CHAPTER 4

[Engrossed Substitute Senate Bill No. 5293]
ADULT FAMILY HOMES—BUSINESS AND OCCUPATION TAX EXEMPTION

AN ACT Relating to the business and occupation taxation of health or social welfare services; adding a new section to chapter 82.04 RCW; and declaring an emergency.

Be it enacted by the Legislature of the State of Washington:

NEW SECTION. Sec. 1. A new section is added to chapter 82.04 RCW to read as follows:

This chapter does not apply to adult family homes which are licensed as such, or which are specifically exempt from licensing, under rules of the department of social and health services.

NEW SECTION. Sec. 2. This act is necessary for the immediate preservation of the public peace, health, and safety, the support of the state government and its existing public institutions, and shall take effect immediately.

Passed the Senate May 15, 1987.
Passed the House May 17, 1987.
Approved by the Governor June 9, 1987.
Filed in Office of Secretary of State June 9, 1987.

CHAPTER 5

[Engrossed Second Substitute House Bill No. 477]
HEALTH CARE ACCESS

AN ACT Relating to health care; amending RCW 74.09.522; amending section 3, chapter 303, Laws of 1986 (uncodified); adding new sections to chapter 43.131 RCW; adding a new section to chapter 50.20 RCW; adding a new section to chapter 51.28 RCW; adding a new section to chapter 74.04 RCW; adding a new section to chapter 74.09 RCW; adding a new chapter to Title 70 RCW; creating new sections; and declaring an emergency.

Be it enacted by the Legislature of the State of Washington:

NEW SECTION. Sec. 1. This chapter shall be known and may be cited as the health care access act of 1987.

NEW SECTION. Sec. 2. The legislature reserves the right to amend or repeal all or any part of this chapter at any time and there shall be no vested private right of any kind against such amendment or repeal. All the rights, privileges, or immunities conferred by this chapter or any acts done pursuant thereto shall exist subject to the power of the legislature to amend or repeal this chapter at any time.

NEW SECTION. Sec. 3. (1) The legislature finds that:

(a) A significant percentage of the population of this state does not have reasonably available insurance or other coverage of the costs of necessary basic health care services;

(b) This lack of basic health care coverage is detrimental to the health of the individuals lacking coverage and to the public welfare, and results in substantial expenditures for emergency and remedial health care, often at the expense of health care providers, health care facilities, and all purchasers of health care, including the state; and

(c) The use of managed health care systems has significant potential to reduce the growth of health care costs incurred by the people of this state generally, and by low-income pregnant women who are an especially vulnerable population, along with their children, and who need greater access to managed health care.

(2) The purpose of this chapter is to provide necessary basic health care services in an appropriate setting to working persons and others who lack coverage, at a cost to these persons that does not create barriers to the utilization of necessary health care services. To that end, this chapter establishes a program to be made available to those residents under sixty-five years of age not otherwise eligible for medicare with gross family income at or below two hundred percent of the federal poverty guidelines who share in the cost of receiving basic health care services from a managed health care system.

(3) It is not the intent of this chapter to provide health care services for those persons who are presently covered through private employer-based health plans, nor to replace employer-based health plans. Further, it is the intent of the legislature to expand, wherever possible, the availability of private health care coverage and to discourage the decline of employer-based coverage.

(4) The program authorized under this chapter is strictly limited in respect to the total number of individuals who may be allowed to participate and the specific areas within the state where it may be established. All such restrictions or limitations shall remain in full force and effect until quantifiable evidence based upon the actual operation of the program, including detailed cost benefit analysis, has been presented to the legislature and the legislature, by specific act at that time, may then modify such limitations.

NEW SECTION. Sec. 4. As used in this chapter:

(1) "Washington basic health plan" or "plan" means the system of enrollment and payment on a prepaid capitated basis for basic health care services, administered by the plan administrator through participating managed health care systems, created by this chapter.

(2) "Administrator" means the Washington basic health plan administrator.

(3) "Managed health care system" means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof, that provides directly or by contract basic health care services, as defined by the administrator and rendered by duly licensed providers, on a prepaid capitated basis to a defined patient population enrolled in the plan and in the managed health care system.

