Universal Health Care Commission's
Finance Technical Advisory Committee meeting

November 9, 2023

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Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission's
Finance Technical Advisory Committee
Meeting Materials

November 9, 2023
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting materials

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission's Finance Technical Advisory Committee (FTAC)

Agenda

Thursday, November 9, 2023

Zoom meeting **2:00 – 4:00 PM**

FTAC members:		
☐ Pam MacEwan, FTAC Liaison	☐ Eddy Rauser	☐ Kai Yeung
☐ Christine Eibner	☐ Esther Lucero	☐ Robert Murray
☐ David DiGiuseppe	☐ Ian Doyle	☐ Roger Gantz

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome & call to order	1	Pam MacEwan, FTAC Liaison
2:05-2:08 (3 min)	Roll call	1	Angela Castro, Senior Health Policy Analyst Health Care Authority
2:08-2:10 (2 min)	Approval of Meeting Summary from 09/14/2023	2	Pam MacEwan, FTAC Liaison
2:10-2:25 (15 min)	Public comment	3	Pam MacEwan, FTAC Liaison
2:25-2:30 (5 min)	• Review 2023 workplan • Updates from UHCC's October meeting	4	Liz Arjun, Senior Consultant Health Management Associates
2:30-2:45 (15 min)	Washington's Medicaid enrollment processes	5	Joan Altman, Director of Government Affairs & Strategic Partnerships Health Benefit Exchange Melissa Rivera, Lead Policy Manager Office of Medicaid Eligibility & Policy Health Care Authority
2:45-3:30 (45 min)	Understanding Washington's Medicaid Program & Opportunities for Universal Health Care	6	Roger Gantz, FTAC member
3:30-4:00 (30 min)	FTAC discussion and preliminary guidance to UHCC	7	Liz Arjun, Senior Consultant Health Management Associates
4:00	Adjournment		Pam MacEwan, FTAC Liaison

Tab 2

Washington State Health Care Authority

Universal Health Care Commission's

Finance Technical Advisory Committee (FTAC) meeting summary

September 14, 2023

Virtual meeting held electronically (Zoom)
2–4 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the committee is available on the **FTAC webpage**.

Members present

Christine Eibner
David DiGiuseppe
Ian Doyle
Kai Yeung
Pam MacEwan
Robert Murray
Roger Gantz

Members absent

Eddy Rauser
Esther Lucero

Call to order

Pam MacEwan, FTAC Liaison, called the meeting to order at 2:02 p.m.

Agenda items

Welcoming remarks

Beginning with a land acknowledgement, Pam MacEwan welcomed members of FTAC to the fifth meeting and provided an overview of the agenda.

Meeting summary review from the previous meeting

The Members present voted by consensus to adopt the Meeting Summary from FTAC's July 2023 meeting.

Public comment

Roger Collier asked if costs doubling for some employers via a payroll tax could be deemed as "exorbitant" and in violation of the Employment Retirement Income Security Act of 1974 (ERISA), and how far out the federal court processes to resolve ERISA preemption would be from Washington's passing of universal health care

legislation. Roger asked if FTAC would allow them a few minutes at the next meeting to discuss their public option proposal submitted in April.

Kathryn Lewandowsky, Co-Chair, Whole Washington, expressed Whole Washington's interest in sharing the Washington Health Trust proposal (beginning at page 59 of the Commission's August meeting materials), particularly financing-related components, with FTAC members at a future meeting.

Lori Bernstein encouraged FTAC members to watch the recording (timestamp 45:50) of Whole Washington's presentation from the Commission's August meeting.

Maureen Brinck-Lund asked whether the Washington Health Trust proposal could be used as a draft model for achieving universal health care under a single-payer financing system.

Presentation: Large employer perspectives on state-based universal health care

Bill Kramer, Director for Health Policy, Purchaser Business Group on Health

Health benefits are key to large employers' recruitment and retention strategies, but rising health care costs impact employers' ability to remain competitive and increase wages. Some large employers are adopting aggressive cost containment strategies, e.g., mental health and substance use access and quality.

Large employers are likely to have some concerns with universal health care, such as the loss of differentiation in employee recruitment and any new taxes. Further, it may create inequities between employees with universal health care versus those with employer benefits. Finally, employers could feel a loss of control in not being permitted to design health benefits to meet employees' needs. Large employers will fiercely defend ERISA preemption.

Universal health care could be made appealing or acceptable to large employers, e.g., employers having a choice of whether to continue offering health benefits or joining the universal health care system. Some of the most important product features for large employers include provider network, benefits, price, and choice of plans. In a unified financing system, employers could maintain differentiation in employee recruitment by offering other benefits, e.g., retirement, or offering wraparound benefits for any services not covered under the universal plan.

It was noted that based on recent research, large employers nationally are paying between 200-300 percent of Medicare (with variation between and within states) for health benefits. Is there an argument that a universal health care system will relieve some of this pressure for employers? Bill Kramer replied that most employers are focusing their influence on systemic solutions via the public policy arena, e.g., cost growth targets, greater oversight over mergers and acquisitions, etc.

The private sector's concerns over government price controls were noted. Are there areas of commonality? Bill Kramer replied that most large employers accept government intervention in areas where markets don't exist or have failed irreparably.

Presentation: ERISA options for Washington

Erin Fuse Brown, Catherine C. Henson Professor, Director of the Center for Law, Health & Society, Georgia State University College of Law

This presentation was not legal advice. To keep employer-based coverage intact, the drafters of the Affordable Care Act (ACA) created the employer mandate where employers with more than 50 employees that fail to provide "minimum essential coverage" that is "affordable" and offers "minimum value" face a penalty. The employer mandate can be waived by the federal government via a 1332 waiver.

A federal ERISA waiver does not exist, and the U.S. Department of Labor (DOL) (entity that administers ERISA) has no authority to waive ERISA preemption provisions. Federal courts, not the DOL, independently determine whether a state law is in violation of ERISA.

Washington's goal in designing a universal health care system is to include the employer-based market (accounts for 52 percent of Washingtonians' health coverage), without running afoul of ERISA preemption because without it, the universal plan is neither "universal" nor fiscally sustainable. The spectrum of policy design options for a state-based universal health care system depends on how "universal" is defined, e.g., universal eligibility, universal enrollment, etc., and whether the transition happens all at once or on a glide path. Additionally, each model on the spectrum entails balancing policy goals with legal and other tradeoffs.

The first option on the spectrum begins where Washington is currently - offering a limited public option (Cascade Select). This option has limited reach by filling gaps in coverage on the individual market but has no ERISA implications because it does not impact employers.

The next option is a comprehensive public option. This may call for a more heavily regulated or government-sponsored health plan made available to all state residents (including those with employer-based coverage). The multi-payer system would persist, but this option could break the link between employment and health coverage. This option would have universal eligibility and could be used as a glide path to a single-payer system. There could be some legal difficulties under ERISA and require waivers to bring in other payers (Medicare, Medicaid, and ACA).

