RCW 74.60.130 Managed care capitation payments. *(Contingent expiration date.)* (1) For state fiscal year 2016 and for each subsequent fiscal year, commencing within thirty days after satisfaction of the conditions in RCW 74.60.150(1) and subsection (5) of this section, the authority shall increase capitation payments in a manner consistent with federal contracting requirements to managed care organizations by an amount at least equal to the amount available from the fund after deducting disbursements authorized by RCW 74.60.020(4) (c) through (f) and payments required by RCW 74.60.080 through 74.60.120. When combined with applicable federal matching funds, the capitation payment under this subsection must be at least three hundred sixty million dollars per year. The initial payment following satisfaction of the conditions in RCW 74.60.150(1) must include all amounts due from July 1, 2015, to the end of the calendar month during which the conditions in RCW 74.60.150(1) are satisfied. Subsequent payments shall be made monthly.

(2) Payments to individual managed care organizations shall be determined by the authority based on each organization's or network's enrollment relative to the anticipated total enrollment in each program for the fiscal year in question, the anticipated utilization of hospital services by an organization's or network's medicaid enrollees, and such other factors as are reasonable and appropriate to ensure that purposes of this chapter are met.

(3) If the federal government determines that total payments to managed care organizations under this section exceed what is permitted under applicable medicaid laws and regulations, payments must be reduced to levels that meet such requirements, and the balance remaining must be applied as provided in RCW 74.60.050. Further, in the event a managed care organization is legally obligated to repay amounts distributed to hospitals under this section to the state or federal government, a managed care organization may recoup the amount it is obligated to repay under the medicaid program from individual hospitals by not more than the amount of overpayment each hospital received from that managed care organization.

(4) Payments under this section do not reduce the amounts that otherwise would be paid to managed care organizations: PROVIDED, That such payments are consistent with actuarial soundness certification and enrollment.

(5) Before making such payments, the authority shall require medicaid managed care organizations to comply with the following requirements:

(a) All payments to managed care organizations under this chapter must be expended for hospital services provided by Washington hospitals, which for purposes of this section includes psychiatric and rehabilitation hospitals, in a manner consistent with the purposes and provisions of this chapter, and must be equal to all increased capitation payments under this section received by the organization or network, consistent with actuarial certification and enrollment, less an allowance for any estimated premium taxes the organization is required to pay under Title 48 RCW associated with the payments under this chapter;

(b) Managed care organizations shall expend the increased capitation payments under this section in a manner consistent with the purposes of this chapter, with the initial expenditures to hospitals to be made within thirty days of receipt of payment from the authority. Subsequent expenditures by the managed care plans are to be

made before the end of the quarter in which funds are received from the authority;

(c) Providing that any delegation or attempted delegation of an organization's or network's obligations under agreements with the authority do not relieve the organization or network of its obligations under this section and related contract provisions.

(6) No hospital or managed care organizations may use the payments under this section to gain advantage in negotiations.

(7) No hospital has a claim or cause of action against a managed care organization for monetary compensation based on the amount of payments under subsection (5) of this section.

(8) If funds cannot be used to pay for services in accordance with this chapter the managed care organization or network must return the funds to the authority which shall return them to the hospital safety net assessment fund. [2017 c 228 § 9; 2015 2nd sp.s. c 5 § 8; 2014 c 143 § 3; 2013 2nd sp.s. c 17 § 12; 2010 1st sp.s. c 30 § 14.]

Effective date—2017 c 228: See note following RCW 74.60.005.

Effective date—2015 2nd sp.s. c 5: See note following RCW 74.60.005.

Effective date—2014 c 143: See note following RCW 74.60.030.

Effective date—2013 2nd sp.s. c 17: See note following RCW 74.60.005.

RCW 74.60.130 Payments to medicaid managed care organizations. ***(Contingent effective date.)*** (1) Beginning on the later of January 1, 2024, or 30 calendar days after satisfaction of the conditions in RCW 74.60.150(1) and subsection (3) of this section, and for each subsequent calendar year so long as none of the conditions stated in RCW 74.60.150(2) have occurred, the authority shall make quarterly payments to medicaid managed care organizations as specified herein in a manner consistent with federal contracting requirements. The authority may delay payments under this section as needed if the collection of hospital assessments under RCW 74.60.050 is delayed. The authority shall direct payments from managed care organizations to hospitals and the payments shall support access to hospitals and quality improvement of hospital services.

