SENATE BILL REPORT
SB 5596

As Reported by Senate Committee On:
Health & Long-Term Care, February 21, 2011
Ways & Means, February 25, 2011

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: Senators Parlette, Zarelli, Becker and Hewitt.

Brief History:
Committee Activity: Health & Long-Term Care: 2/14/11, 2/21/11 [DPS-WM].
Ways & Means: 2/25/11 [DP2S].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 5596 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Keiser, Chair; Conway, Vice Chair; Becker, Ranking Minority Member; Carrell, Kline, Murray, Parlette, Pflug and Pridemore.

Staff: Mich'l Needham (786-7442)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Second Substitute Senate Bill No. 5596 be substituted therefor, and the second substitute bill do pass.

Signed by Senators Murray, Chair; Kilmer, Vice Chair, Capital Budget Chair; Zarelli, Ranking Minority Member; Parlette, Ranking Minority Member Capital; Baumgartner, Baxter, Brown, Conway, Fraser, Hatfield, Hewitt, Holmquist Newbry, Honeyford, Kastama, Keiser, Kohl-Welles, Pflug, Pridemore, Regala, Rockefeller, Schoesler and Tom.

Staff: Tim Yowell (786-7435)

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

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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 non-elderly, non-pregnant 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.

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, non-pregnant, non-disabled, 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 Department of Health and Human Services (HHS) has some authority to grant waivers from certain requirements to allow states to demonstrate innovative approaches in their Medicaid programs. Washington State 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 Bill (Recommended Second Substitute): By October 1, 2011, the Department of Social and Health Services (DSHS) must submit a request to the Centers for Medicare and Medicaid Services (CMS) Innovation Center, and as needed request a Medicaid Modernization Demonstration waiver. DSHS is to report on proposed provisions of the request to the Joint Select Committee on Health Reform by August 1, 2011, and again by September 15, 2011. To the extent permitted under federal law, the waiver request must include:

- Establishment of base-year, eligibility group per capita payments with maximum flexibility for the state to manage within the appropriation.
- Flexibility over benefit design for all categories of eligibility to align with the essential health benefits design that will be required for the private plans and Basic Health, with the ability to provide supplemental benefits for certain populations such as children, pregnant women, individuals with disabilities, and elderly adults.
- The ability to implement limited, reasonable, and enforceable cost-sharing and premiums for all categories of eligibility to encourage informed consumer behavior and lower utilization of health services, while access to preventative and primary care is not hindered.
- The ability to streamline eligibility determination, and to more frequently verify income eligibility.
- The flexibility to adopt innovative reimbursement methods such as bundled, global, and risk bearing payment arrangements, that promote effective purchasing, efficient use of health services, and support health homes, accountable care organizations, and other innovations intended to contain costs, improve health, and incent smart consumer decision making.
- The ability for all Medicaid and CHIP clients to voluntarily enroll in the insurance Exchange, broader authority to enroll clients in employer-sponsored insurance when

available and deemed cost-effective for the state, and authority to require clients to remain enrolled in their chosen plan for the calendar year.
- An expedited process for the Centers for Medicare and Medicaid to respond to any state request for changes within 45 days to ensure the state has the flexibility to manage within its appropriation.

In addition, DSHS must evaluate the merits of moving to an insurance subsidy model for certain Medicaid populations, hold ongoing stakeholder discussions in developing the waiver request, and identify statutory change that may be necessary for implementation. The Legislature must authorize any waiver approved by HHS prior to its implementation.

EFFECT OF CHANGES MADE BY WAYS & MEANS COMMITTEE (Recommended Second Substitute): The waiver request is to be submitted by October 1, 2011. DSHS is to report to the Joint Select Committee on Health Reform regarding the proposed waiver provisions by August 1, 2011, and by September 15, 2011. The waiver is not required to propose the use of "modified adjusted gross income" as defined in the Patient Protection and Affordable Care Act for all eligibility groups. The waiver request is to propose more frequent verification of income eligibility.