Furthest on the spectrum is a state-based single-payer plan which the government would administer and provide the same coverage to all state residents, irradicating the current system. This option would have simplified administration with total market reach and universal enrollment. This option invites more legal and political difficulties and would require the same waivers as mentioned above.

There are legal challenges and policy tradeoffs in capturing employer spend via the comprehensive public option. Washington could not mandate that employers offer the comprehensive public option. Instead, structuring the state plan as voluntary for employers/employees would retain a meaningful set of plan choices and avoid ERISA preemption under the current Ninth Circuit precedent in the Golden Gate and City of Seattle cases (see FTAC's July meeting recording, timestamp 23:08 for more detail on these court cases). Funding for this option could be structured to avoid ERISA preemption, e.g., payroll taxes (levied on wages) don't on their face relate or refer to an employer benefit plan. Employers could be exempt from the payroll tax if they offer coverage at least as affordable and comprehensive as the state plan ("Pay or Play"), versus a payroll tax without exemptions which would accelerate a market-shift to the state plan but increase ERISA difficulty, e.g., employers paying both the payroll tax and continuing to offer their own benefits could be deemed "exorbitant" ("exorbitant" is a concept, not a number). The tax implications of this option are outside the scope of this presentation.

There are also legal challenges and policy tradeoffs of capturing employer spend via a state-based single-payer plan. The three primary mechanisms to navigate around ERISA preemption and capture employer expenditures include Type A, Type B, and Type C. Type A, a funding plan, imposes a payroll tax (calculated as a percentage of wages) on employers and/or premiums on individuals. This option incentivizes employers/employees to switch voluntarily to the universal plan to avoid double paying (e.g., paying property taxes to fund public schools and choosing to pay tuition for private school). Whether this is preempted by ERISA depends on how "exorbitant" is interpreted by a court. Additionally, courts could interpret a payroll tax on employers as coercive.

Under Type B, provider restriction, all provider payments would come from the single-payer plan at single-payer rates. Three types of provider restrictions include: 1) universal provider enrollment and ability to contract with alternate plans (likely not preempted), 2) voluntary provider enrollment, but if they join the state plan, they cannot participate in other plans (likely not preempted), and 3) universal provider enrollment without ability to contract with other plans (may be preempted). ERISA does not preempt state regulation of health care providers

(has only an indirect effect on employer health benefit plans). The question would be whether the indirect effect is enough that it crosses the line toward coercion, e.g., effectively gutting employer provider networks.

Finally, under Type C, pay and recoup provisions, the single-payer plan can pay for services and seek reimbursement from other payers. This, in combination with some sort of provider restriction gives employer plans a plausible way to continue to exist and may help strengthen the ERISA preemption case for the state.

A single-payer plan should include a combination of a funding plan with payroll taxes, income taxes and/or premiums, provider payment restriction and incentives to participate, pay-and-recoup mechanism, and a severability clause to prevent the system from failing if any one of these provisions was determined to be preempted by ERISA.

Non-duplication prohibits any self-funded health plan from offering coverage that duplicates state plan coverage and is likely preempted. However, prohibition on any state-regulated insurance carrier or plan from offering duplicative coverage is likely not preempted. To avoid making a preempted "reference" to ERISA plans, Washington should not explicitly state that self-funded duplicated coverage is permitted (though it is).

The policy design for Washington's universal health care system will be driven by Washington's goals within legal, financial, and political bounds. There are tradeoffs. ERISA legal challenge is inevitable, but whether the state wins will depend on how the plan is crafted. States currently have the power to and have a strong track record of regulating provider rates, e.g., rate caps. There may be discomfort in preventing providers from contracting with certain entities, but this could be framed as a condition of participating in the single-payer plan.

A committee member asked if a payroll tax imposed on employers without condition would be the least risky from an ERISA standpoint. This could be a good option because it makes no mention of employer health benefit design.

FTAC Member vote: recommendations to the Commission regarding ERISA

Pam MacEwan, FTAC Liaison

This vote is intended to provide guidance to the Commission on ERISA options that allow the design process to advance. This guidance is not binding forever.

FTAC members agreed that Option 1, a federal ERISA waiver, does not exist and is therefore impossible to obtain. Gary Cohen, Health Management Associates, noted that this is in the same category as an act of congress. Given how difficult this would be to achieve, members did not recommend Option 1. One member suggested that the Commission work with Oregon's Universal Health Plan Governance Board to influence federal legislation on ERISA.

FTAC members agreed that Option 2, optional employer participation in the universal plan, will likely avoid ERISA preemption. Any path to including employers should be optional to avoid an ERISA challenge and because it may benefit employers.

Option 3 was a pay or play or meaningful alternative (e.g., comprehensive public option). It was suggested that "pay or play" be separated from "meaningful alternative" because of the differences in financing mechanisms. FTAC member Roger Gantz suggested that consolidated state purchasing could be a path with which to build other ERISA options. Some members noted that pay or play is likely to be problematic and that the state could accomplish the same goals through a payroll tax. This is perhaps the most nuanced option and requires further study because pay or play could be structured differently or the same as a meaningful alternative.

There was interest in Option 4, provider regulation/incentives, as a means of containing costs to financially sustain the system. This option may have to be done in conjunction with action on Medicare and Medicaid since the provider community may be concerned about losing employer-sponsored coverage rates which tend to be higher.

Members highlighted some of the pros and cons of Option 5, a payroll tax on employers. This may be a more heavy-handed approach from employers' perspective because they'd have no choice but to pay the tax. It may be more politically feasible to begin with Option 3 at the outset where employers would have a choice of whether to pay into the universal system, then transition to Option 5. This requires further exploration. Erin Fuse Brown added that a payroll tax isn't unique to either a comprehensive public option plan or a single-payer plan, rather it's a financing mechanism designed to capture employer dollars and to incentivize people to join the universal plan. The ERISA questions are along the lines of how high the payroll tax is and whether there are exemptions. This option could be attractive to employers because they could raise employees' salaries in lieu of paying for health benefits.

Option 6 was a combination of two or more options. There was interest in exploring ways to combine multiple options in the interim and for the larger system while also getting a clearer understanding of the greater system design, transitional solutions, and policy goals as determined by the Commission.

Any options that FTAC will support will depend on things that haven't been decided yet, e.g., larger system design and strategies to transition the state to a universal health care system. There was agreement among members that participation by employers must be optional, must include provider incentives to contain costs, and a funding mechanism that may or may not have exceptions on employers is required, but this requires further exploration.

Adjournment

Meeting adjourned at 4:02 p.m.

Next meeting

November 9, 2023
Meeting to be held on Zoom
2–4 p.m.

