H-4269.1

HOUSE BILL 2691

State of Washington 60th Legislature 2008 Regular Session

By Representative Cody

Read first time 01/15/08. Referred to Committee on Health Care & Wellness.

AN ACT Relating to patient referrals by a health care practitioner; amending RCW 74.09.240; reenacting and amending RCW 74.09.522; adding a new section to chapter 48.43 RCW; adding a new section to chapter 41.05 RCW; adding a new section to chapter 70.47 RCW; adding a new section to chapter 74.09 RCW; adding a new chapter to Title 18 RCW; and prescribing penalties.

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

NEW SECTION. **Sec. 1.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Beneficial interest" means ownership, through equity, debt, or other means, of any financial interest. "Beneficial interest" does not include ownership, through equity, debt, or other means, of securities, including shares or bonds, debentures, or other debt instruments:

(a) In a corporation that is traded on a national exchange or over the counter on the national market system;

(b) That at the time of acquisition, were purchased at the same price and on the same terms generally available to the public;

(c) That are available to individuals who are not in a position to

refer patients to the health care entity on the same terms that are offered to health care practitioners who may refer patients to the health care entity;

(d) That are unrelated to the past or expected volume of referrals from the health care practitioner to the health care entity; and

(e) That are not marketed differently to health care practitioners that may make referrals than they are marketed to other individuals.

(2) "Compensation arrangement" means any agreement or system involving any remuneration between a health care practitioner or the immediate family member of the health care practitioner and a health care entity. "Compensation arrangement" does not include:

(a) Compensation or shares under a faculty practice plan or a professional corporation affiliated with a teaching hospital and comprised of health care practitioners who are members of the faculty of a university;

(b) Amounts paid under a good faith employment agreement between a health care entity and a health care practitioner or an immediate family member of the health care practitioner;

(c) An arrangement between a health care entity and a health care practitioner or the immediate family member of a health care practitioner for the provision of any services, as an independent contractor, if:

(i) The arrangement is for identifiable services;

(ii) The amount of the remuneration under the arrangement is consistent with the fair market value of the service and is not determined in a manner that takes into account, directly or indirectly, the volume or value of any referrals by the referring health care practitioner; and

(iii) The compensation is provided in accordance with an agreement that would be commercially reasonable even if no referrals were made to the health care provider;

(d) Compensation for health care services pursuant to a referral from a health care practitioner and rendered by a health care entity, that employs or contracts with an immediate family member of the health care practitioner, in which the immediate family member's compensation is not based on the referral;

(e) An arrangement for compensation that is provided by a health care entity to a health care practitioner or the immediate family

member of the health care practitioner to induce the health care practitioner or the immediate family member of the health care practitioner to relocate to the geographic area served by the health care entity in order to be a member of the medical staff of a hospital, if:

(i) The health care practitioner or the immediate family member of the health care practitioner is not required to refer patients to the health care entity;

(ii) The amount of the compensation under the arrangement is not determined in a manner that takes into account, directly or indirectly, the volume or value of any referrals by the referring health care practitioner; and

(iii) The health care entity needs the services of the practitioner to meet community health care needs and has had difficulty in recruiting a practitioner;

(f) Payments made for the rental or lease of office space if the payments are:

(i) At fair market value; and

(ii) In accordance with an arm's length transaction;

(g) Payments made for the rental or lease of equipment if the payments are:

(i) At fair market value; and

(ii) In accordance with an arm's length transaction; or

(h) Payments made for the sale of property or a health care practice if the payments are:

(i) At fair market value;

(ii) In accordance with an arm's length transaction; and

(iii) The remuneration is provided in accordance with an agreement that would be commercially reasonable even if no referrals were made.

(3) "Direct supervision" means a health care practitioner is present on the premises where the health care services or tests are provided and is available for consultation within the treatment area.

(4) "Disciplining authority" means an agency, board, or commission identified in RCW 18.130.040.

(5) "Faculty practice plan" means a tax exempt organization established under Washington law by or at the direction of a university to accommodate the professional practice of members of the faculty who are health care practitioners.

(6) "Group practice" means a group of two or more health care practitioners legally organized as a partnership, professional corporation, foundation, nonprofit corporation, faculty practice plan, or similar association:

(a) In which each health care practitioner who is a member of the group provides substantially the full range of services that the practitioner routinely provides through the joint use of shared office space, facilities, equipment, and personnel;

(b) For which substantially all of the services of the health care practitioners who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group; and

(c) In which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined on an annual basis by members of the group.

