

**Chapter 74.76 RCW
MEDICAID ACCESS PROGRAM**

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RCW 74.76.010 Definitions. (Contingent expiration date.) The definitions in this section apply throughout this chapter and chapter 48.208 RCW unless the context clearly requires otherwise.

(1) "Authority" means the Washington state health care authority.

(2) "Commissioner" means the insurance commissioner or his or her designee.

(3) "Covered lives" means all persons residing in Washington state who are covered:

(a) Under a fully insured individual or group health plan issued or delivered in Washington state; or

(b) By a medicaid managed care organization.

(4) "Health carrier" or "carrier" has the same meaning as defined in RCW 48.43.005.

(5) "Health plan" has the same meaning as defined in RCW 48.43.005 and does not include medicare advantage plans established under medicare part C or outpatient prescription drug plans established under medicare part D.

(6) "Medicaid managed care organization" means a managed health care system under contract with the state of Washington to provide services to medicaid enrollees under RCW 74.09.522. [2025 c 359 s 1.]

Effective date—2025 c 359 ss 1-12, 14-16, and 18-20: "Sections 1 through 12, 14 through 16, and 18 through 20 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect immediately [May 19, 2025]." [2025 c 359 s 17.]

Contingent expiration date—2025 c 359: "(1) This act expires if by January 1, 2027, the federal centers for medicare and medicaid services does not provide final approval of the state plan amendment or waiver requests under section 2 of this act.

(2) The Washington state health care authority must provide written notice of the expiration date in subsection (1) of this section to affected parties, the chief clerk of the house of representatives, the secretary of the senate, the office of the code reviser, and others as deemed appropriate by the authority." [2025 c 359 s 18.]

RCW 74.76.020 Waiver requests—Funds. (Contingent expiration date.) (1) By September 1, 2025, the authority shall submit any state plan amendments or waiver requests to the centers for medicare and medicaid services that are necessary to implement the medicaid access program established in RCW 74.76.050.

(2) The assessment, collection, and disbursement of funds for this program shall be conditional upon:

(a) Final approval by the centers for medicare and medicaid services of any state plan amendments or waiver requests that are necessary in order to implement the applicable sections of this chapter including, if necessary, waiver of the broad-based or uniformity requirements as specified under section 1903(w)(3)(E) of the federal social security act and 42 C.F.R. Sec. 433.68(e);

(b) To the extent necessary, amendment of contracts between the authority and managed care organizations to implement this chapter; and

(c) Certification by the office of financial management that appropriations have been adopted that fully support the rates established in RCW 74.76.030 for the upcoming fiscal year. [2025 c 359 s 2.]

Effective date—2025 c 359 ss 1-12, 14-16, and 18-20: See note following RCW 74.76.010.

Contingent expiration date—2025 c 359: See note following RCW 74.76.010.

RCW 74.76.030 Covered lives assessment—Notification. (Contingent expiration date.) (1) All health carriers and medicaid managed care organizations shall pay an annual covered lives assessment beginning January 1st of the plan year following the approval in RCW 74.76.020(2)(a) as follows:

(a) For assessments due the first plan year:

(i) The authority shall assess a per member per month assessment of \$16 per covered life for medicaid managed care organizations; and

(ii) The commissioner shall assess a per member per month assessment of \$0.50 per covered life for health carriers.

(b) On or before May 15th of the first plan year of assessments due and on or before May 15th of each subsequent year, the authority shall determine the covered lives assessment at the rate necessary to fund the adjustment based on the inflation factor using the medicare economic index for professional services rates in RCW 74.76.050.

(c) The ratio of the total assessments collected from managed care organizations and health carriers must be set as 36 to one, respectively. Assessments for each calendar year shall be set utilizing the proportion of fully insured to medicaid managed care covered lives from the previous calendar year.

