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NO. 66942-7-I

**COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON**

PHYSICIAN ANESTHESIA ASSOCIATION, INC., P.S.,
Respondent/Cross-Appellant,

v.

MOLINA HEALTHCARE OF WASHINGTON, INC.,
Appellant/Cross-Respondent.

**AMICUS CURIAE BRIEF OF WASHINGTON STATE
DEPARTMENT OF SOCIAL AND HEALTH SERVICES**

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I. INTEREST OF AMICUS CURIAE

At all times relevant to the underlying facts of this case, the Department of Social and Health Services (“Department”) was the executive agency in the State of Washington responsible for administering the Medicaid program. *See* RCW 74.09.500; RCW 74.09.530(1); Crista Senior Cmty. v. Dep’t of Soc. & Health Servs., 77 Wn. App. 398, 401, 892 P.2d 749 (1995).¹

The issues raised by the decision issued by the Snohomish County Superior Court in favor of respondent/cross-appellant, Physician Anesthesia Association, Inc., P.S. (“PAA”), implicate important policy and fiscal questions pertaining to the Medicaid program. These questions include (1) the State’s ability to ensure that Medicaid recipients have access to needed medical services; and (2) the Legislature’s ability to ensure that funding for the program remains within a manageable level.

In light of these questions, and in light of a bill enacted by the Legislature earlier this year, the Department is submitting this amicus brief to assist the Court in understanding the State’s policy with respect to levels of payment for services provided to Medicaid recipients and to

¹ As of July 1, 2011, the Health Care Authority will replace the Department as the agency responsible for administering the Medicaid program. *See* Laws of 2011, 1st Spec. Sess., ch. 15 (Second Engrossed Second Substitute H.B. 1738, 62nd Leg., 1st Spec. Sess. (Wash. 2011)). The change in designation does not affect this case.

demonstrate the potentially negative effect of the Superior Court’s ruling on the State’s budget.²

II. ISSUES PRESENTED

Was the Superior Court correct in holding that PAA is entitled to receive payment rates from appellant/cross-respondent, Molina Healthcare of Washington, Inc. (“Molina”), for services provided to Medicaid recipients enrolled in the State’s *managed care* program, in an amount that exceeds the rates PAA would receive for providing the same services to Medicaid clients enrolled in the State’s *fee-for-service* program, when PAA had a contract with the Department that binds PAA to the Department’s rates for services provided to fee-for-service recipients but did not have a contract with Molina limiting the rates to services provided to managed care recipients?

III. LEGAL BACKGROUND OF STATE-PURCHASED HEALTHCARE PROGRAMS

A. The Medicaid Program In General

“The Medicaid program, which provides joint federal and state funding of medical care for individuals who cannot afford to pay their own medical costs, was launched in 1965 with the enactment of Title XIX of the Social Security Act[.]” Ark. Dep’t of Health & Human Servs. v.

² The State takes no position with respect to the Superior Court’s analysis of the Consumer Protection Act and “open account” claims. This brief focuses solely on the portion of the case dealing with the Medicaid and Basic Health programs.

Ahlborn, 547 U.S. 268, 275, 126 St. Ct. 1752, 164 L. Ed. 2d 459 (2006);
see generally 42 U.S.C. §§ 1396-1396w-1; 42 C.F.R. § 430.0; Indep.
Acceptance Co. v. California, 204 F.3d 1247, 1249 (9th Cir. 2000).

States design and administer their Medicaid programs within broad federal guidelines. A description of the state's implementation of federal guidelines must be submitted in a "State Medicaid Plan" to [the federal government] for approval.

Caritas Services, Inc. v. Dep't of Soc. & Health Servs., 123 Wn.2d 391, 396, 869 P.2d 28 (1994); *see also* 42 U.S.C. § 1396a; 42 C.F.R. § 430.10.

B. Systems For Delivering Medical Care To Medicaid Clients

There are two delivery systems through which Medicaid recipients can receive their government-funded medical care. The first system is known as "fee for service." The second system is known as "managed care."

St. John Med. Ctr. v. Dep't of Soc. & Health Servs., 110 Wn. App. 51, 56, 38 P.3d 383, *review denied*, 146 Wn.2d 1023 (2002).

Under a fee-for-service system, the State directly pays medical providers (such as PAA) for services rendered to Medicaid clients.