(7) "Health care entity" means a business entity that provides health care services for the:

(a) Testing, diagnosis, or treatment of human disease or dysfunction; or

(b) Dispensing of drugs, medical devices, medical appliances, or medical goods for the treatment of human disease or dysfunction.

(8) "Health care practitioner" means a person who holds a credential issued by a disciplining authority identified in RCW 18.130.040 and provides health care services in the ordinary course of business or practice of a profession.

(9) "Health care service" means medical procedures, tests, and services provided to a patient by or through a health care entity.

(10) "Hospital" means a hospital as defined in RCW 70.41.020.

(11) "Immediate family member" means a health care practitioner's:

(a) Spouse;

(b) Child;

(c) Child's spouse;

(d) Parent;

(e) Spouse's parent;

(f) Sibling; or

(g) Sibling's spouse.

(12) "In-office ancillary services" means those basic health care services and tests routinely performed in the office of one or more

health care practitioners. Except for a radiologist group practice or an office consisting solely of one or more radiologists, "in-office ancillary services" does not include:

(a) Magnetic resonance imaging services;

(b) Radiation therapy services; or

(c) Computer tomography scan services.

(13) "Provider-sponsored organization" means an entity that:

(a) Is a legal aggregate of providers operating collectively for the purpose of providing health care services to medicare beneficiaries under the federal medicare advantage program;

(b) Acts through a licensed entity, such as a partnership, corporation, limited liability company, limited liability partnership, or sole proprietorship, that has authority over the entity's activities; and

(c) Provides a substantial proportion of the health care services required to be provided under the federal medicare advantage program directly through providers or affiliated groups of providers.

(14) "Refer" means the act of issuing a referral.

(15) "Referral" means any act of directing a patient for health care services. "Referral" includes:

(a) The forwarding of a patient by one health care practitioner to another health care practitioner or to a health care entity outside the health care practitioner's office or group practice; or

(b) The request or establishment by a health care practitioner of a plan of care for the provision of health care services outside the health care practitioner's office or group practice.

(16) "Related institution" means an adult family home as defined in RCW 70.128.010, a boarding home as defined in RCW 18.20.020, or a nursing home as defined in RCW 18.51.010.

(17) "Secretary" means the secretary of health.

NEW SECTION. **Sec. 2.** (1) Except as provided in subsection (4) of this section, a health care practitioner may not refer a patient, or direct an employee of or person under contract with the health care practitioner to refer a patient, to a health care entity:

(a) In which the health care practitioner or the practitioner in combination with one or more of the practitioner's immediate family members owns a beneficial interest;

(b) In which one or more of the practitioner's immediate family members owns a beneficial interest of three percent or greater; or

(c) With which the health care practitioner, one or more of the practitioner's immediate family members, or the practitioner in combination with one or more of the practitioner's immediate family members has a compensation arrangement.

(2) A health care entity or a referring health care practitioner may not present or cause to be presented to any individual, third-party payor, or other person a claim, bill, or other demand for payment for health care services provided as a result of a referral prohibited by this chapter.

(3) Subsection (1) of this section applies to any arrangement or scheme, including a cross-referral arrangement, that the health care practitioner knows or should know has a principal purpose of assuring indirect referrals that would be in violation of subsection (1) of this section if made directly.

(4) The provisions of this section do not apply to:

(a) A health care practitioner when treating a member of a health maintenance organization as defined in RCW 48.46.020 if the health care practitioner does not have a beneficial interest in the health care entity;

(b) A health care practitioner who refers a patient to another health care practitioner in the same group practice as the referring health care practitioner;

(c) A health care practitioner with a beneficial interest in a health care entity who refers a patient to that health care entity for health care services or tests, if the services or tests are personally performed by or under the direct supervision of the referring health care practitioner;

(d) A health care practitioner who refers in-office ancillary services or tests that are:

(i) Personally furnished by:

(A) The referring health care practitioner;

(B) A health care practitioner in the same group practice as the referring health care practitioner; or

(C) An individual who is employed and personally supervised by the qualified referring health care practitioner or a health care

practitioner in the same group practice as the referring health care practitioner;

(ii) Provided in the same building where the referring health care practitioner or a health care practitioner in the same group practice as the referring health care practitioner furnishes services; and