EFFECT OF CHANGES MADE BY HEALTH & LONG-TERM CARE COMMITTEE (Recommended First Substitute): Section 1 - Revisions to intent: mentions growth in enrollment and constraints in Medicaid program; mentions Washington's transitional bridge waiver, benefit flexibility and payment flexibility have helped keep costs low; mentions CMS Innovation Center projects or an 1115 waiver with capped eligibility group per capita payments; may allow the state to be a laboratory of innovation.

Section 2 - The Department must explore CMS Innovation Center opportunities and an 1115 waiver option as needed. The demonstration will be known as the Medicaid Modernization Demonstration, and must include the following components:
- Replace capped block grant with base-year, eligibility group per capita payments, with provisions for shared savings if the per capita expenditures are below the negotiated rates. Eligibility group per capita payment based on targeted per capita costs and estimated caseload for the demonstration period.
- Explore flexibility with benefit design based on the essential health benefits/private market benefit designs, with option for supplemental benefits for certain populations such as children, individuals with disabilities and elderly.
- Cost-sharing designs must encourage informed consumer behavior and lower utilization, while ensuring access to evidence based, preventive and primary care is not hindered.
- Request to streamline eligibility through use of modified adjusted gross income determination for all eligibility groups (to avoid running multiple systems).
- The flexibility to adopt innovative reimbursement methods such as bundled, global, and risk-bearing payment arrangements that promote effective purchasing, efficient use of health services, and support health homes, accountable care organizations and other innovations intended to contain costs, improve health, and incent smart consumer decision making.
- The ability for all Medicaid and CHIP clients to voluntarily enroll in the Exchange and broadened authority to enroll clients in employer-sponsored insurance when

available and deemed cost-effective for the state, with authority to require clients remain enrolled in their chosen plan for the calendar year.
- The remaining language is the same as the original (explore merits of moving to an insurance subsidy model, explore options to remove administrative silos for other programs, hold on-going stakeholder discussions, identify necessary statutory changes, legislature must authorize any demonstration prior to implementation).

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Original Bill (Health & Long-Term Care): PRO: This is a means to redesigning Medicaid to ensure we have a stable, sustainable program with a manageable budget. States need flexibility for the program and the opportunity to share in the savings if we can create efficiencies. Cost sharing and premiums work as evidenced with our experience with Basic Health.

CON: The current bill would have negative impacts on children and families. The state has had great success covering children in Apple Health and this would set us back. A block grant leaves the state at risk and can result in capped enrollment and the loss of federal Children's Health Insurance Program Reauthorization Act of 2009 bonus money the state has received. Restricting enrollment and having patients bare the costs for care with premiums and co-pays leaves the complicated populations in these programs exposed. The aged, blind, and disabled populations have complex health issues and they would have great exposure under this approach. A better approach for them would be focusing on the development of health homes. The Governor does not support a block grant, but may be comfortable with an indexed per capita agreement similar to the approach negotiated in the Bridge waiver. There is some interest in benefit design flexibility based on the Basic Health design, with a supplemental benefit design for the at-risk populations. Cost sharing and premiums are of some interest for targeted populations, not the entire Medicaid population. There is interest in streamlining eligibility.

OTHER: It is good public policy to have more control over the program and more flexibility with program design. It will be a win-win and result in savings for tax payers and the state and support individual responsibility.

Persons Testifying (Health & Long-Term Care): PRO: Senator Parlette, prime sponsor.

CON: Jen Estroff, Children's Alliance; Kate White Tudor, Healthy Washington Coalition and Washington Association of Community and Migrant Health Centers; Roger Gantz, DSHS.

OTHER: Roger Stark, Washington Policy Center.

Staff Summary of Public Testimony on Recommended First Substitute (Ways & Means): PRO: The purpose of the bill is to seek greater flexibility within which to operate our Medicaid program. Whether federal health reform proceeds as planned or not, we need flexibility to manage this big program more effectively. That becomes still more important if health reform does proceed in its current form, because we're expected to get 400,000 more people into our Medicaid program.

Persons Testifying (Ways & Means): PRO: Senator Parlette, prime sponsor.