FINAL BILL REPORT
E2SSB 5596

C 1 L 11 E 1
Synopsis as Enacted

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).

Senate Committee on Health & Long-Term Care
Senate Committee on Ways & Means
House Committee on Health Care & Wellness
House Committee on Ways & Means

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 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 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.

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.

Summary: By October 1, 2011, the Department of Social and Health Services must submit a request to the federal Centers for Medicare and Medicaid Services (CMS) Innovation Center, and if necessary a request for a Section 1115 demonstration waiver from CMS. 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;
- Coverage of benefits determined to be essential health benefits under federal law, with coverage of additional benefits as appropriate for distinct categories of enrollees such as children, pregnant women, individuals with disabilities, and elderly adults;
- Limited, reasonable, and enforceable cost-sharing and premiums to encourage informed consumer behavior and appropriate utilization of health services, while ensuring that access to evidence-based, preventative and primary care is not hindered;
- Streamlined eligibility determination;
- 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 Medicaid and CHIP enrollees 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; and
- The development of an alternative payment methodology for federally qualified health centers and rural health clinics that enables capitated or global payment of enhanced payments.

The department must provide status reports to the Joint Select Committee on Health Reform Implementation as requested by the committee, as well as multiple opportunities for stakeholders and the general public to review and comment on the request as it is developed. In addition, the department must identify statutory changes that may be necessary for successful and timely implementation.

Votes on Final Passage:

Senate	49	0	

First Special Session

Senate	41	0	
House	96	0	(House amended)
Senate	45	0	(Senate concurred)

Effective: August 24, 2011.