(iii) Billed by:

(A) The health care practitioner performing or supervising the services; or

(B) A group practice of which the health care practitioner performing or supervising the services is a member;

(e) A health care practitioner who has a beneficial interest in a health care entity if, in accordance with rules adopted by the secretary:

(i) The disciplining authority determines that the health care practitioner's beneficial interest is essential to finance the health care entity and provide health care services; and

(ii) The disciplining authority determines that the health care entity is needed to ensure appropriate access for the community to the services provided at the health care entity;

(f) A health care practitioner employed or affiliated with a hospital, who refers a patient to a health care entity that is owned or controlled by a hospital or under common ownership or control with a hospital if the health care practitioner does not have a direct beneficial interest in the health care entity;

(g) A health care practitioner or member of a single specialty group practice, including any person employed or affiliated with a hospital, who has a beneficial interest in a health care entity that is owned or controlled by a hospital or under common ownership or control with a hospital if:

(i) The health care practitioner or other member of that single specialty group practice provides the health care services to a patient pursuant to a referral or in accordance with a consultation requested by another health care practitioner who does not have a beneficial interest in the health care entity; or

(ii) The health care practitioner or other member of that single specialty group practice referring a patient to the facility, service, or entity personally performs or supervises the health care service or procedure;

(h) A health care practitioner with a beneficial interest in, or compensation arrangement with, a hospital or related institution or a facility, service, or other entity that is owned or controlled by a hospital or related institution or under common ownership or control with a hospital or related institution if:

(i) The beneficial interest was held or the compensation arrangement was in existence on January 1, 2008; and

(ii) Thereafter the beneficial interest or compensation arrangement of the health care practitioner does not increase;

(i) A health care practitioner who refers a patient to a dialysis facility, if the patient has been diagnosed with end stage renal disease as defined in the medicare regulations pursuant to the federal social security act;

(j) A health care practitioner who refers a patient to a hospital in which the health care practitioner has a beneficial interest if:

(i) The health care practitioner is authorized to perform services at the hospital; and

(ii) The ownership or investment interest is in the hospital itself and not solely in a subdivision of the hospital; or

(k) A health care practitioner when treating an enrollee of a provider-sponsored organization if the health care practitioner is referring enrollees to an affiliated health care provider of the provider-sponsored organization.

(5) A health care practitioner exempted from the provisions of this section in accordance with subsection (4) of this section is subject to the disclosure provisions of section 3 of this act.

NEW SECTION. **Sec. 3.** (1) Except as provided in subsection (3) of this section, a health care practitioner making a lawful referral shall disclose the existence of the beneficial interest in accordance with the provisions of this section.

(2) Prior to referring a patient to a health care entity in which the practitioner, the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family owns a beneficial interest, the health care practitioner shall:

(a) Except if an oral referral is made by telephone, provide the patient with a written statement that:

(i) Discloses the existence of the ownership of the beneficial interest or compensation arrangement;

(ii) States that the patient may choose to obtain the health care service from another health care entity; and

(iii) Requires the patient to acknowledge in writing receipt of the statement;

(b) Except if an oral referral is made by telephone, insert in the medical record of the patient a copy of the written acknowledgment;

(c) Place on permanent display a written notice that is in a typeface that is large enough to be easily legible to the average person from a distance of eight feet and that is in a location that is plainly visible to the patients of the health care practitioner disclosing all of the health care entities:

(i) In which the practitioner, the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family owns a beneficial interest; and

(ii) To which the practitioner refers patients; and

(d) Documents in the medical record of the patient that:

(i) A valid medical need exists for the referral; and

(ii) The practitioner has disclosed the existence of the beneficial interest to the patient.

(3) The provisions of this section do not apply to:

(a) A health care practitioner when treating a member of a health maintenance organization as defined in RCW 48.46.020 and the health care practitioner does not have a beneficial interest in the health care entity; or

(b) A health care practitioner who refers a patient:

(i) To another health care practitioner in the same group practice as the referring health care practitioner;

(ii) For in-office ancillary services; or

(iii) For health care services provided through or by a health care entity owned or controlled by a hospital.

(4) A health care practitioner who fails to comply with any provision of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding five thousand dollars.

