RCW 70.47.100 Participation by a managed health care system—Expiration of subsections. (1) A managed health care system participating in the plan shall do so by contract with the director and shall provide, directly or by contract with other health care providers, covered basic health care services to each enrollee covered by its contract with the director as long as payments from the director on behalf of the enrollee are current. A participating managed health care system may offer, without additional cost, health care benefits or services not included in the schedule of covered services under the plan. A participating managed health care system shall not give preference in enrollment to enrollees who accept such additional health care benefits or services. Managed health care systems participating in the plan shall not discriminate against any potential or current enrollee based upon health status, sex, race, ethnicity, or religion. The director may receive and act upon complaints from enrollees regarding failure to provide covered services or efforts to obtain payment, other than authorized copayments, for covered services directly from enrollees, but nothing in this chapter empowers the director to impose any sanctions under Title 18 RCW or any other professional or facility licensing statute.

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

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

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

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

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

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

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

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

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

(7)(a) The director may contract with a managed health care system to provide covered basic health care services to subsidized enrollees, nonsubsidized enrollees, health coverage tax credit eligible enrollees, or any combination thereof. At a minimum, such contracts issued on or after January 1, 2012, must include:

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

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

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

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

(c) For the purposes of this subsection, "chronic care management," "chronic condition," and "health home" have the same meaning as in RCW 74.09.010.

(d) Contracts that include the items in (a)(i) through (iii) of this subsection must not exceed the rates that would be paid in the absence of these provisions.

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

(9) Subsections (2) and (3) of this section expire July 1, 2016. [2013 c 251 § 7. Prior: 2011 1st sp.s. c 9 § 4; 2011 c 316 § 5; 2009 c 568 § 5; 2004 c 192 § 4; 2000 c 79 § 35; 1987 1st ex.s. c 5 § 12.]

Residual balance of funds—Effective date—2013 c 251: See notes following RCW 41.06.280.

Findings—Intent—2011 1st sp.s. c 9: See note following RCW 70.47.020.

Effective date—2004 c 192: See note following RCW 70.47.020.

Effective date—Severability—2000 c 79: See notes following RCW 48.04.010.