SENATE BILL REPORT
SHB 1392

As of March 28, 2025

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: Passed House: 3/20/25, 56-39.
Committee Activity: Ways & Means: 4/03/25.

Brief Summary of 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.

SENATE COMMITTEE ON WAYS & MEANS

Staff: Sandy Stith (786-7710)

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,

---

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.

certain disabled individuals, and pregnant women. While some clients receive services through 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. 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 Bill: Medicaid Access Program. By September 1, 2025, HCA must submit any state plan amendments or waiver requests to CMS that are necessary to implement the Medicaid Access Program (Program). The purpose of the Program is to increase, beginning January 1st of the second plan year after 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 1st of the plan year following CMS's approval of the Program. HCA must determine the number of covered persons per calendar year (CY). For assessments collected in the first plan year:

- HCA must assess a per member per month assessment of no more than $18 per covered life for Medicaid MCOs; and
- the Office of the Insurance Commissioner must assess a per member per month

assessment of no more than $0.50 per covered life for health carriers.

Assessments collected in the second year and annually thereafter must be set by 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 HCA to study the impact of the professional service rate increases on Medicaid access;
- for $35.991 million to be used in lieu of state feneral fund from the Account in fiscal year 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.

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 CMS;
- contract amendments between 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.

Appropriation: The bill contains a null and void clause requiring specific funding be provided in an omnibus appropriation act.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

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.