Traditionally, medical care in the United States has been provided on a "fee-for-service" basis. A physician charges so much for a general physical exam, a vaccination, a tonsillectomy, and so on. The physician bills the patient for services provided or, if there is insurance and the doctor is willing, submits the bill for the patient's care to the insurer, for payment subject to the terms of the insurance agreement.

Pegram v. Herdrich, 530 U.S. 211, 218, 120 S. Ct. 2143, 2148-49, 147 L. Ed. 2d 164 (2000); *see also* 67 Fed. Reg. 40,989 (June 14, 2002)

(Medicaid coverage traditionally was “provided through reimbursements by the State agency to health care providers who submitted claims for payment after they provided health care services to Medicaid beneficiaries”).

Under the fee-for-service Medicaid program, potential providers [become] participating providers only after [the Department] assign[s] them a provider number and the provider bill[s] [the Department].

St. John, 110 Wn. App. at 56.

In contrast, under a managed care program, the state pays a fixed per-member, per-month fee to a managed care organization (“MCO”), such as Molina, and Medicaid clients then receive all of their medical services through that organization. RX Pharmacies Plus, Inc. v. Weil, 883 F. Supp. 549, 552 (D. Colo. 1995).³

Under a contract with the Department known as the “Core Provider Agreement,” PAA furnishes services to Medicaid recipients in the fee-for-service delivery system. *See generally* MultiCare Med. Ctr. v. Dep’t of Soc. & Health Servs., 114 Wn.2d 572, 587-88, 790 P.2d 124 (1990) (the Core Provider Agreement is an express, unilateral contract between the

³ Molina is just one of several MCOs that have contracts with the State for purposes of participating in the Healthy Options program. No other MCO is party to this lawsuit.

Department and medical providers who choose to participate in Medicaid).⁴ Meanwhile, under a separate contract with the Department, Molina offers services to Medicaid recipients through a managed care program.⁵

The Department's Medicaid managed care program is called "Healthy Options." *See generally* RCW 74.09.522(2); WAC 388-538; St. John, 110 Wn. App. at 56. Through Healthy Options, the Department provides medical care through contracts under which an MCO, such as Molina, is paid a monthly premium for each Medicaid recipient enrolled with the MCO. *See* WAC 388-538-067(1); WAC 388-538-070(1); St. John, 110 Wn. App. at 56.

Recipients enrolled with the MCO are required to receive services included in the Healthy Options contract through the MCO. *See* WAC 388-538-060(1); WAC 388-538-095(1). The MCO retains the monthly premium from the Department regardless of whether the enrolled recipient receives any services during the month covered by the premium. The MCO must meet its contractual obligations to serve its enrolled Medicaid recipients within the money provided. The MCO is at risk of loss if the cost of care exceeds the premiums.

⁴ It is undisputed that PAA is party to a Core Provider Agreement with the Department. *See* Appellant's Brief dated December 8, 2010, at 15; Respondent/Cross-Appellant's Brief dated February 10, 2011, at 16.

⁵ *See, e.g.*, Appellant's Brief dated December 8, 2010, at 14 (Molina has contracted with the State since 2000 for the Healthy Options program and since 2004 for the Basic Health program).

Under Healthy Options, the MCO is responsible for assuring the State that it maintains a network of providers that is adequate to meet the needs of its Medicaid enrollees. *See, e.g.*, WAC 388-538-067(1)(c). The Department does not dictate the level of payments from an MCO to the providers in its network. *See, e.g.*, Transcript of Deposition of Michael Paulson (Jan. 13, 2010), at CP 509-12.

C. The Basic Health Program

In addition to the Medicaid program, Washington offers healthcare coverage to certain low-income individuals through the Basic Health program. *See generally* RCW 70.47.002. Individuals who qualify for either Medicaid benefits (from the State) or Medicare benefits (from the federal government) are not eligible for coverage under Basic Health. *See* RCW 70.47.010(3); RCW 70.47.010(5)(d).

Basic Health is administered by the Health Care Authority. *See* RCW 70.47.040(1). Enrollees of the Basic Health program receive their healthcare services through MCOs, rather than through a fee-for-service system. *See* RCW 70.47.010(3); RCW 70.47.100(1).

