HOUSE BILL REPORT
E2SSB 5596

As Reported by House Committee On:
Health Care & Wellness
Ways & Means

Title: An act relating to creating flexibility in the medicaid program.

Brief Description: Requiring the department of social and health services to submit a demonstration waiver request to revise the federal medicaid program.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Parlette, Zarelli, Becker and Hewitt).

Brief History:
Committee Activity:
Health Care & Wellness: 3/17/11, 3/21/11 [DPA];
Ways & Means: 3/30/11, 3/31/11 [DPA(HCW)].

Brief Summary of Engrossed Second Substitute Bill
(As Amended by House)

- Requires the Department of Social and Health Services to request federal approval to manage the state's Medicaid program within a targeted rate for each eligibility category.
- Includes cost containment elements in the request such as modified benefit design, enrollee cost sharing, streamlined eligibility, innovative reimbursement, and enrollment in health insurance exchanges and employer-sponsored insurance.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 9 members: Representatives Cody, Chair; Jinkins, Vice Chair; Schmick, Ranking Minority Member; Bailey, Clibborn, Green, Kelley, Moeller and Van De Wege.

Minority Report: Do not pass. Signed by 2 members: Representatives Hinkle, Assistant Ranking Minority Member; Harris.

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

Staff: Chris Blake (786-7392).

Background:

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 federal law has provided a framework for coverage for children, pregnant women, some families, and elderly and disabled adults, with varying income requirements. The Patient Protection and Affordable Care Act (PPACA) creates a new mandatory eligibility category for nonelderly, nonpregnant adults with income at or below 133 percent of the federal poverty level (FPL), beginning January 1, 2014. States have the option to provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a state plan amendment.

The PPACA requires states to maintain the Medicaid eligibility income standards that were in place in March 2010 through December 31, 2013, for all adults. The maintenance of effort requirement extends through September 30, 2019, for all children covered in Medicaid or the Children's Health Insurance Programs. States may be exempt from the maintenance of effort requirement for optional, nonpregnant, nondisabled, adult populations whose income is above 133 percent of FPL if the state certifies it is currently experiencing a budget deficit or projects to have a budget deficit in the following fiscal year.

The Secretary of the federal Department of Health and Human Services has some authority to grant waivers from certain requirements to allow states to demonstrate innovative approaches in their Medicaid programs. Washington recently received approval for a bridge demonstration waiver to allow early federal Medicaid match for the new eligibles (adults that will be eligible for Medicaid in 2014) that are enrolled through our state funded Basic Health and medical care services programs.

Summary of Amended Bill:

By October 1, 2011, the Department of Social and Health Services (DSHS) must submit a request for a demonstration project to the Innovation Center at the federal Centers for Medicare and Medicaid Services' (CMS) to revise the state's Medicaid program to allow for the broadest federal financial participation. The DSHS may submit a waiver request if it is necessary to implement any of the goals of the demonstration project.

The demonstration project shall include several identified components:

- Payment levels shall be established at a targeted level for each eligibility group in the Medicaid program and the state shall be provided with maximum flexibility to manage the health care trend. Expenditures below the targeted rate shall be shared with the federal government.
- The state shall have flexibility in developing the benefit design for the eligibility categories. Benefit design must align with the essential health benefits design under the Patient Protection and Affordable Care Act and provide additional benefits as appropriate for certain populations.

- Cost sharing and premiums may be imposed upon enrollees to encourage informed consumer behavior and reduced utilization, while not excluding access to preventive and primary care.
- Eligibility determinations may be streamlined.
- Innovative reimbursement methods may be adopted to support health homes and promote effective purchasing and efficient use of health services.
- Enrollees in Medicaid and the Children's Health Insurance Program shall be able to voluntarily enroll in the health insurance exchange or employer-sponsored insurance programs as available and cost-effective.
- A process shall be adopted for the state to receive responses from CMS within 45 days when requesting changes needed to allow the state to manage eligibility groups within payment levels.
- An alternative payment methodology shall be established for federally qualified health centers and rural health clinics.

The DSHS must evaluate the merits of establishing an insurance subsidy model for certain Medicaid populations. The DSHS must report to the Joint Select Committee on Health Reform Implementation on the proposed waiver provisions. There must be multiple opportunities for stakeholder comments to be received during the development of the waiver.

Legislative findings are made regarding the need for a more sustainable approach to managing the state's Medicaid program using elements of consumer participation, and benefit and payment design flexibility.