NEW SECTION. **Sec. 4.** (1) A health care practitioner shall disclose the name of a referring health care practitioner on each

request for payment or bill submitted to a third-party payor, including nonprofit health plans and fiscal intermediaries and carriers, that may be responsible for payment, in whole or in part, of the charges for a health care service, if the health care practitioner knows or has reason to believe:

(a) There has been a referral by a health care practitioner; and

(b) The referring health care practitioner has a beneficial interest in or compensation arrangement with the health care entity that is prohibited under section 2 of this act.

(2) A health care practitioner who knows or should have known of the practitioner's failure to comply with the provisions of this section is subject to disciplinary action by the appropriate disciplining authority.

NEW SECTION. **Sec. 5.** (1) If a referring health care practitioner, a health care entity, or other person furnishing health care services collects any amount of money that was billed in violation of section 2(2) of this act and the referring health care practitioner, health care entity, or other person knew or should have known of the violation, the referring health care practitioner, health care entity, or other person is jointly and severally liable to the payor for any amounts collected.

(2) If a claim, bill, or other demand or request for payment for health care services is denied under RCW 74.09.240 or section 7 or 8 of this act the referring health care practitioner, health care entity, or other person furnishing the health care services may not submit a claim, bill, or other demand or request for payment to the person who received the health care services.

NEW SECTION. **Sec. 6.** The failure of a health care practitioner to comply with the provisions of this chapter is considered unprofessional conduct and is subject to disciplinary action under chapter 18.130 RCW by the appropriate disciplining authority under that chapter.

NEW SECTION. **Sec. 7.** A new section is added to chapter 48.43 RCW to read as follows:

(1) For the purposes of this section, "disciplining authority,"

"health care practitioner," "health care entity," and "health care service" have the same meanings as provided in section 1 of this act.

(2) A health carrier may seek repayment from a health care practitioner of any moneys paid for any claim, bill, or other demand or request for payment for the health care services that were determined by the appropriate disciplining authority to be furnished as a result of a referral prohibited by section 2 of this act.

(3) Every contract between a health carrier and its enrollees or a group of enrollees for the provision of health care services shall include a provision excluding payment of any claim, bill, or other demand or request for payment for health care services determined to be furnished as a result of a referral prohibited by section 2 of this act.

(4) A health carrier subject to the provisions of this section shall report to the appropriate disciplining authority any pattern of claims, bills, or other demands or requests for payment submitted for a health care service provided as a result of a referral prohibited by section 2 of this act within thirty days after that health carrier has knowledge of that pattern.

(5)(a) Notwithstanding the provisions of this section, a health carrier reimbursing for health care services is not required to audit or investigate any claim, bill, or other demand or request for payment for the purpose of determining whether those services were the result of a prohibited referral.

(b) Any audit or investigation of any claim, bill, or other demand or request for payment for the purpose of determining whether those services were the result of the prohibited referral are not grounds to delay payment or waive any requirements for the prompt payment of claims.

(6) For any claim, bill, or request for payment that is paid and is subsequently determined to be the result of a prohibited referral, a health carrier may seek a refund of that payment in accordance with the provisions of section 5 of this act.

NEW SECTION. **Sec. 8.** A new section is added to chapter 41.05 RCW to read as follows:

Each health plan that provides medical insurance offered under this

chapter, including plans created by insuring entities, plans not subject to the provisions of Title 48 RCW, and plans created under RCW 41.05.140, is subject to the provisions of section 7 of this act.

NEW SECTION. **Sec. 9.** A new section is added to chapter 70.47 RCW to read as follows:

Each health plan that provides medical insurance offered under this chapter, including plans created by insuring entities, plans not subject to the provisions of Title 48 RCW, and plans created under RCW 41.05.140, is subject to the provisions of section 7 of this act.

Sec. 10. RCW 74.09.240 and 1995 c 319 s 1 are each amended to read as follows:

(1) Any person, including any corporation, that solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind: (a) In return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this chapter((~~,~~)); or (b) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made in whole or in part under this chapter, shall be guilty of a class C felony((~~:~~)). However, the fine, if imposed, shall not be in an amount more than twenty-five thousand dollars, except as authorized by RCW 9A.20.030.

(2) Any person, including any corporation, that offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person: (a) To refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under this chapter((~~,~~)); or (b) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made in whole or in part under this chapter, shall be guilty of a class C felony((~~:~~)). However, the fine, if imposed, shall not be in an amount more than twenty-five thousand dollars, except as authorized by RCW 9A.20.030.