Tab 3

Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission's

FTAC

Written Comments

Received From August 31

Written Comments Submitted by Email

Additional Comments Received at the September FTAC Meeting

- The Zoom video recording is available for viewing here: https://youtu.be/emcfEroMfjc

Public comments received since (August 31) through the deadline for comments for the November meeting (October 26)

Submitted by Lori Bernstein

09/12/2023

Dear FTAC Members,

At the August 10th meeting of the Universal Health Care Commission, Andre Stackhouse and Erin Georgen of Whole Washington gave a 1 hour presentation on SB5335 which will establish the Washington Health Trust. If you were present at that Zoom meeting, thank you!

If you were unable to attend, I strongly urge you to watch the recording of the presentation. Here's the link: August 10, 2023 Universal Health Care Commission meeting

Thank you for your service on this important committee. "See" you at the upcoming FTAC meeting this Thursday, September 14th at 2 pm.

Regards,

Lori Bernstein, PCO LD 24

Submitted by Pam Ketzner

09/13/2023

"Dear FTAC Members, I strongly urge you to watch the recording of Whole Washington's presentation to the UHCC."
https://www.youtube.com/live/YaNuXOQJGto?si=wRGbB_2M2bxQiLsw
This is so important to make Universal Healthcare availability in our great state of Washington.

Thank you,

Pam Ketzner MN, RN

Submitted by Lana Bostic

09/13/2023

Dear FTAC members
Please watch the Whole Washington presentation to the the UHCC that was recorded on August 10! We need Universal Health care now. I am a retired RN and have seen how people suffer when they can't get decent Health care. Please move this forward Thank you Lana Bostic Federal Way

Submitted by Aaron Katz
09/15/2023

September 14, 2023

Comments submitted by Aaron Katz, Principal Lecturer Emeritus. University of Washington School of Public Health

In response to the September 14, 2023 FTAC meeting

I think Bill Kramer's presentation during your September 14th meeting was important, mostly as it might provide guidance for designing and "selling" of a universal health care system.

I would suggest, however, that a little historical perspective on the role and perspectives of employers regarding health care and system reform is important for FTAC and UHCC to consider.

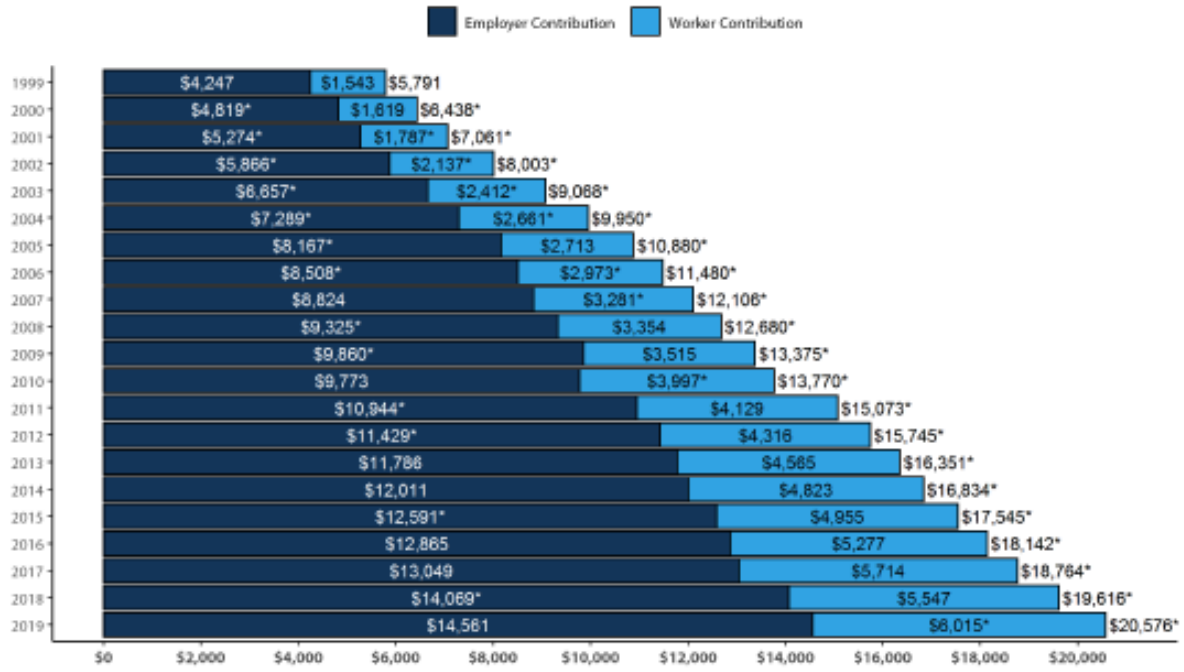
I was involved in the mid-1980s in helping form the Health Care Purchasers Association of Puget Sound, a coalition of large public and private employers. Our purpose of doing so was to, hopefully, create a counterbalance to the market power and political leverage of health care providers. We hoped that large public and private employers would act in concert to push back against the unending trend of health care providers raising prices and inducing demand.

I was then a collaborating researcher on a 15-year study starting in the mid-1990s of health care market changes in 12 markets across the county ("The Community Tracking Study"). One focus of the study was on actions of employers, so we tracked those efforts, including such strategies as "pay-for-performance," operating their own medical clinics, limited provider networks, etc.

The record over the past 40 years demonstrates, pretty unequivocally in my view, that employers do not sustain collective efforts in this arena and that individual employers cannot achieve the improved efficiencies, quality, and effectiveness that Bill's presentation suggested they seek. Yes, some improvements along these dimensions can be seen in small areas and for short periods of time, but I am aware of no compelling evidence of employers' efforts leading to systemic, durable progress either for themselves or the system, at large.

I could offer considerable evidence to support this contention, but I'd just offer this one chart, which I think says it all:

Figure 6.5
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2019



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2019; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

