SENATE BILL REPORT
E2SSB 5596

As Amended by House, May 9, 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: Senate Committee on Ways & Means (originally sponsored by 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].
Passed Senate: 3/07/11, 49-0.
First Special Session: Passed Senate: 4/26/11, 41-0.
Passed House: 5/09/11, 96-0.

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)

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.

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 (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 Engrossed Second Substitute Bill: 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.
- 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.
- 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.

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.

House Amendment(s): Removes the requirement that the demonstration last for a five year period. Removes the request to verify eligibility information more frequently. Removes the requirement that populations receiving additional benefits meet certain clinical criteria, but rather that additional benefits be available for distinct populations as appropriate. Removes the requirement that the Department of Social and Health Services (DSHS) evaluate the merits of moving to an insurance subsidy model for certain Medicaid populations. DSHS must provide multiple opportunities for stakeholder input rather than ongoing discussions. Removes the specific dates that DSHS reports to the Joint Select Committee on Health Reform Implementation and requires status reports as requested by the committee. Removes the requirement that the Legislature approve any demonstration project prior to implementation. Revises terminology for consistency.