(4) "Enrollee" means an individual, or an individual plus the individual's spouse and/or dependent children, all under the age of sixty-five and not otherwise eligible for medicare, who resides in an area of the state served by a managed health care system participating in the plan, whose gross family income at the time of enrollment does not exceed twice the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services, who chooses to obtain basic health care coverage from a particular managed health care system in return for periodic payments to the plan.

(5) "Subsidy" means the difference between the amount of periodic payment the administrator makes, from funds appropriated from the basic health plan trust account, to a managed health care system on behalf of an enrollee and the amount determined to be the enrollee's responsibility under section 8(2) of this act.

(6) "Premium" means a periodic payment, based upon gross family income and determined under section 8(2) of this act, which an enrollee makes to the plan as consideration for enrollment in the plan.

(7) "Rate" means the per capita amount, negotiated by the administrator with and paid to a participating managed health care system, that is based upon the enrollment of enrollees in the plan and in that system.

NEW SECTION. Sec. 5. The basic health plan trust account is hereby established in the state treasury. All funds appropriated for this chapter shall be deposited in the basic health plan trust account and may be expended without further appropriation. Disbursements from other moneys in the account shall be made pursuant to appropriation and upon warrants drawn by the Washington basic health plan administrator. Moneys in the account shall be used exclusively for the purposes of this chapter, including payments to participating managed health care systems on behalf of enrollees in the plan and payment of costs of administering the plan. The earnings on any surplus balances in the basic health plan trust account shall be credited to the account, notwithstanding RCW 43.84.090. After January 1, 1988, the administrator shall not expend or encumber for an ensuing fiscal period amounts exceeding ninety percent of the amounts anticipated to accrue in the account during the fiscal period.

NEW SECTION. Sec. 6. (1) The Washington basic health plan is created as an independent agency of the state. The administrative head and

appointing authority of the plan shall be the administrator who shall be appointed by the governor, with the consent of the senate, and shall serve at the pleasure of the governor. The salary for this office shall be set by the governor pursuant to RCW 43.03.040. The administrator shall appoint a medical director. The administrator, medical director, and up to five other employees shall be exempt from the civil service law, chapter 41.06 RCW.

(2) The administrator shall employ such other staff as are necessary to fulfill the responsibilities and duties of the administrator, such staff to be subject to the civil service law, chapter 41.06 RCW. In addition, the administrator may contract with third parties for services necessary to carry out its activities where this will promote economy, avoid duplication of effort, and make best use of available expertise. Any such contractor or consultant shall be prohibited from releasing, publishing, or otherwise using any information made available to it under its contractual responsibility without specific permission of the plan. The administrator may call upon other agencies of the state to provide available information as necessary to assist the administrator in meeting its responsibilities under this chapter, which information shall be supplied as promptly as circumstances permit.

(3) The administrator may appoint such technical or advisory committees as he or she deems necessary. The administrator shall appoint a standing technical advisory committee that is representative of health care professionals, health care providers, and those directly involved in the purchase, provision, or delivery of health care services, as well as consumers and those knowledgeable of the ethical issues involved with health care public policy. Individuals appointed to any technical or other advisory committee shall serve without compensation for their services as members, but may be reimbursed for their travel expenses pursuant to RCW 43.03.050 and 43.03.060.

(4) The administrator may 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 may make arrangements as to the use of these receipts, including the undertaking of special studies and other projects relating to health care costs and access to health care.

(5) In the design, organization, and administration of the plan under this chapter, the administrator shall consider the report of the Washington health care project commission established under chapter 303, Laws of 1986. Nothing in this chapter requires the administrator to follow any specific recommendation contained in that report except as it may also be included in this chapter or other law.

NEW SECTION. Sec. 7. The administrator 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 34.04 RCW.

NEW SECTION. Sec. 8. The administrator has the following powers and duties:

(1) To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, and other services that may be necessary for basic health care, which enrollees in any participating managed health care system under the Washington basic health plan shall be entitled to receive in return for premium payments to the plan. The schedule of services shall emphasize proven preventive and primary health care, shall include all services necessary for prenatal, postnatal, and well-child care, and shall include a separate schedule of basic health care services for children, eighteen years of age and younger, for those enrollees who choose to secure basic coverage through the plan only for their dependent children. In designing and revising the schedule of services, the administrator shall consider the guidelines for assessing health services under the mandated benefits act of 1984, RCW 48.42.080, and such other factors as the administrator deems appropriate.

