HOUSE BILL REPORT
SHB 1392

As Amended by the Senate

Title: An act relating to creating the medicaid access program.

Brief Description: Creating the medicaid access program.

Sponsors: House Committee on Appropriations (originally sponsored by Representatives Macri, Leavitt, Simmons, Davis, Berry, Ryu, Callan, Rule, Stearns, Peterson, Taylor, Reed, Ramel, Alvarado, Doglio, Tharinger, Fey, Salahuddin, Bernbaum, Fosse, Pollet, Street, Scott and Santos).

Brief History:

Committee Activity:

Appropriations: 2/13/25, 2/27/25 [DPS].

Floor Activity:

Passed House: 3/20/25, 56-39.
Senate Amended.
Passed Senate: 4/14/25, 31-18.

Brief Summary of Substitute Bill

- Establishes the Medicaid Access Program Account.
- Creates a covered-lives assessment on Medicaid managed care organizations and health carriers.
- Increases Medicaid professional services rates up to the equivalent Medicare rates.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 19 members: Representatives Ormsby, Chair; Gregerson, Vice Chair; Macri, Vice Chair; Berg, Bergquist, Callan, Cortes, Doglio, Fitzgibbon, Leavitt, Lekanoff,

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This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

Peterson, Pollet, Ryu, Springer, Stonier, Street, Thai and Tharinger.

Minority Report: Do not pass. Signed by 12 members: Representatives Couture, Ranking Minority Member; Connors, Assistant Ranking Minority Member; Penner, Assistant Ranking Minority Member; Schmick, Assistant Ranking Minority Member; Burnett, Caldier, Corry, Dye, Keaton, Manjarrez, Marshall and Rude.

Staff: Meghan Morris (786-7119).

Background:

Medicaid.
Medicaid is a federal-state partnership with programs established in the federal Social Security Act and implemented at the state level with federal matching funds. The Health Care Authority (HCA) administers the Medicaid program for health care for low-income state residents who meet certain eligibility criteria. Washington's Medicaid program, known as Apple Health, offers a complete medical benefits package, including prescription drug coverage, to eligible families, children under age 19, low-income adults, certain disabled individuals, and pregnant women. While some clients receive services through the HCA on a fee-for-service basis, the majority receive coverage for medical services through managed care systems. Managed care is a prepaid, comprehensive system for delivering a complete medical benefits package that is available for eligible families, children under age 19, low-income adults, certain disabled individuals, and pregnant women. The HCA contracts with managed care organizations (MCOs) under a comprehensive risk contract to provide prepaid health care services to persons enrolled in a managed care Apple Health plan.

Provider Assessments.
Health care provider-related charges, such as assessments, fees, or taxes, have been used in some states to help fund the costs of the Medicaid program. States collect funds from health care providers and pay them back as Medicaid payments. States use these provider-related payments to claim federal matching funds.

Managed Care Directed Payment Programs.
The Centers of Medicare and Medicaid Services (CMS) governs how states may direct plan expenditures when implementing delivery system and provider payment initiatives under Medicaid MCO contracts. These types of payment arrangements permit states to direct specific payments made by MCOs to providers under certain circumstances and can assist states in furthering the goals and priorities of their Medicaid programs. States must obtain written approval of state-directed payments before approval of the corresponding MCO contracts. States can use permissible funding sources to fund the nonfederal share of state-directed payments, including intergovernmental transfers and provider taxes that comply with federal statute and regulations.

Summary of Substitute Bill:

Medicaid Access Program.
By September 1, 2025, the HCA must submit any state plan amendments or waiver requests to the CMS that are necessary to implement the Medicaid Access Program (Program). The purpose of the Program is to increase, beginning January 1 of the second plan year after the CMS's approval of the Program, professional services rates covered by Medicaid including fee-for-service and managed care up to the corresponding Medicare rates as of December 31, 2024, for the same service and site of service. Rates for subsequent years must be annually adjusted for inflation. The professional service categories for the rate increases include anesthesia, diagnostics, intense outpatient, opioid treatment programs, emergency room, inpatient and outpatient surgery, inpatient visits, low-level behavioral health, maternity services, office and home visits, consults, office administered drugs, and other physician services.

Covered Lives Assessments.
All health carriers and Medicaid MCOs shall pay an annual covered lives assessment beginning January 1 of the plan year following the CMS's approval of the Program. The HCA must determine the number of covered persons per calendar year (CY). For assessments collected in the first plan year:

- The HCA must assess a per member per month assessment of no more than $18 per covered life for Medicaid MCOs.
- The Office of the Insurance Commissioner must assess a per member per month assessment of no more than 50 cents per covered life for health carriers.

Assessments collected in the second year and annually thereafter must be set by the HCA at the rate necessary to fund professional services rate increases. The assessments are limited to the first 3 million member months on a per-health carrier basis.

Medicaid Access Program Account.
The Medicaid Access Program Account (Account) is established and requires appropriation. The covered lives assessments, penalties, and interest accrued must be deposited into the Account.