D. The Legislature's Bill In The 2011 Session Regarding Managed Care Payments

In its 2011 session, the Legislature enacted a bill that codifies its policy with respect to payments to providers who furnish services to

individuals enrolled in Healthy Options and Basic Health, when those providers do not have contracts with an MCO. *See* Laws of 2011, 1st Spec. Sess., ch. 9 (Engrossed Substitute S.B. (“ESSB”) 5927, 62nd Leg., 1st Spec. Sess. (Wash. 2011)).⁶

The Legislature noted the “increasing level of dispute and uncertainty” regarding payment rates from MCOs (such as Molina) to “nonparticipating providers” (such as PAA). *See* ESSB 5927, § 1(1)(a). The Legislature observed that the dispute “has resulted in litigation” under which the Superior Court ruled that “nonparticipating providers were entitled to receive [their] billed charges” when furnishing services to Healthy Options and Basic Health clients. *See* ESSB 5927, § 1(1)(b).

The Legislature then explained that, in its operating budgets for previous fiscal years, it had “indicated its intent” that payment rates from MCOs to nonparticipating providers should not exceed the Medicaid fee-for-service rates. *See* ESSB 5927, § 1(1)(c).

The Legislature expressed concern that “failure to resolve this dispute will have adverse impacts on state purchased health care programs serving low-income enrollees[.]” *See* ESSB 5927, § 1(d). The Legislature identified a series of negative effects:

⁶ For the Court’s convenience, a copy of ESSB 5927 is attached as **Appendix A**. The Governor signed the bill into law on May 31, 2011. *See* <http://apps.leg.wa.gov/billinfo/summary.aspx?bill=5927&year=2011> (last visited June 29, 2011).

- Diminished ability for the State to negotiate cost-effective contracts with MCOs.
- Potential for significant reduction in the willingness of providers to participate in MCO provider networks.
- Increased exposure for Healthy Options and Basic Health clients to “balance billing” from nonparticipating providers (in which providers ask clients to make up the difference between the State’s payment and their standard rates).
- Lack of access to care by Healthy Options and Basic Health clients.

See ESSB 5927, § 1(d).

In light of these findings and concerns, the Legislature stated the purpose of ESSB 5927 is to “create a legislative solution” that (1) reduces the State’s costs for paying for healthcare for low-income citizens; (2) protects clients from balance-billing practices; (3) allows for “appropriate payment” to providers who serve Healthy Options and Basic Health clients; and (4) “limits the risk” for MCOs that contract with the State for those programs. *See* ESSB 5927, § 1(2).

In accordance with this intent, and in order to address the payment issues stemming from this lawsuit, the Legislature amended statutes pertaining to both Healthy Options and Basic Health. *See* ESSB 5927, § 2 (amending RCW 74.09.522, regarding Healthy Options) and § 4 (amending RCW 70.47.100, regarding Basic Health).

The amendments require that MCOs (such as Molina) “shall pay” nonparticipating providers (such as PAA) for services furnished to Healthy Options and Basic Health clients “no more than the lowest amount paid for that service under the [MCO’s] contracts with similar providers in the state.” *See* ESSB 5927, § 2(7) (amending RCW 74.09.522) and § 4(2) (amending RCW 70.47.100). The legislation does not necessarily require MCOs to use the State’s fee-for-service rates when paying nonparticipating providers; instead, the legislation ties the payments to “the lowest amount paid” by MCOs to participating providers, which may or may not be the fee-for-service rates.

IV. ARGUMENT

It is the State’s policy that payments to medical providers who furnish services to Medicaid recipients should be at a level commensurate with the fee-for-service rate, not the provider’s “usual and customary” rate. The Legislature has codified this policy in ESSB 5927.

The State’s policy is particularly emphatic with respect to providers such as PAA that have already agreed, through the Core Provider Agreement, to accept the fee-for-service rates for their services to Medicaid recipients. In this situation, there is no logical reason for providers to receive their usual-and-customary rate when furnishing services to Medicaid clients. These providers have acknowledged their

willingness to accept Medicaid rates, and the fact that the providers are furnishing their services through the managed care mechanism, instead of the fee-for-service mechanism, does not mean they are entitled to receive their billed charges.

The State asks the Court to recognize its policy, as now codified in ESSB 5927, that providers who furnish services to Medicaid clients should not be allowed to receive payments for those services in an amount that is not commensurate with what those providers would receive under the Medicaid program.

V. CONCLUSION

If affirmed, the decision of the Superior Court could adversely affect the ability of individuals enrolled in Healthy Options and Basic Health to access medically necessary care, by reducing the number of providers who contract with MCOs to furnish those services. In addition, the ruling could have a significant financial effect on the State, because when providers demand and receive higher payments from MCOs, the MCOs, in turn, demand higher payments from the State, as a condition of

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remaining in the programs. Neither the State nor its low-income citizens
can afford such a result.