(2) To design and implement a structure of periodic premiums due the administrator from enrollees that is based upon gross family income, giving appropriate consideration to family size as well as the ages of all family members. The enrollment of children shall not require the enrollment of their parent or parents who are eligible for the plan.

(3) To design and implement a structure of nominal copayments due a managed health care system from enrollees. The structure shall discourage inappropriate enrollee utilization of health care services, but shall not be so costly to enrollees as to constitute a barrier to appropriate utilization of necessary health care services.

(4) To design and implement, in concert with a sufficient number of potential providers in a discrete area, an enrollee financial participation structure, separate from that otherwise established under this chapter, that has the following characteristics:

(a) Nominal premiums that are based upon ability to pay, but not set at a level that would discourage enrollment;

(b) A modified fee-for-services payment schedule for providers;

(c) Coinsurance rates that are established based on specific service and procedure costs and the enrollee's ability to pay for the care. However, coinsurance rates for families with incomes below one hundred twenty percent of the federal poverty level shall be nominal. No coinsurance shall be required for specific proven prevention programs, such as prenatal care. The coinsurance rate levels shall not have a measurable negative effect upon the enrollee's health status; and

(d) A case management system that fosters a provider-enrollee relationship whereby, in an effort to control cost, maintain or improve the health status of the enrollee, and maximize patient involvement in her or his health care decision-making process, every effort is made by the provider to inform the enrollee of the cost of the specific services and procedures and related health benefits.

The potential financial liability of the plan to any such providers shall not exceed in the aggregate an amount greater than that which might otherwise have been incurred by the plan on the basis of the number of enrollees multiplied by the average of the prepaid capitated rates negotiated with participating managed health care systems under section 12 of this act and reduced by any sums charged enrollees on the basis of the coinsurance rates that are established under this subsection.

(5) To limit enrollment of persons who qualify for subsidies so as to prevent an overexpenditure of appropriations for such purposes. Whenever the administrator finds that there is danger of such an overexpenditure, the administrator shall close enrollment until the administrator finds the danger no longer exists.

(6) To adopt a schedule for the orderly development of the delivery of services and availability of the plan to residents of the state, subject to the limitations contained in section 10 of this act.

In the selection of any area of the state for the initial operation of the plan, the administrator shall take into account the levels and rates of unemployment in different areas of the state, the need to provide basic health care coverage to a population reasonably representative of the portion of the state's population that lacks such coverage, and the need for geographic, demographic, and economic diversity.

Before July 1, 1988, the administrator shall endeavor to secure participation contracts with managed health care systems in discrete geographic areas within at least five congressional districts.

(7) To solicit and accept applications from managed health care systems, as defined in this chapter, for inclusion as eligible basic health care providers under the plan. The administrator shall endeavor to assure that covered basic health care services are available to any enrollee of the plan from among a selection of two or more participating managed health care systems. In adopting any rules or procedures applicable to managed health care systems and in its dealings with such systems, the administrator shall consider and make suitable allowance for the need for health care services and the differences in local availability of health care resources, along with other resources, within and among the several areas of the state.

(8) To receive periodic premiums from enrollees, deposit them in the basic health plan operating account, keep records of enrollee status, and authorize periodic payments to managed health care systems on the basis of the number of enrollees participating in the respective managed health care systems.

(9) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and at least annually thereafter, or at the request

of any enrollee, eligibility due to current gross family income for sliding scale premiums. An enrollee who remains current in payment of the sliding-scale premium, as determined under subsection (2) of this section, and whose gross family income has risen above twice the federal poverty level, may continue enrollment unless and until the enrollee's gross family income has remained above twice the poverty level for six consecutive months, by making payment at the unsubsidized rate required for the managed health care system in which he or she may be enrolled. No subsidy may be paid with respect to any enrollee whose current gross family income exceeds twice the federal poverty level or, subject to section 11 of this act, who is a recipient of medical assistance or medical care services under chapter 74.09 RCW. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to re-enroll in the plan.