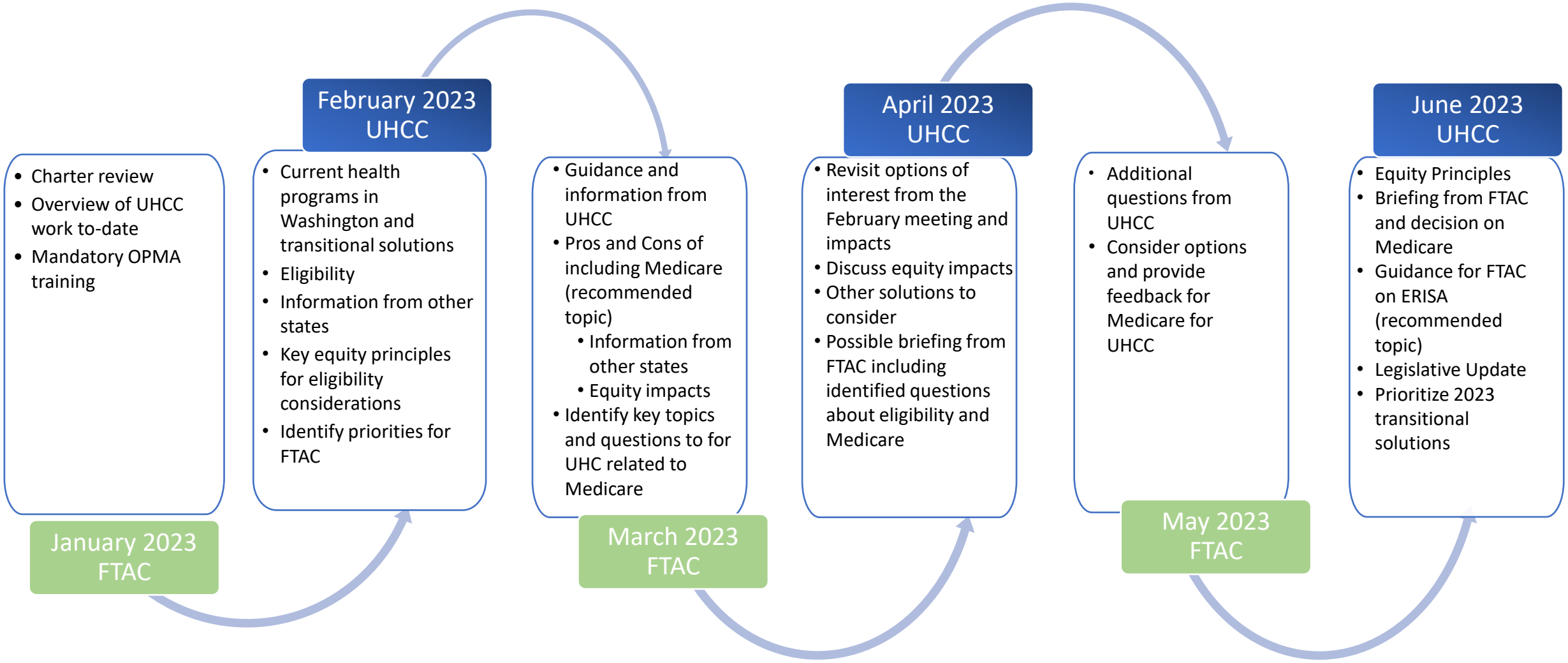
Despite what Bill, I think, accurately reported as employers' interest in having flexibility to design plans that meet their employees' needs, to attract new employees, and to control their expenditures, the reality is that what employers actually do is write ever-larger checks to health care providers/insurers and shift ever higher costs to their employees. That is, employers' believe, as Bill reported, that they have the power or leverage to control their health care benefits destinies, but the reality – demonstrated over and over again over the decades – is they don't.

So, I would urge FTAC and UHCC to move expeditiously forward in designing a universal, unified health system plan, undeterred by the fictions of employer control. As you design this system, you should, however, formulate "the case" for persuading the business community that it should support, or at least not oppose, its enactment,

Tab 4

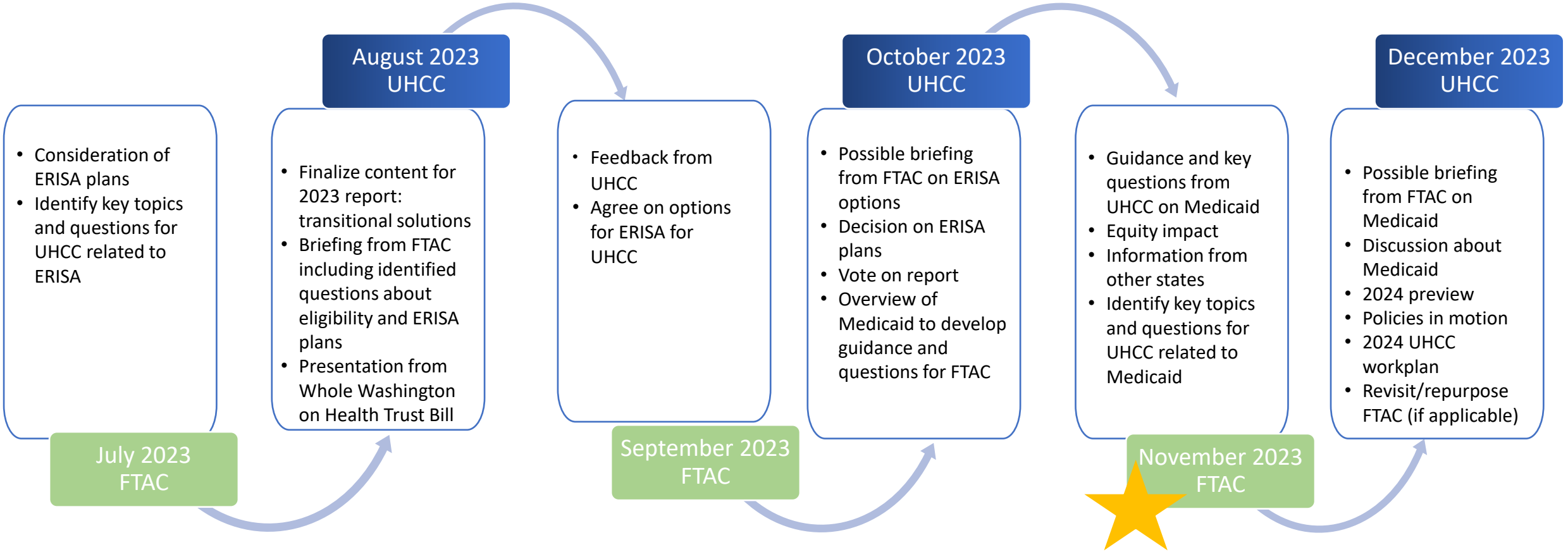
Washington State Health Care Authority

Washington's UHCC 2023 Workplan



Workplan will change depending on progress made in each meeting

Washington's UHCC 2023 Workplan



Workplan will change depending on progress made in each meeting

Updates from the Commission's October Meeting

- **ERISA recommendations**
  - Pam MacEwan, FTAC Liaison, shared with the Commission an overview of FTAC's examination of ERISA eligibility and FTAC's guidance.
  - The Commission agreed that ERISA should be revisited once additional elements of the system, such as the benefits and method(s) of provider reimbursement, have been developed by the Commission.
- **Transitional solutions**
  - FTAC's list of proposed ideas were shared with the Commission.
  - The Commission agreed to prioritize the following categories for further examination in 2024: Coverage/enrollment, Providers, and Purchasing
- **2024 workplan**
  - With the additional resources allocated to the Commission in the 2023 Operating Budget, the UHCC agreed to extend meetings to three hours and continue with the current bi-monthly cadence
    - Would FTAC like to do the same?
    - Morning or afternoon preference for meetings (given our east coast members)

Updates from the Commission's October 2023 Meeting

FTAC's ERISA recommendations

The Commission greatly appreciated FTAC's work to assess options to include employers (ERISA) in Washington's future universal health care system, as well as the development of the ERISA Memo. At the Commission's October meeting, Pam MacEwan, FTAC Liaison, summarized the six options assessed by FTAC at their September meeting.

