23 service provider from operating without a contract, certification, or
24 a license or any other violation of this section. The court may also
25 review, pursuant to procedures contained in chapter 34.05 RCW, any
26 denial, suspension, limitation, restriction, or revocation of
27 certification or license, and grant other relief required to enforce
28 the provisions of this chapter.
29 (9) Upon petition by the secretary of the department of health or
30 the director, and after hearing held upon reasonable notice to the
31 facility, the superior court may issue a warrant to an officer or
32 employee of the secretary of the department of health or the director
33 authorizing him or her to enter at reasonable times, and examine the
34 records, books, and accounts of any behavioral health administrative
35 services organization, managed care organization, or service provider
36 refusing to consent to inspection or examination by the authority.
37 (10) Notwithstanding the existence or pursuit of any other
38 remedy, the secretary of the department of health or the director may
39 file an action for an injunction or other process against any person
40 or governmental unit to restrain or prevent the establishment,

conduct, or operation of a behavioral health administrative services organization, managed care organization, or service provider without a contract, certification, or a license under this chapter.

(11) The authority shall distribute appropriated state and federal funds in accordance with any priorities, terms, or conditions specified in the appropriations act.

(12) The authority, in cooperation with the state congressional delegation, shall actively seek waivers of federal requirements and such modifications of federal regulations as are necessary to allow federal medicaid reimbursement for services provided by freestanding evaluation and treatment facilities licensed under chapter 71.12 RCW or certified under chapter 71.05 RCW. The authority shall periodically share the results of its efforts with the appropriate committees of the senate and the house of representatives.

(13) The authority may:

(a) Plan, establish, and maintain substance use disorder prevention and substance use disorder treatment programs as necessary or desirable;

(b) Coordinate its activities and cooperate with behavioral programs in this and other states, and make contracts and other joint or cooperative arrangements with state, tribal, local, or private agencies in this and other states for behavioral health services and for the common advancement of substance use disorder programs;

(c) Solicit and accept for use any gift of money or property made by will or otherwise, and any grant of money, services, or property from the federal government, the state, or any political subdivision thereof or any private source, and do all things necessary to cooperate with the federal government or any of its agencies in making an application for any grant;

(d) Keep records and engage in research and the gathering of relevant statistics; and

(e) Acquire, hold, or dispose of real property or any interest therein, and construct, lease, or otherwise provide substance use disorder treatment programs.

Sec. 32. RCW 71.24.380 and 2021 c 202 s 16 are each amended to read as follows:

(1) The director shall purchase behavioral health services primarily through managed care contracting, but may continue to

purchase behavioral health services directly from providers serving medicaid clients who are not enrolled in a managed care organization.

(2) The director shall require that contracted managed care organizations have a sufficient network of providers to provide adequate access to behavioral health services for residents of the regional service area that meet eligibility criteria for services, and for maintenance of quality assurance processes. Contracts with managed care organizations must comply with all federal medicaid and state law requirements related to managed health care contracting, including RCW 74.09.522.

(3) A managed care organization must contract with the authority's selected behavioral health administrative services organization for the assigned regional service area for the administration of crisis services. The contract shall require the managed care organization to reimburse the behavioral health administrative services organization for behavioral health crisis services delivered to individuals enrolled in the managed care organization.

(4) ((~~A managed care organization~~)) The authority must contract with the ((~~contracting advocacy organization selected by the state office of behavioral health consumer advocacy established in RCW 71.40.030~~)) department of commerce for the provision of behavioral health consumer advocacy services delivered to individuals enrolled in ((~~the~~)) a managed care organization by the advocacy organization selected by the state office of behavioral health consumer advocacy established in RCW 71.40.030. The contract shall require the ((~~managed care organization~~)) authority to reimburse the ((~~office of behavioral health consumer advocacy~~)) department of commerce for the behavioral health consumer advocacy services delivered to individuals enrolled in ((~~the~~)) a managed care organization.

(5) A managed care organization must collaborate with the authority and its contracted behavioral health administrative services organization to develop and implement strategies to coordinate care with tribes and community behavioral health providers for individuals with a history of frequent crisis system utilization.

(6) A managed care organization must work closely with designated crisis responders, behavioral health administrative services organizations, and behavioral health providers to maximize appropriate placement of persons into community services, ensuring the client receives the least restrictive level of care appropriate

1 for their condition. Additionally, the managed care organization
2 shall work with the authority to expedite the enrollment or
3 reenrollment of eligible persons leaving state or local correctional
4 facilities and institutions for mental diseases.

5 (7) As an incentive to county authorities to become early
6 adopters of fully integrated purchasing of medical and behavioral
7 health services, the standards adopted by the authority shall provide
8 for an incentive payment to counties which elect to move to full
9 integration by January 1, 2016. Subject to federal approval, the
10 incentive payment shall be targeted at ten percent of savings
11 realized by the state within the regional service area in which the
12 fully integrated purchasing takes place. Savings shall be calculated
13 in alignment with the outcome and performance measures established in
14 RCW 71.24.435, 70.320.020, and 71.36.025, and incentive payments for
15 early adopter counties shall be made available for up to a six-year
16 period, or until full integration of medical and behavioral health
17 services is accomplished statewide, whichever comes sooner, according
18 to rules to be developed by the authority.

19 **Sec. 33.** RCW 74.09.010 and 2020 c 80 s 55 are each amended to
20 read as follows:

21 The definitions in this section apply throughout this chapter
22 unless the context clearly requires otherwise.

23 (1) "Authority" means the Washington state health care authority.

24 (2) "Bidirectional integration" means integrating behavioral
25 health services into primary care settings and integrating primary
26 care services into behavioral health settings.

27 (3) "Children's health program" means the health care services
28 program provided to children under eighteen years of age and in
29 households with incomes at or below the federal poverty level as
30 annually defined by the federal department of health and human
31 services as adjusted for family size, and who are not otherwise
32 eligible for medical assistance or the limited casualty program for
33 the medically needy.