(3)(((~~(a) Except as provided in 42 U.S.C. 1395 nn, physicians are prohibited from self-referring any client eligible under this chapter for the following designated health services to a facility in which the physician or an immediate family member has a financial relationship:~~

~~(i) Clinical laboratory services;~~

~~(ii) Physical therapy services;~~

~~(iii) Occupational therapy services;~~

~~(iv) Radiology including magnetic resonance imaging, computerized axial tomography, and ultrasound services;~~

~~(v) Durable medical equipment and supplies;~~

~~(vi) Parenteral and enteral nutrients equipment and supplies;~~

~~(vii) Prosthetics, orthotics, and prosthetic devices;~~

~~(viii) Home health services;~~

~~(ix) Outpatient prescription drugs;~~

~~(x) Inpatient and outpatient hospital services;~~

~~(xi) Radiation therapy services and supplies.~~

~~(b) For purposes of this subsection, "financial relationship" means the relationship between a physician and an entity that includes either:~~

~~(i) An ownership or investment interest; or~~

~~(ii) A compensation arrangement.~~

~~For purposes of this subsection, "compensation arrangement" means an arrangement involving remuneration between a physician, or an immediate family member of a physician, and an entity.~~

~~(c) The department is authorized to adopt by rule amendments to 42 U.S.C. 1395 nn enacted after July 23, 1995.~~

~~(d) This section shall not apply in any case covered by a general exception specified in 42 U.S.C. Sec. 1395 nn.~~

~~(4)~~)) Subsections (1) and (2) of this section shall not apply to:

(a) A discount or other reduction in price obtained by a provider of services or other entity under this chapter if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this chapter((~~,~~)); and

(b) Any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

((~~(5)~~)) (4) Subsections (1) and (2) of this section, if applicable to the conduct involved, shall supersede the criminal provisions of chapter 19.68 RCW, but shall not preclude administrative proceedings authorized by chapter 19.68 RCW.

NEW SECTION. **Sec. 11.** A new section is added to chapter 74.09 RCW to read as follows:

(1) For the purposes of this section, "disciplining authority," "health care practitioner," "health care entity," and "health care service" have the same meanings as provided in section 1 of this act.

(2) The secretary shall seek repayment from a health care practitioner of any moneys paid for any claim, bill, or other demand or request for payment for the health care services that were determined by the appropriate disciplining authority to be furnished as a result of a referral prohibited by section 2 of this act.

(3) The secretary shall report to the appropriate disciplining authority any pattern of claims, bills, or other demands or requests for payment submitted for a health care service provided as a result of a referral prohibited by section 2 of this act within thirty days after the secretary has knowledge of that pattern.

(4)(a) Notwithstanding the provisions of this section, the secretary is not required to audit or investigate any claim, bill, or other demand or request for payment for the purpose of determining whether those services were the result of a prohibited referral.

(b) Any audit or investigation of any claim, bill, or other demand or request for payment for the purpose of determining whether those services were the result of the prohibited referral are not grounds to delay payment or waive any requirements for the prompt payment of claims.

(5) For any claim, bill, or request for payment that is paid and is subsequently determined to be the result of a prohibited referral, the secretary shall seek a refund of that payment in accordance with the provisions of section 5 of this act.

Sec. 12. RCW 74.09.522 and 1997 c 59 s 15 and 1997 c 34 s 1 are each reenacted and amended to read as follows:

(1) For the purposes of this section, "managed health care system" means any health care organization, including health care providers,

insurers, health care service contractors, health maintenance organizations, health insuring organizations, or any combination thereof, that provides directly or by contract health care services covered under RCW 74.09.520 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) All managed health care systems should have an opportunity to contract with the department to the extent that minimum contracting requirements defined by the department are met, at payment rates that enable the department to operate as far below appropriated spending

levels as possible, consistent with the principles established in this section.

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

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

(ii) Quality of services provided to enrollees;

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

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

(v) Payment rates; and

(vi) The ability to meet other specifically defined contract requirements established by the department, 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 department 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 department 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 department and contract bidders or the department 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. In designing such procedures, the department shall give strong consideration to the negotiation and dispute resolution processes used by the Washington state health care authority in its managed health care contracting activities.

(6) The department 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) Each managed health care system that provides health care services under this chapter is subject to the provisions of section 7 of this act.

NEW SECTION. **Sec. 13.** Sections 1 through 6 of this act constitute a new chapter in Title 18 RCW.

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