RESPECTFULLY SUBMITTED this 30th day of June, 2011.

ROBERT M. MCKENNA
Attorney General

A handwritten signature in black ink, appearing to read 'William T. Stephens', is written over a horizontal line. The signature is stylized and extends to the right of the line.

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CERTIFICATE OF SERVICE

I certify that on June 30, 2011, I mailed a copy of the foregoing
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APPENDIX A

CERTIFICATION OF ENROLLMENT

ENGROSSED SUBSTITUTE SENATE BILL 5927

Chapter 9, Laws of 2011

62nd Legislature
2011 1st Special Session

STATE HEALTH CARE--LOW-INCOME ENROLLEES

EFFECTIVE DATE: 08/24/11

Passed by the Senate May 10, 2011
YEAS 34 NAYS 11

BRAD OWEN

President of the Senate

Passed by the House May 9, 2011
YEAS 94 NAYS 2

FRANK CHOPP

Speaker of the House of Representatives

Approved May 31, 2011, 2:24 p.m.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is ENGROSSED SUBSTITUTE SENATE BILL 5927 as passed by the Senate and the House of Representatives on the dates hereon set forth.

THOMAS HOEMANN

Secretary

FILED

June 1, 2011

Secretary of State
State of Washington

ENGROSSED SUBSTITUTE SENATE BILL 5927

AS AMENDED BY THE HOUSE

Passed Legislature - 2011 1st Special Session

State of Washington 62nd Legislature 2011 1st Special Session

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

READ FIRST TIME 04/18/11.

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

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

7 NEW SECTION. **Sec. 1.** (1) The legislature finds that:

8 (a) There is an increasing level of dispute and uncertainty
9 regarding the amount of payment nonparticipating providers may receive
10 for health care services provided to enrollees of state purchased
11 health care programs designed to serve low-income individuals and
12 families, such as basic health and the medicaid managed care programs;

13 (b) The dispute has resulted in litigation, including a recent
14 Washington superior court ruling that determined nonparticipating
15 providers were entitled to receive billed charges from a managed health
16 care system for services provided to medicaid and basic health plan
17 enrollees. The decision would allow a nonparticipating provider to
18 demand and receive payment in an amount exceeding the payment managed

1 health care system network providers receive for the same services.
2 Similar provider lawsuits have now been filed in other jurisdictions in
3 the state;

4 (c) In the biennial operating budget, the legislature has
5 previously indicated its intent that payment to nonparticipating
6 providers for services provided to medicaid managed care enrollees
7 should be limited to amounts paid to medicaid fee-for-service
8 providers. The duration of these provisions is limited to the period
9 during which the operating budget is in effect. A more permanent
10 resolution of these issues is needed; and

11 (d) Continued failure to resolve this dispute will have adverse
12 impacts on state purchased health care programs serving low-income
13 enrollees, including: (i) Diminished ability for the state to
14 negotiate cost-effective contracts with managed health care systems;
15 (ii) a potential for significant reduction in the willingness of
16 providers to participate in managed health care system provider
17 networks; (iii) a reduction in providers participating in the managed
18 health care systems; and (iv) increased exposure for program enrollees
19 to balance billing practices by nonparticipating providers.
20 Ultimately, fewer eligible people will get the care they need as state
21 purchased health care programs will operate with less efficiency and
22 reduced access to cost-effective and quality health care coverage for
23 program enrollees.

24 (2) It is the intent of the legislature to create a legislative
25 solution that reduces the cost borne by the state to provide public
26 health care coverage to low-income enrollees in managed health care
27 systems, protects enrollees and state purchased health care programs
28 from balance billing by nonparticipating providers, provides
29 appropriate payment to health care providers for services provided to
30 enrollees of state purchased health care programs, and limits the risk
31 for managed health care systems that contract with the state programs.

32 **Sec. 2.** RCW 74.09.522 and 1997 c 59 s 15 and 1997 c 34 s 1 are
33 each reenacted and amended to read as follows:

34 (1) For the purposes of this section((7)):

35 (a) "Managed health care system" means any health care
36 organization, including health care providers, insurers, health care
37 service contractors, health maintenance organizations, health insuring

1 organizations, or any combination thereof, that provides directly or by
2 contract health care services covered under ((RCW 74.09.520)) this
3 chapter and rendered by licensed providers, on a prepaid capitated
4 basis and that meets the requirements of section 1903(m)(1)(A) of Title
5 XIX of the federal social security act or federal demonstration waivers
6 granted under section 1115(a) of Title XI of the federal social
7 security act;

8 (b) "Nonparticipating provider" means a person, health care
9 provider, practitioner, facility, or entity, acting within their scope
10 of practice, that does not have a written contract to participate in a
11 managed health care system's provider network, but provides health care
12 services to enrollees of programs authorized under this chapter whose
13 health care services are provided by the managed health care system.