34 (4) "Chronic care management" means the health care management
35 within a health home of persons identified with, or at high risk for,
36 one or more chronic conditions. Effective chronic care management:

37 (a) Actively assists patients to acquire self-care skills to
38 improve functioning and health outcomes, and slow the progression of
39 disease or disability;

1 (b) Employs evidence-based clinical practices;
2 (c) Coordinates care across health care settings and providers,
3 including tracking referrals;
4 (d) Provides ready access to behavioral health services that are,
5 to the extent possible, integrated with primary care; and
6 (e) Uses appropriate community resources to support individual
7 patients and families in managing chronic conditions.
8 (5) "Chronic condition" means a prolonged condition and includes,
9 but is not limited to:
10 (a) A mental health condition;
11 (b) A substance use disorder;
12 (c) Asthma;
13 (d) Diabetes;
14 (e) Heart disease; and
15 (f) Being overweight, as evidenced by a body mass index over
16 twenty-five.
17 (6) "County" means the board of county commissioners, county
18 council, county executive, or tribal jurisdiction, or its designee.
19 (7) "Department" means the department of social and health
20 services.
21 (8) "Department of health" means the Washington state department
22 of health created pursuant to RCW 43.70.020.
23 (9) "Director" means the director of the Washington state health
24 care authority.
25 (10) "Full benefit dual eligible beneficiary" means an individual
26 who, for any month: Has coverage for the month under a medicare
27 prescription drug plan or medicare advantage plan with part D
28 coverage; and is determined eligible by the state for full medicaid
29 benefits for the month under any eligibility category in the state's
30 medicaid plan or a section 1115 demonstration waiver that provides
31 pharmacy benefits.
32 (11) "Health home" or "primary care health home" means
33 coordinated health care provided by a licensed primary care provider
34 coordinating all medical care services, and a multidisciplinary
35 health care team comprised of clinical and nonclinical staff. The
36 term "coordinating all medical care services" shall not be construed
37 to require prior authorization by a primary care provider in order
38 for a patient to receive treatment for covered services by an
39 optometrist licensed under chapter 18.53 RCW. Primary care health
40 home services shall include those services defined as health home

services in 42 U.S.C. Sec. 1396w-4 and, in addition, may include, but are not limited to:

(a) Comprehensive care management including, but not limited to, chronic care treatment and management;

(b) Extended hours of service;

(c) Multiple ways for patients to communicate with the team, including electronically and by phone;

(d) Education of patients on self-care, prevention, and health promotion, including the use of patient decision aids;

(e) Coordinating and assuring smooth transitions and follow-up from inpatient to other settings;

(f) Individual and family support including authorized representatives;

(g) The use of information technology to link services, track tests, generate patient registries, and provide clinical data; and

(h) Ongoing performance reporting and quality improvement.

(12) ((~~"Internal management" means the administration of medical assistance, medical care services, the children's health program, and the limited casualty program.~~

~~(13)~~)) "Limited casualty program" means the medical care program provided to medically needy persons as defined under Title XIX of the federal social security act, and to medically indigent persons who are without income or resources sufficient to secure necessary medical services.

((~~(14)~~)) (13) "Managed care organization" means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, health insuring organizations, or any other entity or 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.

(14) "Medical assistance" means the federal aid medical care program provided to categorically needy persons as defined under Title XIX of the federal social security act.

(15) "Medical care services" means the limited scope of care financed by state funds and provided to persons who are not eligible for medicaid under RCW 74.09.510 and who are eligible for the aged,

1 blind, or disabled assistance program authorized in RCW 74.62.030 or
2 the essential needs and housing support program pursuant to RCW
3 74.04.805.
4 (16) "Multidisciplinary health care team" means an
5 interdisciplinary team of health professionals which may include, but
6 is not limited to, medical specialists, nurses, pharmacists,
7 nutritionists, dieticians, social workers, behavioral and mental
8 health providers including substance use disorder prevention and
9 treatment providers, doctors of chiropractic, physical therapists,
10 licensed complementary and alternative medicine practitioners, home
11 care and other long-term care providers, and physicians' assistants.
12 (17) "Nursing home" means nursing home as defined in RCW
13 18.51.010.
14 (18) "Poverty" means the federal poverty level determined
15 annually by the United States department of health and human
16 services, or successor agency.
17 (19) "Primary care behavioral health" means a health care
18 integration model in which behavioral health care is colocated,
19 collaborative, and integrated within a primary care setting.
20 (20) "Primary care provider" means a general practice physician,
21 family practitioner, internist, pediatrician, osteopathic physician,
22 naturopath, physician assistant, and advanced registered nurse
23 practitioner licensed under Title 18 RCW.
24 (21) "Secretary" means the secretary of social and health
25 services.
26 (22) "Whole-person care in behavioral health" means a health care
27 integration model in which primary care services are integrated into
28 a behavioral health setting either through colocation or community-
29 based care management.

30 **Sec. 34.** RCW 74.09.053 and 2009 c 568 s 6 and 2009 c 479 s 62
31 are each reenacted and amended to read as follows:
32 (1) Beginning in November 2012, the department of social and
33 health services, in coordination with the health care authority,
34 shall by November 15th of each year report to the legislature:
35 (a) The number of medical assistance recipients who: (i) Upon
36 enrollment or recertification had reported being employed, and
37 beginning with the 2008 report, the month and year they reported
38 being hired; or (ii) upon enrollment or recertification had reported
39 being the dependent of someone who was employed, and beginning with

the 2008 report, the month and year they reported the employed person was hired. For recipients identified under (a)(i) and (ii) of this subsection, the department shall report the basis for their medical assistance eligibility, including but not limited to family medical coverage, transitional medical assistance, children's medical coverage, aged coverage, or coverage for ((~~persons~~)) individuals with disabilities; member months; and the total cost to the state for these recipients, expressed as general fund-state and general fund-federal dollars. The information shall be reported by employer size for employers having more than fifty employees as recipients or with dependents as recipients. This information shall be provided for the preceding January and June of that year.

(b) The following aggregated information: (i) The number of employees who are recipients or with dependents as recipients by private and governmental employers; (ii) the number of employees who are recipients or with dependents as recipients by employer size for employers with fifty or fewer employees, fifty-one to one hundred employees, one hundred one to one thousand employees, one thousand one to five thousand employees and more than five thousand employees; and (iii) the number of employees who are recipients or with dependents as recipients by industry type.

(2) For each aggregated classification, the report will include the number of hours worked, the number of department of social and health services covered lives, and the total cost to the state for these recipients. This information shall be for each quarter of the preceding year.

Sec. 35. RCW 74.09.171 and 2014 c 39 s 1 are each amended to read as follows:

(1) The legislature finds that the authority and the department purchase or contract for the delivery of medicaid programs((~~, including medical services with the~~)) through contracts with providers and managed care ((~~plans~~)) organizations under this chapter, ((~~mental health services with regional support networks or other~~)) contractors providing behavioral health services under chapters 71.24 and 71.34 RCW, ((~~chemical dependency services under chapters 74.50 and 70.96A RCW,~~)) and contractors providing long-term care services under chapter 74.39A RCW.

