SENATE BILL REPORT
SB 5894

As of April 4, 2013

Title: An act relating to authorizing the medicaid expansion while ensuring state financial protections, increasing consumer engagement and choice, and establishing expectations for improved health outcomes.

Brief Description: Authorizing the medicaid expansion while ensuring state financial protections, increasing consumer engagement and choice, and establishing expectations for improved health outcomes.

Sponsors: Senator Becker.

Brief History:
Committee Activity: Ways & Means:

SENATE COMMITTEE ON WAYS & MEANS

Staff: Mich'l Needham (786-7442)
Michael Bezanson (786-7449)

Background: Medicaid is a federal-state partnership that provides an array of programs including medical care services, mental health services, long-term care services and supports, and substance abuse and chemical dependency treatment. The Health Care Authority (HCA) is designated as the single-state agency for Medicaid, with responsibility for the medical programs. Other programs are coordinated with the Department of Social and Health Services (DSHS).

The array of Medicaid programs are available for specific eligibility categories, with mandatory and optional categories defined in federal law. Eligibility categories include persons that are aged, blind, and disabled; pregnant women; low-income children and their parents; foster children; and others. Over 50 Medicaid medical programs exist, serving approximately 1.2 million enrollees, of which 740,000 are children. Approximately 65 percent of the population is enrolled in managed care plans.

The federal Affordable Care Act included a number of changes for the Medicaid program, including streamlining of the eligibility process, with application of a modified adjusted gross income that will be applied to many existing programs and a new category of adults known as the expansion population. The expansion population includes adults ages 19 to 65

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with incomes below 133 percent of the federal poverty level – approximately $14,856 per year for an individual, that are not otherwise eligible for Medicaid or Medicare. Enhanced federal funding is available to fund the new adults, starting with 100 percent in 2014, gradually declining to 90 percent in 2020. The Urban Institute estimates 494,000 adults may be newly eligible in Washington, and they estimated 250,000 of the newly eligible will enroll if an expansion is implemented.

Streamlining the existing programs, eliminating duplicative categories, and transitioning those in some partial-coverage programs to the comprehensive Medicaid expansion could save an estimated $303 million in state general fund expenditures.

Summary of Bill: The bill as referred to committee not considered.

Summary of Bill (Proposed Substitute): HCA is authorized to implement the Medicaid expansion for the new adult population consistent with budget authorization provided in the state budget, as long as the federal Medicaid funding remains at the level outlined in the federal law. A circuit breaker is provided to ensure the state budget is not adversely impacted by the federal government. If the federal funding rate for the expansion falls below 90 percent, HCA must ensure the state does not incur any additional costs above what the state would have incurred. The director or HCA is authorized to make any necessary program adjustments to comply, including adding or adjusting premiums, modifying benefits, or reducing optional programs. If a waiver is needed to accomplish this, the director must apply for the waiver. If a waiver is not approved to respond to a reduction in the federal funding, the expansion program must be closed upon appropriate notification to the Legislature and enrollees.

The definition of medical assistance is modified to include the Medicaid expansion population, contingent upon state and federal funding. The Medical Care Services program for Disability Lifeline and Alcohol and Drug Addiction Treatment and Support currently authorized through the federal bridge waiver, expires December 31, 2013, consistent with the terms of the waiver agreement. References to categorically eligible individuals are modified to reflect changes in federal law. The breast and cervical cancer program is closed to new enrollees after December 31, 2013, but enrollees receiving treatment may complete treatment or transfer to more comprehensive coverage available through the Medicaid expansion.

HCA must seek a waiver to implement cost-sharing levels, similar to the cost sharing applied to the Basic Health population in the bridge waiver, for those with similar incomes.

By January 1, 2015, enrollees in the Medicaid expansion must be provided a choice of plan consistent with enrollment practices offered to other enrollees processed through the Health Benefit Exchange. HCA must report to the Legislature on the enrollment outcome and any adverse budget impact that may necessitate program modification. Outdated references to the HCA contracts with managed care plans are removed. The contracts with managed care plans must incorporate accountability measures that monitor patient health and improved health outcomes, and may include an expectation that each patient receive a wellness examination that documents the baseline health status and allows for monitoring of health improvements and outcome measures. Contracts may allow plans to offer small incentives for enrollees to participate in prevention and wellness activities.

HCA must develop contract performance measures that demonstrate meaningful measurement of enrollee health status and wellness, efforts by the managed care plan to increase enrollee participation in meaningful activities including a wellness visit, and application of evidence-based practices. The performance measures must assist in monitoring managed care plan accountability, and monitoring for limited access to appropriate care or fraud.

HCA, in cooperation with DSHS, must complete a study by October 1, 2014, on the integration of the behavioral health system into the medical purchasing. The Medicaid expansion provides an opportunity to redesign the medical package and align the delivery system to ensure enrollees can access the full scope of medical care, including mental health services and chemical dependency services. The integration of behavioral health services may include contracting with the regional support networks as providers within the managed care contracts, or other community-based delivery strategies that ensure the full range of care is available to enrollees. The study must identify the pathway to integration with a focus on administrative efficiency, seamless delivery of care for enrollees, and critical connectivity with social support systems, crisis intervention systems, and criminal justice systems.

The annual report monitoring Medicaid enrollees and their employment is modified. Beginning November 2015, the reports must include information on Medicaid enrollees that may have dropped employer coverage. Data must be gathered to monitor any crowd-out of employer coverage related to the expansion of Medicaid coverage. The crowd-out data should be shared with the Washington State Institute for Public Policy for monitoring and inclusion in their research on Medicaid. HCA must work with the U.S. Department of Health and Human Services to explore alternatives that may allow an efficient method of providing premium assistance to help enrollees retain their employer coverage or other private coverage, if cost effective to the state.

The Medical Care Services program and the Basic Health Program, covered in the bridge waiver, are repealed December 31, 2013.

Appropriation: None.

Fiscal Note: Requested on April 3, 2013.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed. Section 303 is effective December 31, 2013.