Disbursements from the Account may be made only:

- to make payments to health care providers and MCOs consistent with federal contracting requirements and direct payments from MCOs to health care providers;
- to Medicaid MCOs for funding the nonfederal share of increased capitation payments based on their projected assessment obligation;
- for HCA's Medicaid Access Program administrative expenses;
- for administrative and service-related costs to expand Medicaid access in schools through the school-based health services program, school-based health clinics, and on-site behavioral health services;
- for the HCA to study the impact of the professional service rate increases on Medicaid access;

- for $35,991,000 to be used in lieu of State General Fund from the Account in fiscal year (FY) 2027;
- to refund erroneous or excessive payments made by health carriers and Medicaid MCOs; and
- to repay the federal government for any excess payments made to health care providers if the assessments or payment increases are deemed out of compliance with federal statutes and regulations.

The HCA may require health care providers receiving excess payments to refund the payments in question to the Account. The state in turn shall return funds to the federal government in the same proportion as the original financing. If a health care provider is unable to refund payments, the state shall develop either a payment plan, or deduct moneys from future Medicaid payments, or both.

The assessment, collection, and disbursement of funds are conditioned upon:
- final approval from the CMS;
- contract amendments between the HCA and MCOs, to the extent necessary; and
- the Office of Financial Management certification that appropriations are available to fully support the professional services rate increases for the upcoming CY.

EFFECT OF SENATE AMENDMENT(S):

The Senate amendment:
- reduces the amount the Health Care Authority shall assess managed care organizations in the first plan year following approval from $18 to $16;
- reduces the number of member months to which the assessment may be applied from 3 million to 2.3 million for both managed care organizations and health carriers;
- reduces the amount of funding that may be used in lieu of state general fund from $35,991,000 to not exceed $35,000,000; and
- clarifies how professional rate services increases are calculated under the Medicaid Access Program.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on April 15, 2025.

Effective Date: Sections 1 through 12, 14 through 16, and 18 through 20 of the bill contain an emergency clause and take effect immediately. The remainder of the bill contains multiple effective dates. Please see the bill. However, the bill is null and void unless funded in the budget.

Staff Summary of Public Testimony:

(In support) Medicaid reimbursement rates are important investments largely funded by the

federal government. The covered lives assessment is complex and is patterned on a model that's been put in place in California and New York. This proposal is subject to approval from the CMS and while that approval is uncertain, this is the best opportunity to increase investments in the Medicaid program.

This is a crucial step to long-term financial stability for Medicaid safety net providers. The Program addresses a significant health equity issue where providers are paid less for providing the exact same care and service to low-income members. Medicaid covers less than half of the cost of care for some services. Reimbursement rates must cover the cost of providing care to avoid clinic closures, losing providers, and service reductions. Direct investments in Medicaid will increase provider access, expand services, and keep people healthy, especially in rural areas. These investments also allow people to seek medical care before receiving care at higher cost facilities and increasing costs for the state's Medicaid program.

Insufficient access to health care is not acceptable for our children, but current Medicaid rates result in fewer pediatricians. The number of medical students going into pediatrics has been declining for 20 years and fair reimbursement is a major concern. Medicaid covers about half of the children and births. Increasing access to health care services, especially for children, has been associated with more than just long-term benefits to health. Health care access also improves educational outcomes, which directly impacts employment, wages, and the economy.

(Opposed) Medicaid providers should be reimbursed appropriately by the Medicaid program, but funding that obligation with a tax will directly increase the cost of health insurance, which already costs too much. Both individual and small group insurance markets have seen double-digit rate increases over the last several years. When individuals and employers cannot afford these increases, they must select health insurance with fewer benefits or forego coverage altogether. This tax will make the monthly premiums more expensive. Increasing insurance costs on small businesses and their employees puts group coverage even further out of reach for small employers and the working families. The Legislature should increase affordability and access to quality health care, not increase costs for businesses and families.

(Other) The state needs to strike the right balance on fairness with health care affordability. Medicaid providers need to be paid fairly, but health care affordability for the private insurance market is also an issue. There are 1.1 million people with state regulated health plans, which includes individuals and small businesses. This bill does not affect the 2.5 million people who get insurance from a large employer or in the self-insured market. Patients in the individual and small group markets already face premium increases which will be worse with this bill. Federal premium tax credits expire next year, so without careful consideration this proposal could have a regressive effect.

This bill does not include safeguards to ensure patient access improves. The state should

rely on data to ensure funding is directed where it's needed most. The HCA's data should guide the understanding of where access challenges are most acute. The bill proposes a pathway to across-the-board reimbursement increases, but does not target investments towards access challenges. The bill does not include metrics to measure whether the investment is working.

Persons Testifying: (In support) Representative Nicole Macri, prime sponsor; Reilly Dever; Sean Graham, Washington State Medical Association; Nicole Kern, Planned Parenthood Alliance Advocates; Amy Brackenbury, Washington State Public Health Association; Douglas Seiler, MD, TRA Medical Imaging; Beth Ebel, MD, Washington Chapter of the American Academy of Pediatrics; and Jay Fathi, Molina Healthcare.

(Opposed) Mike Ennis, Building Industry Association of Washington; Christine Brewer, Premera Blue Cross; and Chris Bandoli, National Association of Benefits and Insurance Professionals Washington.

(Other) Sam Hatzenbeler, Economic Opportunity Institute; Jim Freeburg, Patient Coalition of Washington; and Emily Brice, Northwest Health Law Advocates.

Persons Signed In To Testify But Not Testifying: None.