(2) The authority and department must collaborate and seek opportunities to expand access to care for enrollees in the medicaid

1 programs identified in subsection (1) of this section living in
2 border communities that may require contractual agreements with
3 providers across the state border when care is appropriate,
4 available, and cost-effective.

5 (3) All authority and department contracts for medicaid services
6 issued or renewed after July 1, 2014, must include provisions that
7 allow for care to be accessed cross-border ensuring timely access to
8 necessary care, including inpatient and outpatient services. The
9 contracts must include reciprocal arrangements that allow Washington,
10 Oregon, and Idaho border residents to access care when care is
11 appropriate, available, and cost-effective.

12 ((~~(4) The agencies must jointly report to the health care~~
13 ~~committees and fiscal committees of the legislature by November 1,~~
14 ~~2014, with an update on the contractual opportunities and the~~
15 ~~anticipated impacts on patient access to timely care, the impact on~~
16 ~~the availability of inpatient and outpatient services, and the fiscal~~
17 ~~implications for the medicaid programs.~~))

18 **Sec. 36.** RCW 74.09.215 and 2019 c 334 s 14 are each amended to
19 read as follows:

20 The medicaid fraud penalty account is created in the state
21 treasury. All receipts from civil penalties collected under RCW
22 74.09.210, all receipts received under judgments or settlements that
23 originated under a filing under the federal false claims act, all
24 receipts from fines received pursuant to RCW 43.71C.090, and all
25 receipts received under judgments or settlements that originated
26 under the state medicaid fraud false claims act, chapter 74.66 RCW,
27 must be deposited into the account. Moneys in the account may be
28 spent only after appropriation and must be used only for medicaid
29 services, fraud detection and prevention activities, recovery of
30 improper payments, for other medicaid fraud enforcement activities,
31 and the prescription monitoring program established in chapter 70.225
32 RCW. ((~~For the 2013-2015 fiscal biennium, moneys in the account may~~
33 ~~be spent on inpatient and outpatient rebasing and conversion to the~~
34 ~~tenth version of the international classification of diseases. For~~
35 ~~the 2011-2013 fiscal biennium, moneys in the account may be spent on~~
36 ~~inpatient and outpatient rebasing.~~))

37 **Sec. 37.** RCW 74.09.220 and 2018 c 201 s 7010 are each amended to
38 read as follows:

Any person, firm, corporation, partnership, association, agency, institution or other legal entity, but not including an individual public assistance recipient of health care, that, without intent to violate this chapter or other applicable law, obtains benefits or payments under this code to which such person or entity is not entitled, or in a greater amount than that to which entitled, shall be liable for (1) any excess benefits or payments received, and (2) interest calculated at the rate and in the manner provided in RCW 43.20B.695 or 41.05A.220. Whenever a penalty is due under RCW 74.09.210 or interest is due under RCW 43.20B.695 or 41.05A.220, such penalty or interest shall not be reimbursable by the state as an allowable cost under any of the provisions of this chapter or other applicable law.

Sec. 38. RCW 74.09.325 and 2022 c 213 s 4 are each amended to read as follows:

(1)(a) ((~~Upon initiation or renewal of a contract with the Washington state health care authority to administer a medicaid managed care plan, a managed health care system~~)) All managed care organizations contracted with the authority for the medicaid program shall reimburse a provider for a health care service provided to a covered person through telemedicine or store and forward technology if:

(i) The ((~~medicaid~~)) managed care ((~~plan~~)) organization in which the covered person is enrolled provides coverage of the health care service when provided in person by the provider;

(ii) The health care service is medically necessary;

(iii) The health care service is a service recognized as an essential health benefit under section 1302(b) of the federal patient protection and affordable care act in effect on January 1, 2015;

(iv) The health care service is determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards, and the technology used to provide the health care service meets the standards required by state and federal laws governing the privacy and security of protected health information; and

(v) Beginning January 1, 2023, for audio-only telemedicine, the covered person has an established relationship with the provider.

(b)(i) Except as provided in (b)(ii) of this subsection, ((~~upon initiation or renewal of a contract with the Washington state health~~

~~care authority to administer a medicaid managed care plan,~~)) a managed ((~~health~~)) care ((~~system~~)) organization shall reimburse a provider for a health care service provided to a covered person through telemedicine the same amount of compensation the managed ((~~health~~)) care ((~~system~~)) organization would pay the provider if the health care service was provided in person by the provider.

(ii) Hospitals, hospital systems, telemedicine companies, and provider groups consisting of eleven or more providers may elect to negotiate an amount of compensation for telemedicine services that differs from the amount of compensation for in-person services.

(iii) For purposes of this subsection (1)(b), the number of providers in a provider group refers to all providers within the group, regardless of a provider's location.

(iv) A rural health clinic shall be reimbursed for audio-only telemedicine at the rural health clinic encounter rate.

(2) For purposes of this section, reimbursement of store and forward technology is available only for those services specified in the negotiated agreement between the managed ((~~health~~)) care ((~~system~~)) organization and health care provider.

(3) An originating site for a telemedicine health care service subject to subsection (1) of this section includes a:

(a) Hospital;

(b) Rural health clinic;

(c) Federally qualified health center;

(d) Physician's or other health care provider's office;

(e) Licensed or certified behavioral health agency;

(f) Skilled nursing facility;

(g) Home or any location determined by the individual receiving the service; or

(h) Renal dialysis center, except an independent renal dialysis center.

(4) Except for subsection (3)(g) of this section, any originating site under subsection (3) of this section may charge a facility fee for infrastructure and preparation of the patient. Reimbursement for a facility fee must be subject to a negotiated agreement between the originating site and the managed ((~~health~~)) care ((~~system~~)) organization. A distant site, a hospital that is an originating site for audio-only telemedicine, or any other site not identified in subsection (3) of this section may not charge a facility fee.