14 (2) The department of social and health services shall enter into
15 agreements with managed health care systems to provide health care
16 services to recipients of temporary assistance for needy families under
17 the following conditions:

18 (a) Agreements shall be made for at least thirty thousand
19 recipients statewide;

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

22 (c) To the extent that this provision is consistent with section
23 1903(m) of Title XIX of the federal social security act or federal
24 demonstration waivers granted under section 1115(a) of Title XI of the
25 federal social security act, recipients shall have a choice of systems
26 in which to enroll and shall have the right to terminate their
27 enrollment in a system: PROVIDED, That the department may limit
28 recipient termination of enrollment without cause to the first month of
29 a period of enrollment, which period shall not exceed twelve months:
30 AND PROVIDED FURTHER, That the department shall not restrict a
31 recipient's right to terminate enrollment in a system for good cause as
32 established by the department by rule;

33 (d) To the extent that this provision is consistent with section
34 1903(m) of Title XIX of the federal social security act, participating
35 managed health care systems shall not enroll a disproportionate number
36 of medical assistance recipients within the total numbers of persons
37 served by the managed health care systems, except as authorized by the

1 department under federal demonstration waivers granted under section
2 1115(a) of Title XI of the federal social security act;

3 (e) In negotiating with managed health care systems the department
4 shall adopt a uniform procedure to negotiate and enter into contractual
5 arrangements, including standards regarding the quality of services to
6 be provided; and financial integrity of the responding system;

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

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

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

16 (i) Nothing in this section prevents the department from entering
17 into similar agreements for other groups of people eligible to receive
18 services under this chapter.

19 (3) The department shall ensure that publicly supported community
20 health centers and providers in rural areas, who show serious intent
21 and apparent capability to participate as managed health care systems
22 are seriously considered as contractors. The department shall
23 coordinate its managed care activities with activities under chapter
24 70.47 RCW.

25 (4) The department shall work jointly with the state of Oregon and
26 other states in this geographical region in order to develop
27 recommendations to be presented to the appropriate federal agencies and
28 the United States congress for improving health care of the poor, while
29 controlling related costs.

30 (5) The legislature finds that competition in the managed health
31 care marketplace is enhanced, in the long term, by the existence of a
32 large number of managed health care system options for medicaid
33 clients. In a managed care delivery system, whose goal is to focus on
34 prevention, primary care, and improved enrollee health status,
35 continuity in care relationships is of substantial importance, and
36 disruption to clients and health care providers should be minimized.
37 To help ensure these goals are met, the following principles shall

1 guide the department in its healthy options managed health care
2 purchasing efforts:

3 (a) All managed health care systems should have an opportunity to
4 contract with the department to the extent that minimum contracting
5 requirements defined by the department are met, at payment rates that
6 enable the department to operate as far below appropriated spending
7 levels as possible, consistent with the principles established in this
8 section.

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

12 (i) Demonstrated commitment to or experience in serving low-income
13 populations;

14 (ii) Quality of services provided to enrollees;

15 (iii) Accessibility, including appropriate utilization, of services
16 offered to enrollees;

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

19 (v) Payment rates; and

20 (vi) The ability to meet other specifically defined contract
21 requirements established by the department, including consideration of
22 past and current performance and participation in other state or
23 federal health programs as a contractor.

24 (c) Consideration should be given to using multiple year
25 contracting periods.

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

29 (e) All contractors that are regulated health carriers must meet
30 state minimum net worth requirements as defined in applicable state
31 laws. The department shall adopt rules establishing the minimum net
32 worth requirements for contractors that are not regulated health
33 carriers. This subsection does not limit the authority of the
34 department to take action under a contract upon finding that a
35 contractor's financial status seriously jeopardizes the contractor's
36 ability to meet its contract obligations.

37 (f) Procedures for resolution of disputes between the department
38 and contract bidders or the department and contracting carriers related

1 to the award of, or failure to award, a managed care contract must be
2 clearly set out in the procurement document. In designing such
3 procedures, the department shall give strong consideration to the
4 negotiation and dispute resolution processes used by the Washington
5 state health care authority in its managed health care contracting
6 activities.