(a) For the first six months of calendar year 2024, $158,700,000, and for the second six months, $182,500,000 from the fund, plus federal matching funds to medicaid managed care organizations for directed inpatient payments to medicaid prospective payment system hospitals. For calendar year 2025, $365,000,000 from the fund, plus federal matching funds to medicaid managed care organizations for directed inpatient payments to medicaid prospective payment system hospitals;

(b) For the first six months of calendar year 2024, $99,000,000, and for the second six months $114,000,000 from the fund, plus federal matching funds to medicaid managed care organizations for directed outpatient payments to medicaid prospective payment system hospitals. For calendar year 2025, $228,000,000 from the fund, plus federal matching funds to medicaid managed care organizations for directed outpatient payments to medicaid prospective payment system hospitals;

(c) For calendar years 2024 and 2025, $400,000 plus federal matching funds to medicaid managed care organizations for directed inpatient payments to critical access hospitals;

(d) For the first six months of calendar year 2024, $8,100,000, and for the second six months $9,300,000 from the fund, plus federal matching funds to medicaid managed care organizations for directed outpatient payments to critical access hospitals. For calendar year 2025, $18,600,000 from the fund, plus federal matching funds to medicaid managed care organizations for directed outpatient payments to critical access hospitals;

(e) For subsequent calendar years, including 2025, the authority shall adjust the payments under (a) through (d) of this subsection based on the inflation factor;

(f) The initial payment following satisfaction of the conditions in RCW 74.60.150(1) must include all amounts due from January 1, 2024, to the end of the calendar month during which the conditions in RCW 74.60.150(1) are satisfied. Subsequent payments shall be made quarterly.

(2) The amounts paid to individual managed care organizations under this section shall be determined by the authority based on each organization's payments made for medicaid inpatient and outpatient services as determined under subsection (4)(a) and (b) of this section. These payments do not reduce the amounts that otherwise would be paid to managed care organizations, provided that such payments are consistent with actuarial certification and enrollment. For purposes of this section, medicaid includes both Titles XIX and XXI of the social security act.

(3) Before making such payments, the authority shall modify its contracts with managed care organizations or otherwise require:

(a) Payment of the entire amount payable to hospitals as directed by the authority under subsection (4) of this section, less an allowance for premium taxes the organization is required to pay under Title 48 RCW;

(b) That payments to hospitals be made within 21 calendar days of receipt of payment in full from the authority;

(c) That any delegation or attempted delegation of an organization's obligations under agreements with the authority does not relieve the organization of its obligations under this section and related contract provisions; and

(d) That if funds cannot be paid to hospitals, the managed care organization shall return the funds to the authority, which shall return them to the hospital safety net assessment fund.

(4) The authority shall direct each managed care organization to make quarterly payments to eligible hospitals. Directed inpatient payments shall be a fixed amount per medicaid inpatient discharge, excluding normal newborns, and directed outpatient payments shall be a percentage of medicaid managed care outpatient payments, which the authority shall set so as to pay hospitals the amounts stated in subsection (1) of this section, less premium taxes on the managed care organizations.

(a) Quarterly interim payments shall be made using the authority's encounter data to determine volumes of medicaid discharges and medicaid outpatient payments. The interim payments will be based on volumes of services for each hospital within each medicaid managed care organization for the equivalent period beginning nine months prior to the start of the payment period. Before providing direction to the medicaid managed care organizations the authority shall share

the hospital specific data on volumes, proposed payments, and other supporting documentation with the Washington state hospital association.

(b) The authority shall perform an annual reconciliation of amounts paid to each hospital based on its annual encounter data, and direct managed care organizations to make adjusted payments in the subsequent quarter or quarters based on such reconciliation. Before the annual reconciliation, the authority shall send the medicaid managed care inpatient discharges and medicaid managed care outpatient payments data to each hospital and the Washington state hospital association for verification.

(c) Managed care organizations shall make payments to hospitals within 21 calendar days of receipt of payment in full from the authority.

(d) Any delegation or attempted delegation of an organization's or network's obligations under agreements with the authority does not relieve the organization or network of its obligations under this section and related contract provisions.

(5) If federal restrictions prevent the full amount of payments under this section from being delivered to any class or classes of hospital, the authority, in consultation with the Washington state hospital association, will alter payment rates per medicaid managed care inpatient discharge and per dollar of medicaid managed care outpatient payments in a manner so that in the aggregate each class of hospital receives the same total net benefit as would have otherwise been achieved. If the combined aggregate amount for inpatient and outpatient payments under this section for each class of hospital cannot be paid due to federal requirements, then the payment rates described in this section will be reduced to meet the limitations.

(6) If a managed care organization is legally obligated to repay the state or federal government amounts distributed to hospitals under this section, it may recoup the amount it is obligated to repay from individual hospitals under the medicaid program by not more than the amount of overpayment each hospital received from that managed care organization.

(7) No hospital or managed care organizations may use the payments under this section to gain advantage in negotiations.

(8) If funds cannot be used to pay for services in accordance with this chapter the managed care organization or network must return the funds to the authority which shall return them to the hospital safety net assessment fund. [2023 c 430 § 12; 2017 c 228 § 9; 2015 2nd sp.s. c 5 § 8; 2014 c 143 § 3; 2013 2nd sp.s. c 17 § 12; 2010 1st sp.s. c 30 § 14.]

Contingent effective date—2023 c 430: See note following RCW 74.60.005.

Effective date—2017 c 228: See note following RCW 74.60.005.

Effective date—2015 2nd sp.s. c 5: See note following RCW 74.60.005.

Effective date—2014 c 143: See note following RCW 74.60.030.

Effective date—2013 2nd sp.s. c 17: See note following RCW 74.60.005.