(2) The assessments as applied in subsection (1) of this section are limited to:

(a) The first 2,300,000 member months of fully insured lives per medicaid managed care organization on a per medicaid managed care organization basis; and

(b) The first 2,300,000 member months of fully insured lives per health carrier. For each health carrier, the assessment shall apply to

member months of all group health plan lives first, followed by member months of individual health plans lives.

(3) If an assessment against a health carrier or medicaid managed care organization is prohibited by court order, the assessment for the remaining health carriers and medicaid managed care organizations may be adjusted in a manner consistent with subsection (1) of this section to ensure that the assessment amount calculated in subsection (1)(b) of this section will be collected.

(4) The authority shall annually notify, in writing, each medicaid managed care organization of the estimated total assessment and its payment obligation for the upcoming year. The authority shall determine a payment schedule for receipt of assessments under this section in accordance with the medicaid access program rules as defined by the authority. Payment collections may be made no more frequently than quarterly.

(5) Payments from managed care organizations are due to the authority within 45 days of the payment schedule determined under subsection (4) of this section. The authority shall charge interest as defined by RCW 43.17.240, which begins to accrue on the 46th day, on amounts received after the 45-day period. The authority may allow each managed care organization in arrears to submit a payment plan, subject to approval by the authority and initial payment under an approved payment plan.

(6) The authority may abate or defer, in whole or in part, the assessment of a managed care organization if, in the opinion of the authority, payment of the assessment would endanger the ability of the managed care organization to fulfill its contractual obligations under chapter 74.09 RCW. If an assessment against a managed care organization is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other managed care organizations in a manner consistent with the basis for assessments in subsection (1) of this section. The managed care organization receiving such abatement or deferment remains liable to the program for the deficiency plus interest the rate established in RCW 43.17.240. Upon receipt of payment of any abatement or deferment by a managed care organization, the authority shall adjust future assessments made against other managed care organizations under this subsection to reflect receipt of the payment.

(7) The authority shall deposit annual assessments and interest collected under this section with the state treasurer to the credit of the medicaid access program account created in RCW 74.76.040.

(8) Managed care organizations shall submit any annual statements or other reports deemed necessary by the authority to calculate the assessment under this section in a manner consistent with the schedule and procedures in accordance with the medicaid access program rules as defined by the authority. [2025 c 359 s 3.]

Effective date—2025 c 359 ss 1-12, 14-16, and 18-20: See note following RCW 74.76.010.

Contingent expiration date—2025 c 359: See note following RCW 74.76.010.

RCW 74.76.040 Medicaid access program account. (Contingent expiration date.) (1) The medicaid access program account is created

in the state treasury. All receipts from the assessments, interest, and penalties collected by the authority and commissioner under RCW 74.76.030 and 48.208.010 must be deposited into the account. Moneys in the account may be spent only after appropriation. Expenditures from the account may be used only for the administration and implementation of the medicaid access program as established in RCW 74.76.050.

(2) Disbursements from the account may be made only:

(a) To make payments to health care providers and managed care organizations;

(b) To medicaid managed care organizations to fund the nonfederal share of increased capitation payments based on their projected assessment obligation established by the medicaid access program and the medicaid managed care rate setting process;

(c) To refund erroneous or excessive payments made by health carriers and medicaid managed care organizations;

(d) To pay for administrative expenses incurred by the authority in performing the activities authorized by this chapter;

(e) To be used in lieu of state general fund payments for medicaid services in an amount not to exceed \$35,000,000 in the first fiscal year following the approval in RCW 74.76.020(2)(a) and assessment by the authority authorized in RCW 74.76.030(1)(a)(i);

(f) To repay the federal government for any excess payments made to health care providers from the account if the assessments or payment increases set forth by the medicaid access program are deemed out of compliance with federal statutes and regulations in a final determination by a court of competent jurisdiction with all appeals exhausted. In such a case, the authority 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, deduct moneys from future medicaid payments, or both; and

(g) To pay up to \$2,000,000 for administrative and service-related costs to expand medicaid access in schools by maximizing medicaid funding opportunities to support the school-based health services program, school-based health centers, and on-site behavioral health services. [2025 c 359 s 5.]