Amended Bill Compared to Engrossed Second Substitute Bill:

The amended bill removes the requirement that the demonstration last for a five-year period and that eligibility for Medicaid be verified on a more frequent basis. Populations may receive additional benefits as appropriate, rather than according to certain clinical criteria. The Department of Social and Health Services (DSHS) is no longer required to evaluate the merits of moving to an insurance subsidy model for certain Medicaid populations.

The amended bill requires the DSHS to provide "multiple" opportunities for input rather than holding "ongoing" discussions with stakeholders. The DSHS must report to the Joint Select Committee on Health Reform Implementation as requested rather than on specific dates. The requirement that the Legislature approve any demonstration project prior to implementation is removed.

The amended bill revises terminology for consistency.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) State spending on low-income medical expenses has grown three to four times faster than the total state budget over the past 20 years. There are limited options for states to reduce spending and there is a need for more flexibility. This bill has received unanimous votes in the Senate. The Governor is also interested in applying for a grant from the federal Innovation Centers. The intent of this legislation is not to limit enrollment for low-income people, but to maintain and improve critical programs while establishing a stable, sustainable budgeting process for Medicaid.

(In support with concerns) The Department of Social and Health Services (DSHS) has been asked to work with the federal Innovations Center to see how it can help Washington modernize the Medicaid program. The state is looking for better ways to integrate services for individuals eligible for both Medicaid and Medicare into Medicaid delivery systems. This is not a block grant waiver, but an attempt to negotiate a per capita cost for various eligibility groups to set a trend factor and then realize savings compared to that trend factor. This bill is consistent with the DSHS's current efforts to seek a federal grant.

(With concerns) This bill could have a potential impact on children's health coverage. While streamlining the eligibility process is good, conducting more frequent eligibility checks creates unnecessary red tape, costs the state more in administration, and risks future federal bonuses. Children need specific health services that are distinct from those for adults and there is no protection in the bill for current children's benefits. There should be a reference to the federal statutes governing payments to federally-qualified health centers which recognizes the limited ability of community health centers to recover losses incurred by seeing low-income patients. The challenge of controlling state health care spending should not come at the expense of vulnerable state residents who are already facing other cuts. This bill should be limited to seeking federal funding for promising practices to improve care coordination and efficiency. The state should not have open-ended authority to seek an undefined Medicaid waiver which could limit benefits, impose unaffordable cost-sharing, and make it harder for some to stay on the program. Cuts to Medicaid also result in a loss of federal funding. We should not spend money on obtaining a waiver that may never be granted. The benefit reductions, cost-sharing increases, and more frequent eligibility reviews will negatively affect enrollees, providers, and the state. The waiver language should be removed and replaced with an innovation grant request related to care coordination and case management for the elderly and high-risk populations.

(Opposed) None.

Persons Testifying: (In support) Senator Parlette, prime sponsor.

(In support with concerns) Roger Gantz, Department of Social and Health Services.

(With concerns) Jen Estroff, Children's Alliance; Kate White Tudor, Washington Association of Community and Migrant Health Centers; Janet Varon, Northwest Health Law Advocates and Parents Organizing for Welfare and Economic Rights; and Pamela Crone, Community Health Network of Washington.

Persons Signed In To Testify But Not Testifying: None.

HOUSE COMMITTEE ON WAYS & MEANS

Majority Report: Do pass as amended by Committee on Health Care & Wellness. Signed by 27 members: Representatives Hunter, Chair; Darneille, Vice Chair; Hasegawa, Vice Chair; Alexander, Ranking Minority Member; Bailey, Assistant Ranking Minority Member; Dammeier, Assistant Ranking Minority Member; Orcutt, Assistant Ranking Minority Member; Carlyle, Chandler, Cody, Dickerson, Haigh, Haler, Hinkle, Hudgins, Hunt, Kagi, Kenney, Ormsby, Parker, Pettigrew, Ross, Schmick, Seaquist, Springer, Sullivan and Wilcox.

Staff: Erik Cornellier (786-7116).

Summary of Recommendation of Committee On Ways & Means Compared to Recommendation of Committee On Health Care & Wellness:

No new changes were recommended.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) This bill started out as an index block grant proposal and it was obvious it would not be well received. The bill that passed the Senate Health Care Committee was the result of work by committee staff, Democratic staff, Republican staff, and the Department of Social and Health Services. Whether or not health reform follows through, Washington needs flexibility in Medicaid. This bill does not attempt to remove people from Medicaid, but to serve them better and more efficiently instead. The Office of the Governor stated that it would be helpful to have legislative support for these efforts.

(Opposed) None.

Persons Testifying: Senator Parlette, prime sponsor.

Persons Signed In To Testify But Not Testifying: None.