- Some members expressed concerns with implementing a payroll tax on all employers regardless of whether they already offer benefits. This and other funding mechanisms will need to be revisited.
- Commission members agreed unanimously to take FTAC's guidance under advisement as they continue to design the larger system and will come back to ERISA once more design components have been addressed.

Guidance to FTAC on Medicaid

In addition to the revisions and adoptions on next steps for Medicare, the Commission was asked to revisit and refine questions they would like FTAC to explore regarding Medicaid. Below is a summary of the Commission's questions for FTAC to surface options to include Medicaid in Washington's universal system:

Questions from the Commission for FTAC to provide guidance:

- Does a comparison of benefits exist for Medicare, Medicaid, and Public Employee Benefits (PEB)?
- What have other states done (if anything) using 1115 waivers to expand eligibility?
- What are the main barriers to access and care for Medicaid enrollees (e.g., lower reimbursement rates)?
- What barriers exist with regards to Medicaid provider rate increases, (e.g., ongoing work to increase primary care rates)? Or, what can be used to increase provider rates?
- What federal barriers exist with regards to:
    - Asset limitations for enrollees of classic Medicaid?
    - Provider reimbursement?

Transitional solutions

FTAC's proposed ideas (part of a larger menu of options gathered from interviews with Commission members earlier this year) were shared with the Commission. Transitional solutions were grouped into the following categories: affordability/cost containment/pricing; capacity/infrastructure; coverage/enrollment; providers; purchasing; and subsidies. The Commission agreed to prioritize the following categories for further examination in 2024:

- Coverage/enrollment
- Providers
- Purchasing

The Commission selected these because many of the other categories under consideration were being addressed in other venues (e.g. Health Care Cost Transparency Board), and because these areas align with where the Commission anticipates making larger system design decisions.

Medicaid

Medicaid is jointly regulated and financed by federal and state governments, presenting barriers to ensuring that all Washingtonians receive the same level of benefits under a *state-based* universal system. As the Commission continues to develop design elements of the new system, they requested FTAC's guidance on options to include Medicaid enrollees in the system design.

UHCC guidance to FTAC & additional considerations

UHC goal: to increase access to quality and affordable health care by streamlining access to coverage, and to reduce fragmentation of health care financing, unnecessary administrative costs, and health disparities.

November – Begin discussions

- Richness of benefits for Medicaid compared to what may be covered under the new system
  - Does a comparison of benefits exist for Medicare, Medicaid, and Public Employee Benefits (PEB)?
- Provider reimbursement
  - What are the main barriers to access and care for Medicaid enrollees, e.g., lower reimbursement rates?
  - What barriers exist with regards to Medicaid provider rate increases, e.g., ongoing work to increase primary care rates? Or, what can be used to increase provider rates?
- Eligibility
  - What federal barriers exist with regards to:
    - Asset limitations for enrollees of classic Medicaid?

January – Deeper dive

- What other information/presentations will FTAC need at their January meeting for further discussion on this topic?
  - What have other states done (if anything) using 1115 waivers to expand eligibility?

Tab 5

Washington State Health Care Authority

Apple Health Enrollment Through Washington Healthplanfinder

Universal Health Care Commission's Financial Technical Advisory Committee

Joan Altman, (She/Her), Director of Government Affairs & Strategic Partnerships

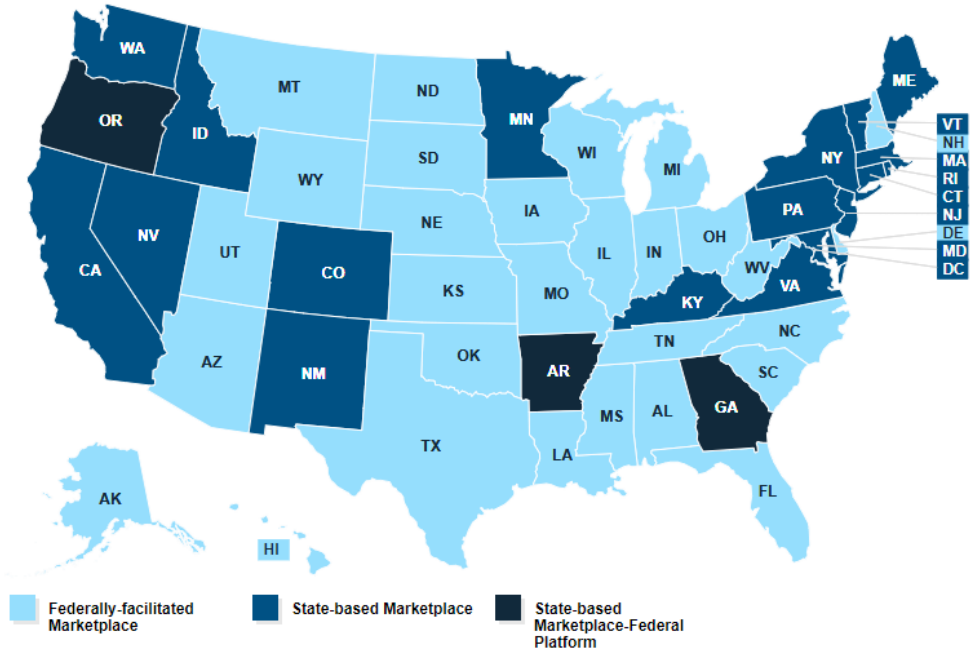
washington healthbenefitexchange
powering washington healthplanfinder

Topics

- Overview of the Exchange & *Washington Healthplanfinder* customers, including Medicaid-eligible Washingtonians
- How *Washington Healthplanfinder* supports Apple Health enrollment
- How *Washington Healthplanfinder* supports Medicaid Redeterminations

Washington State & Implementation of the Affordable Care Act (ACA)

- Under the ACA, Washington state expanded Medicaid up to 138% FPL and established a state-based marketplace
- Washington is one of 19 state-based marketplaces
- Washington is among just a handful of state-based marketplaces that have a streamlined application for both Medicaid and individual market coverage