(10) To require that prospective enrollees who may be eligible for categorically needy medical coverage under RCW 74.09.510 or whose income does not exceed the medically needy income level under RCW 74.09.700 apply for such coverage, but the administrator shall enroll the individuals in the plan pending the determination of eligibility under chapter 74.09 RCW.

(11) To determine the rate to be paid to each participating managed health care system in return for the provision of covered basic health care services to enrollees in the system. Although the schedule of covered basic health care services will be the same for similar enrollees, the rates negotiated with participating managed health care systems may vary among the systems. In negotiating rates with participating systems, the administrator shall consider the characteristics of the populations served by the respective systems, economic circumstances of the local area, the need to conserve the resources of the basic health plan trust account, and other factors the administrator finds relevant.

(12) To monitor the provision of covered services to enrollees by participating managed health care systems in order to assure enrollee access to good quality basic health care, to require periodic data reports concerning the utilization of health care services rendered to enrollees in order to provide adequate information for evaluation, and to inspect the books and records of participating managed health care systems to assure compliance with the purposes of this chapter. In requiring reports from participating managed health care systems, including data on services rendered enrollees, the administrator shall endeavor to minimize costs, both to the managed health care systems and to the administrator. The administrator shall coordinate any such reporting requirements with other state agencies, such as the insurance commissioner and the hospital commission, to minimize duplication of effort.

(13) To monitor the access that state residents have to adequate and necessary health care services, determine the extent of any unmet needs for such services or lack of access that may exist from time to time, and make such reports and recommendations to the legislature as the administrator deems appropriate.

(14) To evaluate the effects this chapter has on private employer-based health care coverage and to take appropriate measures consistent with state and federal statutes that will discourage the reduction of such coverage in the state.

(15) To develop a program of proven preventive health measures and to integrate it into the plan wherever possible and consistent with this chapter.

(16) To provide, consistent with available resources, technical assistance for rural health activities that endeavor to develop needed health care services in rural parts of the state.

NEW SECTION. Sec. 9. The benefits available under the plan shall be subject to RCW 48.21.200 and shall be excess to the benefits payable under the terms of any insurance policy issued to or on the behalf of an enrollee that provides payments toward medical expenses without a determination of liability for the injury.

NEW SECTION. Sec. 10. On and after July 1, 1988, the administrator shall accept for enrollment applicants eligible to receive covered basic health care services from the respective managed health care systems which are then participating in the plan. The administrator shall not allow the total enrollment of those eligible for subsidies to exceed thirty thousand.

Thereafter, total enrollment shall not exceed the number established by the legislature in any act appropriating funds to the plan.

Before July 1, 1988, the administrator shall endeavor to secure participation contracts from managed health care systems in discrete geographic areas within at least five congressional districts of the state and in such manner as to allow residents of both urban and rural areas access to enrollment in the plan. The administrator shall make a special effort to secure agreements with health care providers in one such area that meets the requirements set forth in section 8(4) of this act.

The administrator shall at all times closely monitor growth patterns of enrollment so as not to exceed that consistent with the orderly development of the plan as a whole, in any area of the state or in any participating managed health care system.

NEW SECTION. Sec. 11. Any enrollee whose premium payments to the plan are delinquent or who moves his or her residence out of an area served by the plan may be dropped from enrollment status. An enrollee whose premium is the responsibility of the department of social and health services under section 13 of this act may not be dropped solely because of

nonpayment by the department. The administrator shall provide delinquent enrollees with advance written notice of their removal from the plan and shall provide for a hearing under chapters 34.04 and 34.12 RCW for any enrollee who contests the decision to drop the enrollee from the plan. Upon removal of an enrollee from the plan, the administrator shall promptly notify the managed health care system in which the enrollee has been enrolled, and shall not be responsible for payment for health care services provided to the enrollee (including, if applicable, members of the enrollee's family) after the date of notification. A managed health care system may contest the denial of payment for coverage of an enrollee through a hearing under chapters 34.04 and 34.12 RCW.

NEW SECTION. Sec. 12. Managed health care systems participating in the plan shall do so by contract with the administrator and shall provide, directly or by contract with other health care providers, covered basic health care services to each enrollee as long as payments from the administrator 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 administrator 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 administrator to impose any sanctions under Title 18 RCW or any other professional or facility licensing statute.