1 (5) A managed ((~~health~~)) care ((~~system~~)) organization may not
2 distinguish between originating sites that are rural and urban in
3 providing the coverage required in subsection (1) of this section.
4 (6) A managed ((~~health~~)) care ((~~system~~)) organization may subject
5 coverage of a telemedicine or store and forward technology health
6 service under subsection (1) of this section to all terms and
7 conditions of the plan in which the covered person is enrolled
8 including, but not limited to, utilization review, prior
9 authorization, deductible, copayment, or coinsurance requirements
10 that are applicable to coverage of a comparable health care service
11 provided in person.
12 (7) This section does not require a managed ((~~health~~)) care
13 ((~~system~~)) organization to reimburse:
14 (a) An originating site for professional fees;
15 (b) A provider for a health care service that is not a covered
16 benefit under the plan; or
17 (c) An originating site or health care provider when the site or
18 provider is not a contracted provider under the plan.
19 (8)(a) If a provider intends to bill a patient or a managed
20 ((~~health~~)) care ((~~system~~)) organization for an audio-only
21 telemedicine service, the provider must obtain patient consent for
22 the billing in advance of the service being delivered and comply with
23 all rules created by the authority related to restrictions on billing
24 medicaid recipients. The authority may submit information on any
25 potential violations of this subsection to the appropriate
26 disciplining authority, as defined in RCW 18.130.020, or take
27 contractual actions against the provider's agreement for
28 participation in the medicaid program, or both.
29 (b) If the health care authority has cause to believe that a
30 provider has engaged in a pattern of unresolved violations of this
31 subsection (8), the health care authority may submit information to
32 the appropriate disciplining authority for action. Prior to
33 submitting information to the appropriate disciplining authority, the
34 health care authority may provide the provider with an opportunity to
35 cure the alleged violations or explain why the actions in question
36 did not violate this subsection (8).
37 (c) If the provider has engaged in a pattern of unresolved
38 violations of this subsection (8), the appropriate disciplining
39 authority may levy a fine or cost recovery upon the provider in an
40 amount not to exceed the applicable statutory amount per violation

and take other action as permitted under the authority of the disciplining authority. Upon completion of its review of any potential violation submitted by the health care authority or initiated directly by an enrollee, the disciplining authority shall notify the health care authority of the results of the review, including whether the violation was substantiated and any enforcement action taken as a result of a finding of a substantiated violation.

(9) For purposes of this section:

(a)(i) "Audio-only telemedicine" means the delivery of health care services through the use of audio-only technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment.

(ii) For purposes of this section only, "audio-only telemedicine" does not include:

(A) The use of facsimile or email; or

(B) The delivery of health care services that are customarily delivered by audio-only technology and customarily not billed as separate services by the provider, such as the sharing of laboratory results;

(b) "Disciplining authority" has the same meaning as in RCW 18.130.020;

(c) "Distant site" means the site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine;

(d) "Established relationship" means the provider providing audio-only telemedicine has access to sufficient health records to ensure safe, effective, and appropriate care services and:

(i) For health care services included in the essential health benefits category of mental health and substance use disorder services, including behavioral health treatment:

(A) The covered person has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the provider providing audio-only telemedicine or with a provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the provider providing audio-only telemedicine; or

1 (B) The covered person was referred to the provider providing
2 audio-only telemedicine by another provider who has had, within the
3 past three years, at least one in-person appointment, or at least one
4 real-time interactive appointment using both audio and video
5 technology, with the covered person and has provided relevant medical
6 information to the provider providing audio-only telemedicine;
7 (ii) For any other health care service:
8 (A) The covered person has had, within the past two years, at
9 least one in-person appointment, or, until January 1, 2024, at least
10 one real-time interactive appointment using both audio and video
11 technology, with the provider providing audio-only telemedicine or
12 with a provider employed at the same medical group, at the same
13 clinic, or by the same integrated delivery system operated by a
14 carrier licensed under chapter 48.44 or 48.46 RCW as the provider
15 providing audio-only telemedicine; or
16 (B) The covered person was referred to the provider providing
17 audio-only telemedicine by another provider who has had, within the
18 past two years, at least one in-person appointment, or, until January
19 1, 2024, at least one real-time interactive appointment using both
20 audio and video technology, with the covered person and has provided
21 relevant medical information to the provider providing audio-only
22 telemedicine;
23 (e) "Health care service" has the same meaning as in RCW
24 48.43.005;
25 (f) "Hospital" means a facility licensed under chapter 70.41,
26 71.12, or 72.23 RCW;
27 (g) ((~~"Managed health care system" means any health care~~
28 ~~organization, including health care providers, insurers, health care~~
29 ~~service contractors, health maintenance organizations, health~~
30 ~~insuring organizations, or any combination thereof, that provides~~
31 ~~directly or by contract health care services covered under this~~
32 ~~chapter and rendered by licensed providers, on a prepaid capitated~~
33 ~~basis and that meets the requirements of section 1903(m)(1)(A) of~~
34 ~~Title XIX of the federal social security act or federal demonstration~~
35 ~~waivers granted under section 1115(a) of Title XI of the federal~~
36 ~~social security act;~~
37 ~~(h)~~)) "Originating site" means the physical location of a patient
38 receiving health care services through telemedicine;
39 ((~~(i)~~)) <u>(h)</u> "Provider" has the same meaning as in RCW 48.43.005;

((~~(j)~~)) (i) "Store and forward technology" means use of an asynchronous transmission of a covered person's medical information from an originating site to the health care provider at a distant site which results in medical diagnosis and management of the covered person, and does not include the use of audio-only telephone, facsimile, or email; and

((~~(k)~~)) (j) "Telemedicine" means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this section only, "telemedicine" includes audio-only telemedicine, but does not include facsimile or email.

Sec. 39. RCW 74.09.328 and 2020 c 4 s 3 are each amended to read as follows:

(1) In order to protect patients and ensure that they benefit from seamless quality care when contracted providers are absent from their practices or when there is a temporary vacancy in a position while a hospital, rural health clinic, or rural provider is recruiting to meet patient demand, hospitals, rural health clinics, and rural providers may use substitute providers to provide services. Medicaid managed care organizations must allow for the use of substitute providers and provide payment consistent with the provisions in this section.

(2) Hospitals, rural health clinics, and rural providers that are contracted with a medicaid managed care organization may use substitute providers that are not contracted with a managed care organization when:

(a) A contracted provider is absent for a limited period of time due to vacation, illness, disability, continuing medical education, or other short-term absence; or

(b) A contracted hospital, rural health clinic, or rural provider is recruiting to fill an open position.

(3) For a substitute provider providing services under subsection (2)(a) of this section, a contracted hospital, rural health clinic, or rural provider may bill and receive payment for services at the contracted rate under its contract with the managed care organization for up to sixty days.

(4) To be eligible for reimbursement under this section for services provided on behalf of a contracted provider for greater than sixty days, a substitute provider must enroll in a medicaid managed care organization. Enrollment of a substitute provider in a medicaid managed care organization is effective on the later of:

(a) The date the substitute provider filed an enrollment application that was subsequently approved; or

(b) The date the substitute provider first began providing services at the hospital, rural health clinic, or rural provider.