7 (6) The department may apply the principles set forth in subsection
8 (5) of this section to its managed health care purchasing efforts on
9 behalf of clients receiving supplemental security income benefits to
10 the extent appropriate.

11 (7) A managed health care system shall pay a nonparticipating
12 provider that provides a service covered under this chapter to the
13 system's enrollee no more than the lowest amount paid for that service
14 under the managed health care system's contracts with similar providers
15 in the state.

16 (8) For services covered under this chapter to medical assistance
17 or medical care services enrollees and provided on or after the
18 effective date of this section, nonparticipating providers must accept
19 as payment in full the amount paid by the managed health care system
20 under subsection (7) of this section in addition to any deductible,
21 coinsurance, or copayment that is due from the enrollee for the service
22 provided. An enrollee is not liable to any nonparticipating provider
23 for covered services, except for amounts due for any deductible,
24 coinsurance, or copayment under the terms and conditions set forth in
25 the managed health care system contract to provide services under this
26 section.

27 (9) Pursuant to federal managed care access standards, 42 C.F.R.
28 Sec. 438, managed health care systems must maintain a network of
29 appropriate providers that is supported by written agreements
30 sufficient to provide adequate access to all services covered under the
31 contract with the department, including hospital-based physician
32 services. The department will monitor and periodically report on the
33 proportion of services provided by contracted providers and
34 nonparticipating providers, by county, for each managed health care
35 system to ensure that managed health care systems are meeting network
36 adequacy requirements. No later than January 1st of each year, the
37 department will review and report its findings to the appropriate

1 policy and fiscal committees of the legislature for the preceding state
2 fiscal year.

3 (10) Subsections (7) through (9) of this section expire July 1,
4 2016.

5 **Sec. 3.** RCW 70.47.020 and 2011 c 205 s 1 are each reenacted and
6 amended to read as follows:

7 As used in this chapter:

8 (1) "Administrator" means the Washington basic health plan
9 administrator, who also holds the position of administrator of the
10 Washington state health care authority.

11 (2) "Health coverage tax credit eligible enrollee" means individual
12 workers and their qualified family members who lose their jobs due to
13 the effects of international trade and are eligible for certain trade
14 adjustment assistance benefits; or are eligible for benefits under the
15 alternative trade adjustment assistance program; or are people who
16 receive benefits from the pension benefit guaranty corporation and are
17 at least fifty-five years old.

18 (3) "Health coverage tax credit program" means the program created
19 by the Trade Act of 2002 (P.L. 107-210) that provides a federal tax
20 credit that subsidizes private health insurance coverage for displaced
21 workers certified to receive certain trade adjustment assistance
22 benefits and for individuals receiving benefits from the pension
23 benefit guaranty corporation.

24 (4) "Managed health care system" means: (a) Any health care
25 organization, including health care providers, insurers, health care
26 service contractors, health maintenance organizations, or any
27 combination thereof, that provides directly or by contract basic health
28 care services, as defined by the administrator and rendered by duly
29 licensed providers, to a defined patient population enrolled in the
30 plan and in the managed health care system; or (b) a self-funded or
31 self-insured method of providing insurance coverage to subsidized
32 enrollees provided under RCW 41.05.140 and subject to the limitations
33 under RCW 70.47.100(~~(7)~~) (9).

34 (5) "Nonparticipating provider" means a person, health care
35 provider, practitioner, facility, or entity, acting within their
36 authorized scope of practice or licensure, that does not have a written

1 contract to participate in a managed health care system's provider
2 network, but provides services to plan enrollees who receive coverage
3 through the managed health care system.

4 (6) "Nonsubsidized enrollee" means an individual, or an individual
5 plus the individual's spouse or dependent children: (a) Who is not
6 eligible for medicare; (b) who is not confined or residing in a
7 government-operated institution, unless he or she meets eligibility
8 criteria adopted by the administrator; (c) who is accepted for
9 enrollment by the administrator as provided in RCW 48.43.018, either
10 because the potential enrollee cannot be required to complete the
11 standard health questionnaire under RCW 48.43.018, or, based upon the
12 results of the standard health questionnaire, the potential enrollee
13 would not qualify for coverage under the Washington state health
14 insurance pool; (d) who resides in an area of the state served by a
15 managed health care system participating in the plan; (e) who chooses
16 to obtain basic health care coverage from a particular managed health
17 care system; and (f) who pays or on whose behalf is paid the full costs
18 for participation in the plan, without any subsidy from the plan.