Effective date—2025 c 359 ss 1-12, 14-16, and 18-20: See note following RCW 74.76.010.

Contingent expiration date—2025 c 359: See note following RCW 74.76.010.

RCW 74.76.050 Medicaid access program—Rates—Study. (Contingent expiration date.) (1) The medicaid access program is hereby created.

(2) By January 1st of the second plan year after conditions of RCW 74.76.020 are met, professional services rates for 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, vision, and other physician services, for services that are not reimbursed at or above medicare rates as of December 31, 2024, must be increased uniformly across

professional service categories by a percentage of corresponding medicare rates as of December 31, 2024, based on availability of funds in the account created in RCW 74.76.040 for rate increases from collections in the preceding plan year.

(3) By January 1st of the third plan year after the conditions of RCW 74.76.020 are met, and annually thereafter, the rates for all services listed in subsection (2) of this section shall be adjusted using the most recently published medicare economic index available at the time rates are established for the plan year.

(4) (a) Beginning January 1st of the third plan year after the conditions of RCW 74.76.020 are met and by January 1st in each of the two subsequent plan years, the authority shall study the impact of the professional services rate increases described in this section on medicaid access. The authority shall provide information to fiscal and health committees of the legislature whether these rate increases have increased access for medicaid enrollees, using metrics including but not limited to:

(i) Increases in utilization of services from licensed health care providers;

(ii) Number of contracts with identifiable provider types enrolled to provide services to medicaid enrollees;

(iii) Patient access measures in the CAHPS [consumer assessment of healthcare providers and systems] health plan surveys of managed care organizations; and

(iv) Other external quality review metrics.

(b) The authority shall provide the information in a fashion that disaggregates managed care organizations and fee-for-service. [2025 c 359 s 6.]

Effective date—2025 c 359 ss 1-12, 14-16, and 18-20: See note following RCW 74.76.010.

Contingent expiration date—2025 c 359: See note following RCW 74.76.010.

RCW 74.76.060 Medicaid access program—Rules. (Contingent expiration date.) The authority may adopt rules and undertake actions necessary to carry out RCW 74.76.020, 74.76.030, and 74.76.050 including, but not limited to, rules prescribing the medicaid access program plan of operations, measures to enforce reporting of covered lives, audits of covered lives reporting, and payment of applicable assessments. [2025 c 359 s 8.]

Effective date—2025 c 359 ss 1-12, 14-16, and 18-20: See note following RCW 74.76.010.

Contingent expiration date—2025 c 359: See note following RCW 74.76.010.

RCW 74.76.070 Medicaid access program—Liability. (Contingent expiration date.) The medicaid access program, health carriers and medicaid managed care organizations assessed by the program, the authority, and employees of the authority are not civilly or criminally liable and may not have any penalty or cause of action of

any nature arise against them for any action or inaction, including any discretionary decision or failure to make a discretionary decision, when the action or inaction is done in good faith and in the performance of the powers and duties assigned to the program. This section does not prohibit legal actions against the program to enforce the program's statutory or contractual duties or obligations. [2025 c 359 s 10.]

Effective date—2025 c 359 ss 1-12, 14-16, and 18-20: See note following RCW 74.76.010.

Contingent expiration date—2025 c 359: See note following RCW 74.76.010.

RCW 74.76.900 Construction—2025 c 359. (*Contingent expiration date.*) Nothing in chapter 359, Laws of 2025 shall be construed to alter the requirements: (1) Under 42 C.F.R. Sec. 438.4 that the rates paid by the state to managed care organizations be actuarially sound; and (2) that the state develop the rates in compliance with standards under 42 C.F.R. Sec. 438.5. [2025 c 359 s 7.]

Effective date—2025 c 359 ss 1-12, 14-16, and 18-20: See note following RCW 74.76.010.

Contingent expiration date—2025 c 359: See note following RCW 74.76.010.