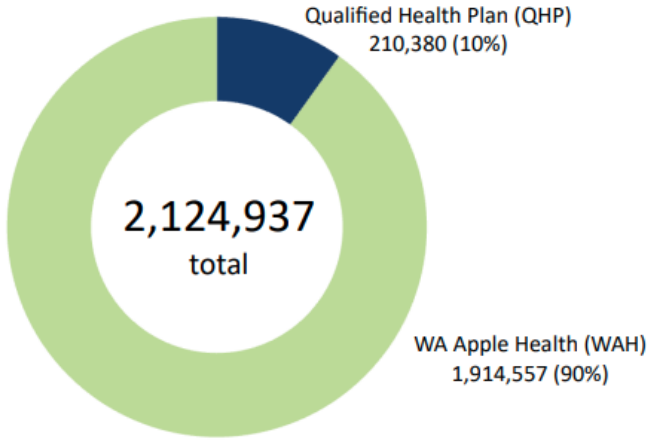
Source:
State Health Insurance Marketplace Types, 2023: https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/

Exchange & *Washington Healthplanfinder*

The Exchange operates *Washington Healthplanfinder*,
the state's integrated online health-insurance marketplace,
a Spokane Valley based customer support center,
and a statewide community-based assister network

Over 2 million people – 1 out of every 4 – Washingtonians use **www.wahealthplanfinder.org** to find coverage and access financial help that lowers health care costs

- **~2M Apple Health (Medicaid) customers**
- ~200k Qualified Health Plan (QHP) customers



As of Spring 2023 Enrollment Report

Washington Healthplanfinder connects Washington residents to available financial assistance and social service programs

- Apple Health programs
- Federal premium subsidies
- State premium subsidies (Cascade Care Savings)
- Premium assistance/sponsorship programs (Tribes, Project Access, EHIP, child care workers, etc.)

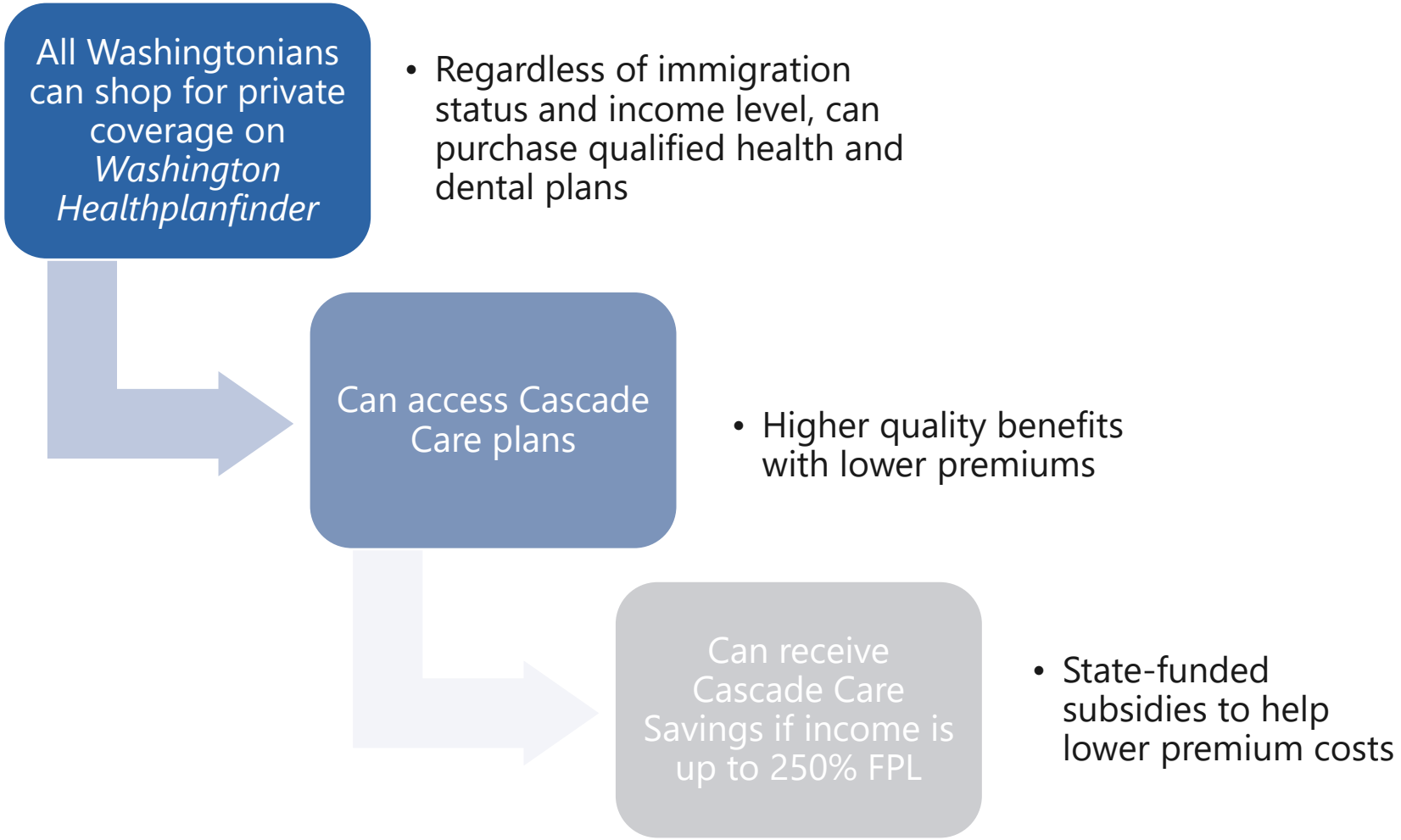
Washington Healthplanfinder Customers

Through *Washington Healthplanfinder* the Exchange*:*

- Connects individuals and families to Washington Apple Health (Medicaid) and individual market coverage - relied on by those losing their job; working for themselves or an employer that doesn't offer coverage; seasonally employed; and not yet eligible for Medicare

- Determines eligibility for Apple Health programs, facilitates Apple Health plan selection, automatic enrollment, renewals and notices
  - Washington Healthplanfinder generates related customer notices (request for information, termination/renewal, etc.) and processes renewals.
  - Apple Health/Medicaid enrollment and renewals occur year-round
  - Health Care Authority (HCA) administers Washington Apple Health programs