19 ~~((6))~~ (7) "Premium" means a periodic payment, which an
20 individual, their employer or another financial sponsor makes to the
21 plan as consideration for enrollment in the plan as a subsidized
22 enrollee, a nonsubsidized enrollee, or a health coverage tax credit
23 eligible enrollee.

24 ~~((7))~~ (8) "Rate" means the amount, negotiated by the
25 administrator with and paid to a participating managed health care
26 system, that is based upon the enrollment of subsidized, nonsubsidized,
27 and health coverage tax credit eligible enrollees in the plan and in
28 that system.

29 ~~((8))~~ (9) "Subsidy" means the difference between the amount of
30 periodic payment the administrator makes to a managed health care
31 system on behalf of a subsidized enrollee plus the administrative cost
32 to the plan of providing the plan to that subsidized enrollee, and the
33 amount determined to be the subsidized enrollee's responsibility under
34 RCW 70.47.060(2).

35 ~~((9))~~ (10) "Subsidized enrollee" means:

36 (a) An individual, or an individual plus the individual's spouse or
37 dependent children:

38 (i) Who is not eligible for medicare;

1 (ii) Who is not confined or residing in a government-operated
2 institution, unless he or she meets eligibility criteria adopted by the
3 administrator;

4 (iii) Who is not a full-time student who has received a temporary
5 visa to study in the United States;

6 (iv) Who resides in an area of the state served by a managed health
7 care system participating in the plan;

8 (v) Until March 1, 2011, whose gross family income at the time of
9 enrollment does not exceed two hundred percent of the federal poverty
10 level as adjusted for family size and determined annually by the
11 federal department of health and human services;

12 (vi) Who chooses to obtain basic health care coverage from a
13 particular managed health care system in return for periodic payments
14 to the plan;

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

17 (viii) After February 28, 2011, who is in the basic health
18 transition eligibles population under 1115 medicaid demonstration
19 project number 11-W-00254/10;

20 (b) An individual who meets the requirements in (a)(i) through
21 (iv), (vi), and (vii) of this subsection and who is a foster parent
22 licensed under chapter 74.15 RCW and whose gross family income at the
23 time of enrollment does not exceed three hundred percent of the federal
24 poverty level as adjusted for family size and determined annually by
25 the federal department of health and human services; and

26 (c) To the extent that state funds are specifically appropriated
27 for this purpose, with a corresponding federal match, an individual, or
28 an individual's spouse or dependent children, who meets the
29 requirements in (a)(i) through (iv), (vi), and (vii) of this subsection
30 and whose gross family income at the time of enrollment is more than
31 two hundred percent, but less than two hundred fifty-one percent, of
32 the federal poverty level as adjusted for family size and determined
33 annually by the federal department of health and human services.

34 ~~((10))~~ (11) "Washington basic health plan" or "plan" means the
35 system of enrollment and payment for basic health care services,
36 administered by the plan administrator through participating managed
37 health care systems, created by this chapter.

1 **Sec. 4.** RCW 70.47.100 and 2009 c 568 s 5 are each amended to read
2 as follows:

3 (1) A managed health care system participating in the plan shall do
4 so by contract with the administrator and shall provide, directly or by
5 contract with other health care providers, covered basic health care
6 services to each enrollee covered by its contract with the
7 administrator as long as payments from the administrator on behalf of
8 the enrollee are current. A participating managed health care system
9 may offer, without additional cost, health care benefits or services
10 not included in the schedule of covered services under the plan. A
11 participating managed health care system shall not give preference in
12 enrollment to enrollees who accept such additional health care benefits
13 or services. Managed health care systems participating in the plan
14 shall not discriminate against any potential or current enrollee based
15 upon health status, sex, race, ethnicity, or religion. The
16 administrator may receive and act upon complaints from enrollees
17 regarding failure to provide covered services or efforts to obtain
18 payment, other than authorized copayments, for covered services
19 directly from enrollees, but nothing in this chapter empowers the
20 administrator to impose any sanctions under Title 18 RCW or any other
21 professional or facility licensing statute.

22 (2) A managed health care system shall pay a nonparticipating
23 provider that provides a service covered under this chapter to the
24 system's enrollee no more than the lowest amount paid for that service
25 under the managed health care system's contracts with similar providers
26 in the state.