(5) A substitute provider who enrolls with a medicaid managed care organization may not bill under subsection (4) of this section for any services billed to the medicaid managed care organization pursuant to subsection (3) of this section.

(6) Nothing in this section obligates a managed care organization to enroll any substitute provider who requests enrollment if they do not meet the organizations enrollment criteria.

(7) For purposes of this section:

(a) "Circumstances precluded enrollment" means that the provider has met all program requirements including state licensure during the thirty-day period before an application was submitted and no final adverse determination precluded enrollment. If a final adverse determination precluded enrollment during this thirty-day period, the contractor shall only establish an effective billing date the day after the date that the final adverse action was resolved, as long as it is not more than thirty days prior to the date on which the application was submitted.

(b) "Contracted provider" means a provider who is contracted with a medicaid managed care organization.

(c) "Hospital" means a facility licensed under chapter 70.41 or 71.12 RCW.

(d) "Rural health clinic" means a federally designated rural health clinic.

(e) "Rural provider" means physicians licensed under chapter 18.71 RCW, osteopathic physicians and surgeons licensed under chapter 18.57 RCW, podiatric physicians and surgeons licensed under chapter 18.22 RCW, physician assistants licensed under chapter 18.71A RCW, osteopathic physician assistants licensed under chapter ((~~18.57A~~)) 18.71A RCW, and advanced registered nurse practitioners licensed under chapter 18.79 RCW, who are located in a rural county as defined in RCW 82.14.370.

1 (f) "Substitute provider" includes physicians licensed under
2 chapter 18.71 RCW, osteopathic physicians and surgeons licensed under
3 chapter 18.57 RCW, podiatric physicians and surgeons licensed under
4 chapter 18.22 RCW, physician assistants licensed under chapter 18.71A
5 RCW, osteopathic physician assistants licensed under chapter
6 ((~~18.57A~~)) 18.71A RCW, and advanced registered nurse practitioners
7 licensed under chapter 18.79 RCW.

8 **Sec. 40.** RCW 74.09.470 and 2018 c 58 s 2 are each amended to
9 read as follows:
10 (1) Consistent with the goals established in RCW 74.09.402,
11 through the apple health for kids program authorized in this section,
12 the authority shall provide affordable health care coverage to
13 children under the age of nineteen who reside in Washington state and
14 whose family income at the time of enrollment is not greater than
15 ((~~two hundred fifty~~)) 260 percent of the federal poverty level as
16 adjusted for family size and determined annually by the federal
17 department of health and human services, and effective January 1,
18 2009, and only to the extent that funds are specifically appropriated
19 therefor, to children whose family income is not greater than ((~~three~~
20 ~~hundred~~)) 312 percent of the federal poverty level. In administering
21 the program, the authority shall take such actions as may be
22 necessary to ensure the receipt of federal financial participation
23 under the medical assistance program, as codified at Title XIX of the
24 federal social security act, the state children's health insurance
25 program, as codified at Title XXI of the federal social security act,
26 and any other federal funding sources that are now available or may
27 become available in the future. The authority and the caseload
28 forecast council shall estimate the anticipated caseload and costs of
29 the program established in this section.
30 (2) The authority shall accept applications for enrollment for
31 children's health care coverage; establish appropriate minimum-
32 enrollment periods, as may be necessary; and determine eligibility
33 based on current family income. The authority shall make eligibility
34 determinations within the time frames for establishing eligibility
35 for children on medical assistance, as defined by RCW 74.09.510. The
36 application and annual renewal processes shall be designed to
37 minimize administrative barriers for applicants and enrolled clients,
38 and to minimize gaps in eligibility for families who are eligible for
39 coverage. If a change in family income results in a change in the

source of funding for coverage, the authority shall transfer the family members to the appropriate source of funding and notify the family with respect to any change in premium obligation, without a break in eligibility. The authority shall use the same eligibility redetermination and appeals procedures as those provided for children on medical assistance programs. The authority shall modify its eligibility renewal procedures to lower the percentage of children failing to annually renew. The authority shall manage its outreach, application, and renewal procedures with the goals of: (a) Achieving year by year improvements in enrollment, enrollment rates, renewals, and renewal rates; (b) maximizing the use of existing program databases to obtain information related to earned and unearned income for purposes of eligibility determination and renewals, including, but not limited to, the basic food program, the child care subsidy program, federal social security administration programs, and the employment security department wage database; (c) streamlining renewal processes to rely primarily upon data matches, online submissions, and telephone interviews; and (d) implementing any other eligibility determination and renewal processes to allow the state to receive an enhanced federal matching rate and additional federal outreach funding available through the federal children's health insurance program reauthorization act of 2009 by January 2010. The department shall advise the governor and the legislature regarding the status of these efforts by September 30, 2009. The information provided should include the status of the department's efforts, the anticipated impact of those efforts on enrollment, and the costs associated with that enrollment.

(3) To ensure continuity of care and ease of understanding for families and health care providers, and to maximize the efficiency of the program, the amount, scope, and duration of health care services provided to children under this section shall be the same as that provided to children under medical assistance, as defined in RCW 74.09.520.

(4) The primary mechanism for purchasing health care coverage under this section shall be through contracts with managed health care systems as defined in RCW 74.09.522, subject to conditions, limitations, and appropriations provided in the biennial appropriations act. However, the authority shall make every effort within available resources to purchase health care coverage for uninsured children whose families have access to dependent coverage

through an employer-sponsored health plan or another source when it is cost-effective for the state to do so, and the purchase is consistent with requirements of Title XIX and Title XXI of the federal social security act. To the extent allowable under federal law, the authority shall require families to enroll in available employer-sponsored coverage, as a condition of participating in the program established under this section, when it is cost-effective for the state to do so. Families who enroll in available employer-sponsored coverage under this section shall be accounted for separately in the annual report required by RCW 74.09.053.

(5)(a) To reflect appropriate parental responsibility, the authority shall develop and implement a schedule of premiums for children's health care coverage due to the authority from families with income greater than ((~~two hundred~~)) 210 percent of the federal poverty level. For families with income greater than ((~~two hundred fifty~~)) 260 percent of the federal poverty level, the premiums shall be established in consultation with the senate majority and minority leaders and the speaker and minority leader of the house of representatives. For children eligible for coverage under the federally funded children's health insurance program, Title XXI of the federal social security act, premiums shall be set at a reasonable level that does not pose a barrier to enrollment. The amount of the premium shall be based upon family income and shall not exceed the premium limitations in Title XXI of the federal social security act. For children who are not eligible for coverage under the federally funded children's health insurance program, premiums shall be set every two years in an amount no greater than the average state-only share of the per capita cost of coverage in the state-funded children's health program.