New Expansion - Started Nov. 1, 2023 for 2024 coverage



Expanding access to coverage through *Washington Healthplanfinder*

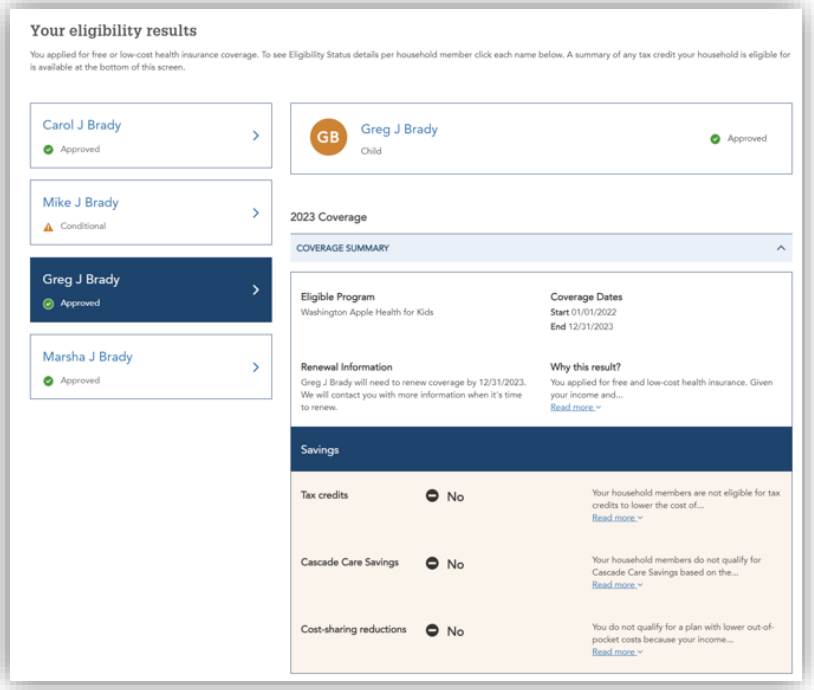
- At the direction of the Legislature, Washington applied and received approval for a Section 1332 State Innovation Waiver (1332 Waiver) in 2022.
- Washington's first-in-kind 1332 waiver eliminates the "lawfully present" requirement in the Affordable Care Act (ACA).
- Under the 1332 waiver, starting Nov. 1, 2023, all Washington residents, regardless of immigration status, will be able to access health and dental coverage through *Washington Healthplanfinder* for plan year 2024.
- The section of the ACA that prevents people who are undocumented from accessing federal premium tax credits and cost sharing reductions could not be waived.

Expanding access to coverage through *Washington Healthplanfinder*

- In 2023, the Legislature directed the Health Care Authority to expand Apple Health (Medicaid) coverage to residents who meet income requirements regardless of immigration status.
- Coverage under Apple Health expansion will start **July 1, 2024**.
- Premiums and cost-sharing are $0 under this new program.
- Enrollment will be limited based on current funding levels.

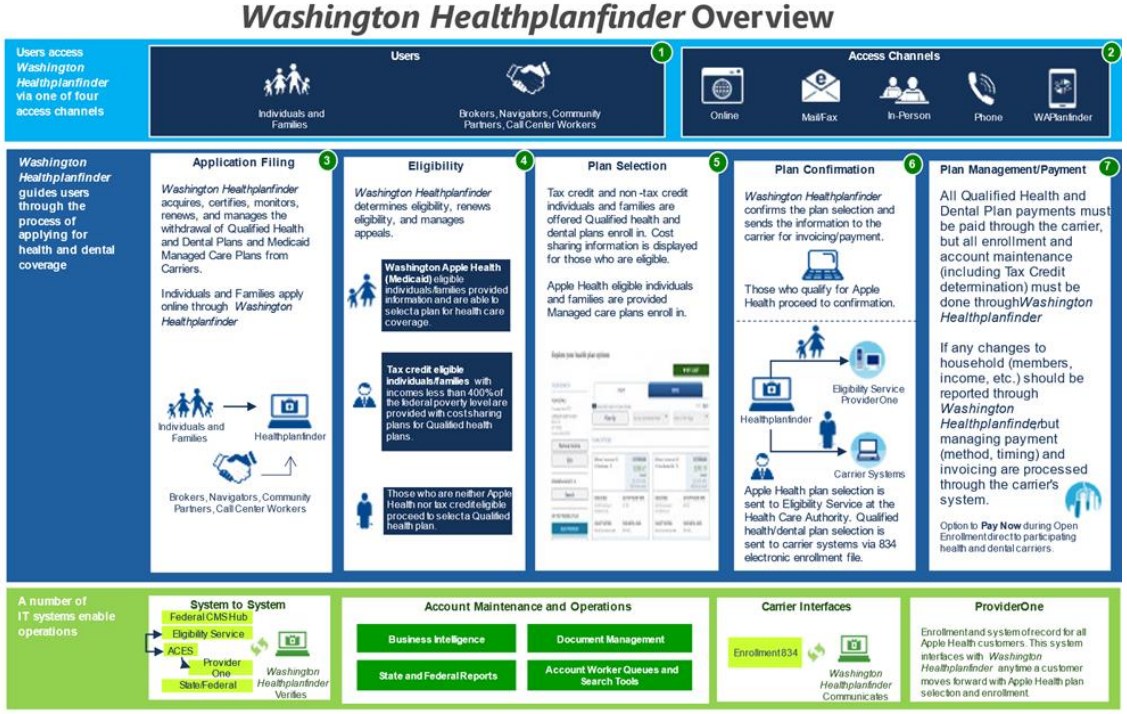
Shopping for Coverage – Apple Health (Medicaid)

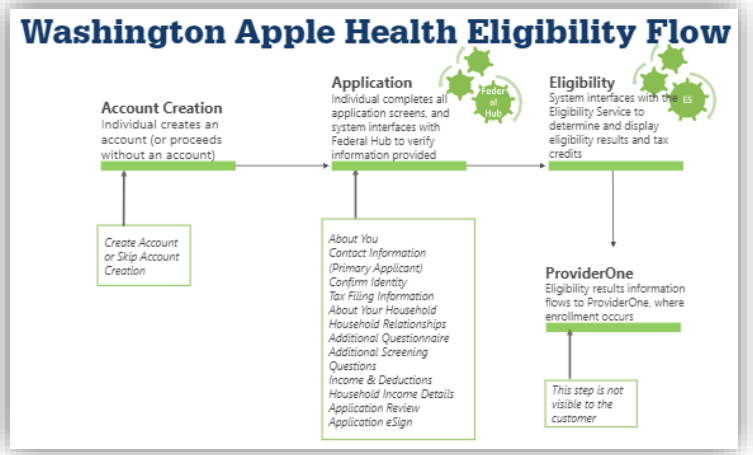
- *Washington Healthplanfinder* screens for multiple Apple Health programs
- Household members with mixed program eligibility are each enrolled into the applicable program
- Apple Health customers who do not select a Medicaid plan are automatically enrolled