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 administrator 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 administrator 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.

Any contract between a hospital and a participating managed health care system under this chapter is subject to the requirements of RCW 70.39.140(1) regarding negotiated rates.

Prior to negotiating with any managed health care system, the administrator 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. In negotiating with managed health care systems for participation in the plan, the administrator shall adopt a uniform procedure that includes at least the following:

(1) The administrator 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;

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

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

(4) The administrator 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.

NEW SECTION. Sec. 13. The department of social and health services shall make periodic payments to the administrator as an agent for the participating managed health care systems on behalf of any enrollee who is a recipient of medical assistance, medical care-limited casualty program, or medical care services under chapter 74.09 RCW, at the maximum rate allowable for federal matching purposes under Title XIX of the social security act, but not to exceed the rate negotiated by the administrator with the participating managed health care system for the services covered by the plan, and no premium or copayment may be charged to such an enrollee. Any enrollee on whose behalf the department of social and health services makes payments to the administrator under this section and chapter 74.09 RCW may continue as an enrollee, making premium payments based on the enrollee's own income as determined under the sliding scale, after eligibility for coverage under chapter 74.09 RCW has ended, as long as the enrollee remains eligible under this chapter. Nothing in this section affects the right of any person eligible for coverage under chapter 74.09 RCW to receive the services offered to other persons under that chapter but not included in the schedule of basic health care services covered by the plan. The administrator and the department of social and health services shall cooperatively adopt procedures to facilitate the transition of plan enrollees and payments on their behalf between the plan and the programs established under chapter 74.09 RCW.

NEW SECTION. Sec. 14. In addition to the powers and duties specified in sections 6 and 8 of this act, the administrator has the power to enter into contracts for the following functions and services:

(1) With public or private agencies, to assist the administrator in her or his duties to design or revise the schedule of covered basic health care services, and/or to monitor or evaluate the performance of participating managed health care systems.

(2) With public or private agencies, to provide technical or professional assistance to health care providers, particularly public or private nonprofit organizations and providers serving rural areas, who show serious intent and apparent capability to participate in the plan as managed health care systems.

(3) With public or private agencies, including health care service contractors registered under RCW 48.44.015, and doing business in the state, for marketing and administrative services in connection with participation of managed health care systems, enrollment of enrollees, billing and collection services to the administrator, and other administrative functions ordinarily performed by health care service contractors, other than insurance. Any activities of a health care service contractor pursuant to a contract with the administrator under this section shall be exempt from the provisions and requirements of Title 48 RCW.

NEW SECTION. Sec. 15. The activities and operations of the Washington basic health plan under this chapter, including those of managed health care systems to the extent of their participation in the plan, are exempt from the provisions and requirements of Title 48 RCW, except as provided in section 9 of this act.

NEW SECTION. Sec. 16. A new section is added to chapter 50.20 RCW to read as follows:

The commissioner shall notify any person filing a claim under this chapter who resides in a local area served by the Washington basic health plan of the availability of basic health care coverage to qualified enrollees in the Washington basic health plan under chapter 70.— RCW (sections 1 through 15 of this act), unless the Washington basic health plan administrator has notified the commissioner of a closure of enrollment in the area. The commissioner shall maintain a supply of Washington basic health plan enrollment application forms, which shall be provided in reasonably necessary quantities by the administrator, in each appropriate employment service office for the use of persons wishing to apply for enrollment in the Washington basic health plan.

NEW SECTION. Sec. 17. A new section is added to chapter 51.28 RCW to read as follows:

The director shall notify persons receiving time-loss payments under this chapter of the availability of basic health care coverage to qualified enrollees under chapter 70.— RCW (sections 1 through 15 of this act), unless the Washington basic health plan administrator has notified the director of closure of enrollment in the plan. The director shall maintain supplies of Washington basic health plan enrollment application forms in all field service offices where the plan is available, which shall be provided in reasonably necessary quantities by the administrator for the use of persons wishing to apply for enrollment in the Washington basic health plan.