(b) Premiums shall not be imposed on children in households at or below ((~~two hundred~~)) 210 percent of the federal poverty level as articulated in RCW 74.09.055.

(c) ((~~Beginning no later than January 1, 2010, the~~)) The authority shall offer families whose income is greater than ((~~three hundred~~)) 312 percent of the federal poverty level the opportunity to purchase health care coverage for their children through the programs administered under this section without an explicit premium subsidy from the state. The design of the health benefit package offered to these children should provide a benefit package substantially similar to that offered in the apple health for kids program, and may differ

with respect to cost-sharing, and other appropriate elements from that provided to children under subsection (3) of this section including, but not limited to, application of preexisting conditions, waiting periods, and other design changes needed to offer affordable coverage. The amount paid by the family shall be in an amount equal to the rate paid by the state to the managed health care system for coverage of the child, including any associated and administrative costs to the state of providing coverage for the child. Any pooling of the program enrollees that results in state fiscal impact must be identified and brought to the legislature for consideration.

(6) The authority shall undertake and continue a proactive, targeted outreach and education effort with the goal of enrolling children in health coverage and improving the health literacy of youth and parents. The authority shall collaborate with the department of social and health services, department of health, local public health jurisdictions, the office of the superintendent of public instruction, the department of children, youth, and families, health educators, health care providers, health carriers, community-based organizations, and parents in the design and development of this effort. The outreach and education effort shall include the following components:

(a) Broad dissemination of information about the availability of coverage, including media campaigns;

(b) Assistance with completing applications, and community-based outreach efforts to help people apply for coverage. Community-based outreach efforts should be targeted to the populations least likely to be covered;

(c) Use of existing systems, such as enrollment information from the free and reduced-price lunch program, the department of children, youth, and families child care subsidy program, the department of health's women, infants, and children program, and the early childhood education and assistance program, to identify children who may be eligible but not enrolled in coverage;

(d) Contracting with community-based organizations and government entities to support community-based outreach efforts to help families apply for coverage. These efforts should be targeted to the populations least likely to be covered. The authority shall provide informational materials for use by government entities and community-based organizations in their outreach activities, and should identify any available federal matching funds to support these efforts;

(e) Development and dissemination of materials to engage and inform parents and families statewide on issues such as: The benefits of health insurance coverage; the appropriate use of health services, including primary care provided by health care practitioners licensed under chapters 18.71, 18.57, 18.36A, and 18.79 RCW, and emergency services; the value of a medical home, well-child services and immunization, and other preventive health services with linkages to department of health child profile efforts; identifying and managing chronic conditions such as asthma and diabetes; and the value of good nutrition and physical activity;

(f) An evaluation of the outreach and education efforts, based upon clear, cost-effective outcome measures that are included in contracts with entities that undertake components of the outreach and education effort;

(g) An implementation plan to develop online application capability that is integrated with the automated client eligibility system, and to develop data linkages with the office of the superintendent of public instruction for free and reduced-price lunch enrollment information and the department of children, youth, and families for child care subsidy program enrollment information.

(7) The authority shall take action to increase the number of primary care physicians providing dental disease preventive services including oral health screenings, risk assessment, family education, the application of fluoride varnish, and referral to a dentist as needed.

(8) The department shall monitor the rates of substitution between private-sector health care coverage and the coverage provided under this section.

Sec. 41. RCW 74.09.4701 and 2011 c 4 s 19 are each amended to read as follows:

For apple health for kids, the department shall not count the twenty-five dollar increase paid as part of an individual's weekly benefit amount ((~~as provided in RCW 50.20.1202~~)) when determining family income, eligibility, and payment levels.

Sec. 42. RCW 74.09.480 and 2017 c 294 s 4 are each amended to read as follows:

(1) The authority, in collaboration with the department of health, department of social and health services, health carriers,

1 local public health jurisdictions, children's health care providers
2 including pediatricians, family practitioners, advanced registered
3 nurse practitioners, certified nurse midwives, and pediatric
4 subspecialists, community and migrant health centers, parents, and
5 other purchasers, shall establish a concise set of explicit
6 performance measures that can indicate whether children enrolled in
7 the program are receiving health care through an established and
8 effective medical home, and whether the overall health of enrolled
9 children is improving. Such indicators may include, but are not
10 limited to:

11 (a) Childhood immunization rates;

12 (b) Well child care utilization rates, including the use of
13 behavioral and oral health screening, and validated, structured
14 developmental screens using tools, that are consistent with
15 nationally accepted pediatric guidelines and recommended
16 administration schedule, once funding is specifically appropriated
17 for this purpose;

18 (c) Care management for children with chronic illnesses;

19 (d) Emergency room utilization;

20 (e) Visual acuity and eye health;

21 (f) Preventive oral health service utilization; and

22 (g) Children's mental health status. In defining these measures
23 the authority shall be guided by the measures provided in RCW
24 71.36.025.

25 Performance measures and targets for each performance measure
26 must be established and monitored each biennium, with a goal of
27 achieving measurable, improved health outcomes for the children of
28 Washington state each biennium.

29 (2) Beginning in calendar year 2009, targeted provider rate
30 increases shall be linked to quality improvement measures established
31 under this section. The authority, in conjunction with those groups
32 identified in subsection (1) of this section, shall develop
33 parameters for determining criteria for increased payment,
34 alternative payment methodologies, or other incentives for those
35 practices and health plans that incorporate evidence-based practice
36 ((~~and improve~~)) and achieve sustained improvement with respect to the
37 measures.