27 (3) Pursuant to federal managed care access standards, 42 C.F.R.
28 Sec. 438, managed health care systems must maintain a network of
29 appropriate providers that is supported by written agreements
30 sufficient to provide adequate access to all services covered under the
31 contract with the authority, including hospital-based physician
32 services. The authority will monitor and periodically report on the
33 proportion of services provided by contracted providers and
34 nonparticipating providers, by county, for each managed health care
35 system to ensure that managed health care systems are meeting network
36 adequacy requirements. No later than January 1st of each year, the
37 authority will review and report its findings to the appropriate policy

1 and fiscal committees of the legislature for the preceding state fiscal
2 year.

3 (4) The plan shall allow, at least annually, an opportunity for
4 enrollees to transfer their enrollments among participating managed
5 health care systems serving their respective areas. The administrator
6 shall establish a period of at least twenty days in a given year when
7 this opportunity is afforded enrollees, and in those areas served by
8 more than one participating managed health care system the
9 administrator shall endeavor to establish a uniform period for such
10 opportunity. The plan shall allow enrollees to transfer their
11 enrollment to another participating managed health care system at any
12 time upon a showing of good cause for the transfer.

13 ~~((3))~~ (5) Prior to negotiating with any managed health care
14 system, the administrator shall determine, on an actuarially sound
15 basis, the reasonable cost of providing the schedule of basic health
16 care services, expressed in terms of upper and lower limits, and
17 recognizing variations in the cost of providing the services through
18 the various systems and in different areas of the state.

19 ~~((4))~~ (6) In negotiating with managed health care systems for
20 participation in the plan, the administrator shall adopt a uniform
21 procedure that includes at least the following:

22 (a) The administrator shall issue a request for proposals,
23 including standards regarding the quality of services to be provided;
24 financial integrity of the responding systems; and responsiveness to
25 the unmet health care needs of the local communities or populations
26 that may be served;

27 (b) The administrator shall then review responsive proposals and
28 may negotiate with respondents to the extent necessary to refine any
29 proposals;

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

32 (d) The administrator may adopt a policy that gives preference to
33 respondents, such as nonprofit community health clinics, that have a
34 history of providing quality health care services to low-income
35 persons.

36 ~~((5))~~ (7) The administrator may contract with a managed health
37 care system to provide covered basic health care services to subsidized

1 enrollees, nonsubsidized enrollees, health coverage tax credit eligible
2 enrollees, or any combination thereof.

3 ~~((6))~~ (8) The administrator may establish procedures and policies
4 to further negotiate and contract with managed health care systems
5 following completion of the request for proposal process in subsection
6 ~~((4))~~ (6) of this section, upon a determination by the administrator
7 that it is necessary to provide access, as defined in the request for
8 proposal documents, to covered basic health care services for
9 enrollees.

10 ~~((7))~~ (9) The administrator may implement a self-funded or self-
11 insured method of providing insurance coverage to subsidized enrollees,
12 as provided under RCW 41.05.140. Prior to implementing a self-funded
13 or self-insured method, the administrator shall ensure that funding
14 available in the basic health plan self-insurance reserve account is
15 sufficient for the self-funded or self-insured risk assumed, or
16 expected to be assumed, by the administrator. If implementing a self-
17 funded or self-insured method, the administrator may request funds to
18 be moved from the basic health plan trust account or the basic health
19 plan subscription account to the basic health plan self-insurance
20 reserve account established in RCW 41.05.140.

21 (10) Subsections (2) and (3) of this section expire July 1, 2016.

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

24 (1) For services provided to plan enrollees on or after the
25 effective date of this section, nonparticipating providers must accept
26 as payment in full the amount paid by the managed health care system
27 under RCW 70.47.100(2) in addition to any deductible, coinsurance, or
28 copayment that is due from the enrollee under the terms and conditions
29 set forth in the managed health care system contract with the
30 administrator. A plan enrollee is not liable to any nonparticipating
31 provider for covered services, except for amounts due for any
32 deductible, coinsurance, or copayment under the terms and conditions
33 set forth in the managed health care system contract with the
34 administrator.

35 (2) This section expires July 1, 2016.

1 NEW SECTION. **Sec. 6.** If any provision of this act or its
2 application to any person or circumstance is held invalid, the
3 remainder of the act or the application of the provision to other
4 persons or circumstances is not affected.

Passed by the Senate May 10, 2011.

Passed by the House May 9, 2011.

Approved by the Governor May 31, 2011.

Filed in Office of Secretary of State June 1, 2011.