NEW SECTION. Sec. 18. A new section is added to chapter 74.04 RCW to read as follows:

The department shall notify any applicant for public assistance who resides in a local area served by the Washington basic health plan and is under sixty-five years of age of the availability of basic health care coverage to qualified enrollees in the Washington basic health plan under chapter 70.— RCW (sections 1 through 15 of this act), unless the Washington basic health plan administrator has notified the department of a closure of enrollment in the area. The department shall maintain a supply of Washington basic health plan enrollment application forms, which shall be provided in reasonably necessary quantities by the administrator, in each appropriate community service office for the use of persons wishing to apply for enrollment in the Washington basic health plan.

NEW SECTION. Sec. 19. The Washington basic health plan administrator shall be appointed and commence operations as promptly as practicable after the effective date of this section. Not later than January 1, 1988, the administrator shall submit to the legislature a progress report including:

(1) The schedule of covered basic health care services adopted under section 8 of this act;

(2) A descriptive listing of managed health care systems expected to participate in the Washington basic health plan, along with an identification of prospective local areas for initial participation in the plan;

(3) The approximate amount of funds estimated to be on deposit in the basic health plan trust account as of March 31 and June 30, 1988;

(4) A description of the sliding fee schedule for enrollee premium payments and copayments adopted by the administrator under section 8 of this act;

(5) An evaluation of the financial viability of rural hospitals and the availability of necessary health care services in such areas, based upon any contacts or negotiations either the administrator or staff may have had with providers in rural areas of the state, together with any specific recommendations they may wish to make;

(6) Any proposals for statutory changes which the administrator deems necessary to implement the purposes of this chapter; and

(7) Any other information which the administrator deems appropriate.

Not later than January 1, 1989, the administrator shall submit to the legislature a further progress report, updating its 1988 report, and covering the same items provided for therein, with projections based upon implementation of the plan to date. Further, the report shall include a description of the performance of the first managed health care systems included as eligible providers as provided in section 10 of this act. The administrator shall submit an annual report to the legislature by January 1 of each year thereafter.

NEW SECTION. Sec. 20. A new section is added to chapter 74.09 RCW to read as follows:

(1) The department of social and health services shall, to the extent that funds are specifically appropriated for this purpose, provide matching grants on a one-to-one state/local basis to hospitals that are designated by the hospital commission as meeting all of the following criteria:

(a) Providing an amount of charity care equal to or greater than two hundred fifty percent of the state average;

(b) A tertiary care center; and

(c) Providing ten percent of the tertiary care to patients from outside the county in which the hospital is located.

(2) Grants shall be allocated to eligible hospitals based on the hospital's relative amount of charity care.

(3) Local matching funds shall be from a nonrate-setting revenue source as defined by the hospital commission.

(4) The department shall seek matching federal Title XIX medicaid funds pursuant to the "disproportionate share" provisions of the federal social security act. If necessary to obtain federal funds, the department may use the following provision in lieu of those set forth in subsections (1), (2), and (3) of this section: A hospital is eligible for a grant if it is designated by the hospital commission as having medical assistance charges exceeding twenty percent of the hospital's total rate-setting revenue during the preceding calendar year.

Sec. 21. Section 2, chapter 303, Laws of 1986 and RCW 74.09.522 are each 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 case management basis and that meets the requirements of section 1903(m)(1)(A) of Title XIX of the federal social security act.

(2) No later than July 1, ((~~1991~~)) 1989, the department of social and health services shall enter into agreements with managed health care systems to provide health care services to recipients of aid to families with dependent children under the following conditions:

(a) Agreements shall be made within one class A county in the eastern part of the state for at least ten thousand recipients; and one class AA county for at least fifteen thousand recipients in the western part of the state; and one first class county of at least five thousand recipients in the western part of the state;

(b) At least one of the agreements shall include enrollment of all recipients of aid to families with dependent children residing in a defined geographical area;

(c) ((~~The department shall, to the extent possible, ensure that recipients have a choice of systems in which to enroll and, if necessary and medically appropriate treatment for a recipient is not available from or through a participating managed health care system, the department shall exempt the recipient from any requirement to receive some or all of their medical services from such a system~~)) To the extent that this provision is consistent with section 1903(m) of Title XIX 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 six months: AND PROVIDED FURTHER, That the department shall not restrict a recipient's right to terminate enrollment in a system for cause;