38 (3) The department shall provide a report to the governor and the
39 legislature related to provider performance on these measures, as
40 well as the information collected under RCW 74.09.475, beginning in

1 September 2010 for 2007 through 2009 and the authority shall provide
2 the report biennially thereafter.

3 **Sec. 43.** RCW 74.09.522 and 2020 c 260 s 1 are each amended to
4 read as follows:
5 (1) For the purposes of this section((~~:~~
6 ~~(a) "Managed health care system" means any health care~~
7 ~~organization, including health care providers, insurers, health care~~
8 ~~service contractors, health maintenance organizations, health~~
9 ~~insuring organizations, or any combination thereof, that provides~~
10 ~~directly or by contract health care services covered under this~~
11 ~~chapter or other applicable law and rendered by licensed providers,~~
12 ~~on a prepaid capitated basis and that meets the requirements of~~
13 ~~section 1903(m)(1)(A) of Title XIX of the federal social security act~~
14 ~~or federal demonstration waivers granted under section 1115(a) of~~
15 ~~Title XI of the federal social security act;~~
16 ~~(b) "Nonparticipating~~)), "nonparticipating provider" means a
17 person, health care provider, practitioner, facility, or entity,
18 acting within their scope of practice, that does not have a written
19 contract to participate in a managed ((~~health~~)) care ((~~system's~~))
20 organization's provider network, but provides health care services to
21 enrollees of programs authorized under this chapter or other
22 applicable law whose health care services are provided by the managed
23 ((~~health~~)) care ((~~system~~)) organization.
24 (2) The authority shall enter into agreements with managed
25 ((~~health~~)) care ((~~systems~~)) organizations to provide health care
26 services to recipients of medicaid under the following conditions:
27 (a) Agreements shall be made for at least thirty thousand
28 recipients statewide;
29 (b) Agreements in at least one county shall include enrollment of
30 all recipients of programs as allowed for in the approved state plan
31 amendment or federal waiver for Washington state's medicaid program;
32 (c) To the extent that this provision is consistent with section
33 1903(m) of Title XIX of the federal social security act or federal
34 demonstration waivers granted under section 1115(a) of Title XI of
35 the federal social security act, recipients shall have a choice of
36 systems in which to enroll and shall have the right to terminate
37 their enrollment in a system: PROVIDED, That the authority may limit
38 recipient termination of enrollment without cause to the first month
39 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~~)) organizations shall not enroll a disproportionate number of medical assistance recipients within the total numbers of persons served by the managed ((~~health~~)) care ((~~systems~~)) organizations, 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~~)) organizations the authority shall adopt a uniform procedure to enter into contractual arrangements, 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, including comprehensive medication management services for patients with multiple chronic conditions 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~~)) organization 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~~)) organization 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 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~~)) organizations 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~~)) organization 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~~)) <u>organizations</u> 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~~)) <u>organizations</u> 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) Any contract with a managed ((~~health~~)) care ((~~system~~)) organization to provide services to medical assistance enrollees shall require that managed ((~~health~~)) care ((~~systems~~)) organizations offer contracts to mental health providers and substance use disorder 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~~)) organization contracts effective on or after April 1, 2016, shall serve geographic areas that correspond to the regional service areas established in RCW 74.09.870.

(9) A managed ((~~health~~)) care ((~~system~~)) organization shall pay a nonparticipating provider that provides a service covered under this chapter or other applicable law to the ((~~system's~~)) organization's enrollee no more than the lowest amount paid for that service under the managed ((~~health~~)) care ((~~system's~~)) organization's contracts with similar providers in the state if the managed ((~~health~~)) care ((~~system~~)) organization has made good faith efforts to contract with the nonparticipating provider.

(10) For services covered under this chapter or other applicable law to medical assistance or medical care services enrollees, nonparticipating providers must accept as payment in full the amount paid by the managed ((~~health~~)) care ((~~system~~)) organization 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~~)) organization 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~~)) organizations 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~~)) organization 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.

Sec. 44. RCW 74.09.630 and 2021 c 273 s 5 are each amended to read as follows:

Until the opioid overdose reversal medication bulk purchasing and distribution program established in RCW 70.14.170 is operational:

(1) ((~~Upon initiation or renewal of a contract with the authority to administer a~~)) All medicaid managed care ((~~plan, a managed care~~)) organizations must reimburse a hospital or behavioral health agency for dispensing or distributing opioid overdose reversal medication to a covered person under RCW 70.41.485 and 71.24.594.

(2) If the person is not enrolled in a medicaid managed care ((~~plan~~)) organization and does not have any other available insurance coverage, the authority must reimburse a hospital, behavioral health agency, or pharmacy for dispensing or distributing opioid overdose reversal medication under RCW 70.41.485 and 71.24.594.

Sec. 45. RCW 74.09.634 and 2021 c 273 s 12 are each amended to read as follows:

(1) ((~~Upon initiation or renewal of a contract with the authority to administer a medicaid managed care plan, a~~)) All medicaid contracted managed health care ((~~system~~)) organizations must participate in the opioid overdose reversal medication bulk purchasing and distribution program established in RCW 70.14.170 once the program is operational.

1 (2) The health care authority must participate in the opioid
2 overdose reversal medication bulk purchasing and distribution program
3 established in RCW 70.14.170 once the program is operational for
4 purposes of individuals enrolled in medical assistance under this
5 chapter that are not enrolled in a managed care ((~~plan~~)) organization
6 and are uninsured individuals.

7 **Sec. 46.** RCW 74.09.645 and 2019 c 314 s 38 are each amended to
8 read as follows:
9 ((~~Upon initiation or renewal of a contract with the authority to~~
10 ~~administer a medicaid managed care plan, a~~)) All medicaid contracted
11 managed ((~~health~~)) care ((~~system~~)) organizations shall provide
12 coverage without prior authorization of at least one federal food and
13 drug administration approved product for the treatment of opioid use
14 disorder in the drug classes opioid agonists, opioid antagonists, and
15 opioid partial agonists.

16 **Sec. 47.** RCW 74.09.650 and 2003 1st sp.s. c 29 s 2 are each
17 amended to read as follows:
18 (1) To the extent funds are appropriated specifically for this
19 purpose, and subject to any conditions placed on appropriations made
20 for this purpose, the ((~~department~~)) authority shall design a
21 medicaid prescription drug assistance program. Neither the benefits
22 of, nor eligibility for, the program is considered to be an
23 entitlement.
24 (2) The ((~~department~~)) authority shall request any federal waiver
25 necessary to implement this program. Consistent with federal waiver
26 conditions, the department may charge enrollment fees, premiums, or
27 point-of-service cost-sharing to program enrollees.
28 (3) Eligibility for this program is limited to persons:
29 (a) Who are eligible for medicare or age sixty-five and older;
30 (b) Whose family income does not exceed two hundred percent of
31 the federal poverty level as adjusted for family size and determined
32 annually by the federal department of health and human services;
33 (c) Who lack insurance that provides prescription drug coverage;
34 and
35 (d) Who are not otherwise eligible under Title XIX of the federal
36 social security act.
37 (4) The ((~~department~~)) authority shall use a cost-effective
38 prescription drug benefit design. Consistent with federal waiver

conditions, this benefit design may be different than the benefit design offered under the medical assistance program. The benefit design may include a deductible benefit that provides coverage when enrollees incur higher prescription drug costs as defined by the department. The ((~~department~~)) authority also may offer more than one benefit design.