(d) To the extent ((~~possible, the department shall ensure that participating managed health care systems do not enroll a disproportionate number of medical assistance recipients within the total numbers of persons served by the managed health care systems~~)) 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 that this subsection (d) shall not apply to entities described in subparagraph (B) of section 1903(m) of Title XIX of the federal social security act;

(e) Prior to negotiating with any managed health care system, the department shall estimate, on an actuarially sound basis, the expected cost of providing the 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 project areas. In negotiating with managed health care systems the department shall adopt a uniform procedure that includes at least request for proposals, including standards regarding the quality of services to be provided; and financial integrity of the responding system. The department may negotiate with respondents to the extent necessary to refine any proposals;

(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-system 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 in additional counties or for other groups of people eligible to receive services under chapter 74.09 RCW.

(3) The department shall seek to obtain a large number of contracts with providers of health services to medicaid recipients. The department shall ensure that publicly supported community health centers and providers in rural areas, who show serious intent and apparent capability to participate in the project as managed health care systems are seriously considered as providers in the project. The department shall coordinate these projects with the plans developed under chapter 70.— RCW (sections 1 through 15 of this 1987 act).

(((~~(3)~~))) (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.

Sec. 22. Section 3, chapter 303, Laws of 1986 (uncodified) is amended to read as follows:

The department shall report to the legislature not later than January 1, ((~~1987~~)) 1988, on progress toward implementation of the requirements of ((~~this~~)) chapter 303, Laws of 1986, but shall not delay implementation on account of this reporting requirement.

The report shall also include an analysis of the possible expansion of the use of managed health care within other medical assistance programs, including making it available to certain recipients of general assistance and supplemental security income.

NEW SECTION. Sec. 23. Sections 1 through 15 of this act shall constitute a new chapter in Title 70 RCW.

NEW SECTION. Sec. 24. A new section is added to chapter 43.131 RCW to read as follows:

The Washington basic health plan administrator and its powers and duties shall be terminated on June 30, 1992, as provided in section 25 of this act.

NEW SECTION. Sec. 25. A new section is added to chapter 43.131 RCW to read as follows:

The following acts or parts of acts, as now existing or hereafter amended, are each repealed, effective June 30, 1993:

(1) Section 1 of this act and RCW 70.__.___;

(2) Section 2 of this act and RCW 70.__.___;

(3) Section 3 of this act and RCW 70.__.___;

(4) Section 4 of this act and RCW 70.__.___;
(5) Section 5 of this act and RCW 70.__.___;
(6) Section 6 of this act and RCW 70.__.___;
(7) Section 7 of this act and RCW 70.__.___;
(8) Section 8 of this act and RCW 70.__.___;
(9) Section 9 of this act and RCW 70.__.___;
(10) Section 10 of this act and RCW 70.__.___;
(11) Section 11 of this act and RCW 70.__.___;
(12) Section 12 of this act and RCW 70.__.___;
(13) Section 13 of this act and RCW 70.__.___;
(14) Section 14 of this act and RCW 70.__.___;
(15) Section 15 of this act and RCW 70.__.___;
(16) Section 16 of this act and RCW 50.20.___;
(17) Section 17 of this act and RCW 51.28.___; and
(18) Section 18 of this act and RCW 74.04.___.

NEW SECTION. Sec. 26. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. Sec. 27. This act is necessary for the immediate preservation of the public peace, health, and safety, the support of the state government and its existing public institutions, and shall take effect immediately.

Passed the House May 17, 1987.
Passed the Senate May 17, 1987.
Approved by the Governor June 10, 1987.
Filed in Office of Secretary of State June 10, 1987.

CHAPTER 6

[Reengrossed Substitute House Bill No. 327]
CAPITAL BUDGET

AN ACT Adopting the capital budget; making appropriations and authorizing expenditures for capital improvements; authorizing certain projects; providing an effective date; and declaring an emergency.

Be it enacted by the Legislature of the State of Washington:

NEW SECTION. Sec. 1. A capital budget is hereby adopted and, subject to the provisions set forth in this act, the several dollar amounts hereinafter specified, or so much thereof as shall be sufficient to accomplish the purposes designated, are hereby appropriated and authorized to be incurred for capital projects during the period ending June 30, 1989, out of the several funds specified in this act.