(5) The ((~~department~~)) authority shall limit enrollment of persons who qualify for the program so as to prevent an overexpenditure of appropriations for this program or to assure necessary compliance with federal waiver budget neutrality requirements. The ((~~department~~)) authority may not reduce existing medical assistance program eligibility or benefits to assure compliance with federal waiver budget neutrality requirements.

(6) Premiums paid by medicaid enrollees not in the medicaid prescription drug assistance program may not be used to finance the medicaid prescription drug assistance program.

(7) This program will be terminated within twelve months after implementation of a prescription drug benefit under Title XVIII of the federal social security act.

((~~(8) The department shall provide recommendations to the appropriate committees of the senate and house of representatives by November 15, 2003, on financing options available to support the medicaid prescription drug assistance program. In recommending financing options, the department shall explore every opportunity to maximize federal funding to support the program.~~))

Sec. 48. RCW 74.09.653 and 2011 1st sp.s. c 15 s 60 are each amended to read as follows:

A committee or council required by federal law, within the health care authority, that makes policy recommendations regarding reimbursement for drugs under the requirements of federal law or regulations is subject to chapter((~~s~~)) 42.30 ((~~and 42.32~~)) RCW.

Sec. 49. RCW 74.09.655 and 2011 1st sp.s. c 15 s 39 are each amended to read as follows:

The authority shall provide coverage under this chapter for smoking cessation counseling services, as well as prescription and nonprescription agents when used to promote smoking cessation, so long as such agents otherwise meet the definition of "covered outpatient drug" in 42 U.S.C. Sec. 1396r-8(k). However, the authority

may initiate an individualized inquiry and determine and implement by rule appropriate coverage limitations as may be required to encourage the use of effective, evidence-based services and prescription and nonprescription agents. ((~~The authority shall track per-capita expenditures for a cohort of clients that receive smoking cessation benefits, and submit a cost-benefit analysis to the legislature on or before January 1, 2012.~~))

Sec. 50. RCW 74.09.657 and 2011 1st sp.s. c 41 s 1 are each amended to read as follows:

The legislature finds that:

(1) Over half of all births in Washington state are covered by public programs;

(2) Research has demonstrated that children of unintended pregnancies receive less prenatal care and are at higher risk for premature birth, low birth weight, neurological disorders, and poor academic performance;

(3) In Washington state, over ((~~fifty~~)) 50 percent of unintended pregnancies occur in women age ((~~twenty-five~~)) 25 years and older;

(4) Washington state's take charge program has been successful in helping women avoid unintended pregnancies; however, when the caseload declined due to federally mandated changes, the rate of unintended pregnancies increased dramatically;

(5) Expanding family planning services to cover women to ((~~two hundred fifty~~)) 260 percent of the federal poverty level would align that program's eligibility standard with income eligibility for publicly funded maternity care service; and

(6) Such an expansion would reduce unintended pregnancies and associated costs to the state.

Sec. 51. RCW 74.09.659 and 2011 1st sp.s. c 41 s 2 and 2011 1st sp.s. c 15 s 41 are each reenacted and amended to read as follows:

(1) The authority shall continue to submit applications for the family planning waiver program.

(2) The authority shall submit a request to the federal department of health and human services to amend the current family planning waiver program as follows:

(a) Provide coverage for sexually transmitted disease testing and treatment; and

1 (b) Return to the eligibility standards used in 2005 including, 2 but not limited to, citizenship determination based on declaration or 3 matching with federal social security databases, insurance 4 eligibility standards comparable to 2005, and confidential service 5 availability for minors and survivors of domestic and sexual 6 violence((~~; and~~

7 ~~(c) By September 30, 2011, submit an application to increase~~ 8 ~~income eligibility to two hundred fifty percent of the federal~~ 9 ~~poverty level, to correspond with income eligibility for publicly~~ 10 ~~funded maternity care services~~)).

11 **Sec. 52.** RCW 74.09.860 and 2018 c 27 s 1 are each amended to 12 read as follows:

13 (1) The authority shall issue a request for proposals to provide 14 integrated managed health and behavioral health care for foster 15 children receiving care through the medical assistance program. 16 Behavioral health services provided under chapters 71.24 and 71.34 17 RCW must be integrated into the managed ((~~health~~)) care ((~~plan~~)) 18 organization for foster children beginning January 1, 2019. The 19 request for proposals must address the program elements described in 20 section 110, chapter 225, Laws of 2014, including development of a 21 service delivery system, benefit design, reimbursement mechanisms, 22 incorporation or coordination of services currently provided by the 23 regional support networks, and standards for contracting with health 24 ((~~plans~~)) organizations. The request for proposals must be issued and 25 completed in time for services under the integrated managed care plan 26 to begin on October 1, 2016.

27 (2) The parent or guardian of a child who is no longer a 28 dependent child pursuant to chapter 13.34 RCW may choose to continue 29 in the transitional foster care eligibility category for up to twelve 30 months following reunification with the child's parents or guardian 31 if the child:

32 (a) Is under eighteen years of age;

33 (b) Was in foster care under the legal responsibility of the 34 department of social and health services, the department of children, 35 youth, and families, or a federally recognized Indian tribe located 36 within the state; and

37 (c) Meets income and other eligibility standards for medical 38 assistance coverage.

1 NEW SECTION. **Sec. 53.** The following acts or parts of acts are
2 each repealed:
3 (1) RCW 41.05.090 (Continuation of coverage of employee, spouse,
4 or covered dependent ineligible under state plan—Exceptions) and 1990
5 c 222 s 5 & 1979 c 125 s 3;
6 (2) RCW 41.05.205 (Tricare supplemental insurance policy—
7 Authority to offer—Rules) and 2005 c 46 s 1;
8 (3) RCW 41.05.240 (American Indian health care delivery plan) and
9 1993 c 492 s 468; and
10 (4) RCW 74.09.720 (Prevention of blindness program) and 2011 1st
11 sp.s. c 15 s 45 & 1983 c 194 s 26.

12 NEW SECTION. **Sec. 54.** The following sections are decodified:
13 (1) RCW 41.05.033 (Shared decision-making demonstration project—
14 Preference-sensitive care);
15 (2) RCW 41.05.110 (Chapter not applicable to officers and
16 employees of state convention and trade center);
17 (3) RCW 41.05.280 (Department of corrections—Inmate health care);
18 (4) RCW 41.05.680 (Report—Chronic care management); and
19 (5) RCW 74.09.756 (Medicaid and state children's health insurance
20 program demonstration project).

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