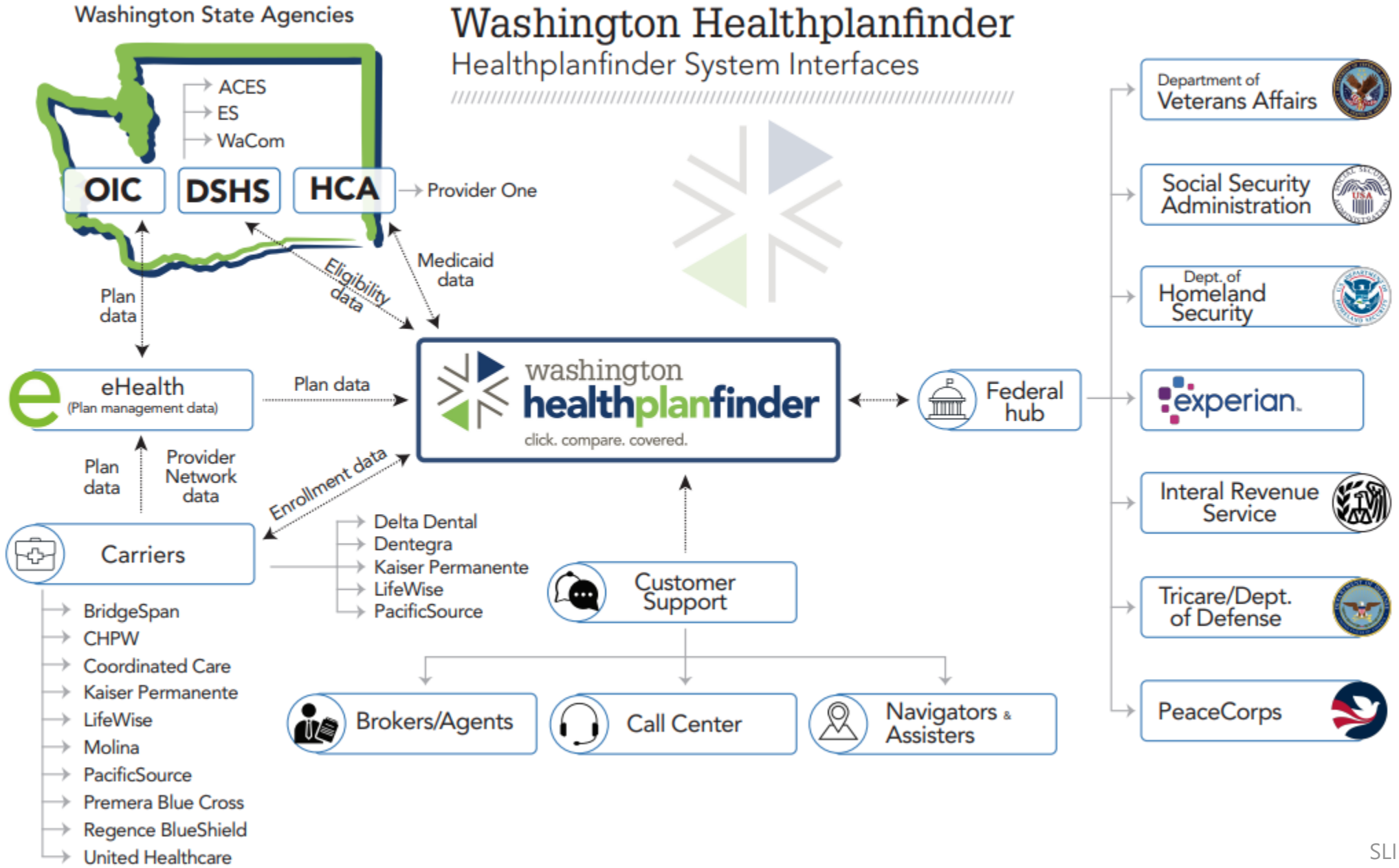
What sits behind externally facing HPF features

- Extensive security and privacy measures (e.g., identity proofing, cybersecurity)
- Account management
- Real-time eligibility and verifications (e.g., SSN, citizenship, lawful presence, incarceration, household income, minimum essential coverage)
- Integrations with multiple federal and state databases, and external data partners
- Separate eligibility determinations for each household member seeking coverage on one application
- Rules to determine countable v. not countable income
- Rules and functionality to redetermine eligibility
- Triggers to generate all applicable notices
- Document upload functionality
- Technology to support compatibility with mobile devices/tablets and assistive devices
- Tribal policy/exceptions
- Referrals to sister agencies (WaConn supported programs, voter registration, etc.)
- User testing
- Data storage and monitoring
- Compliance and audit activities
- Flexibility to quickly responding to federal and state changes





Real-time Elibility & Verification

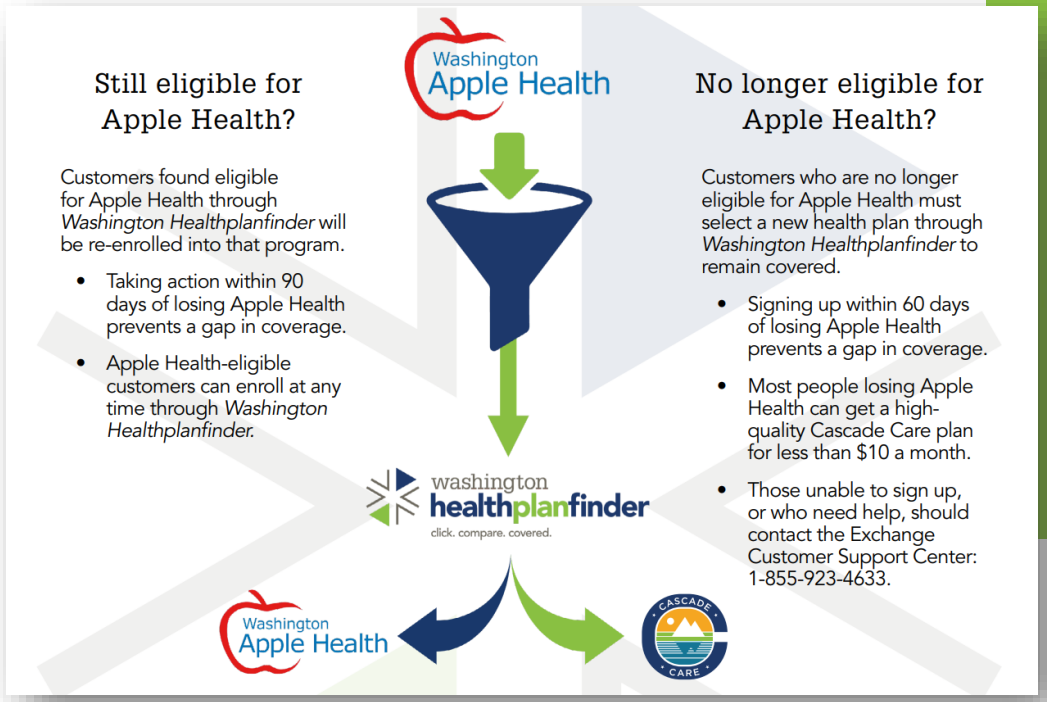


Supporting Medicaid Redeterminations

Keeping people covered during the Medicaid transitions

- Washington Healthplanfinder determines eligibility for Apple Health programs, facilitates Apple Health plan selection, automatic enrollment, generates related customer notices (request for information, termination/renewal, etc.) and processes renewals.

- Health Care Authority, the Exchange, carrier and outreach partners reach out to customers before they lose Apple Health coverage, to encourage them to take needed actions.



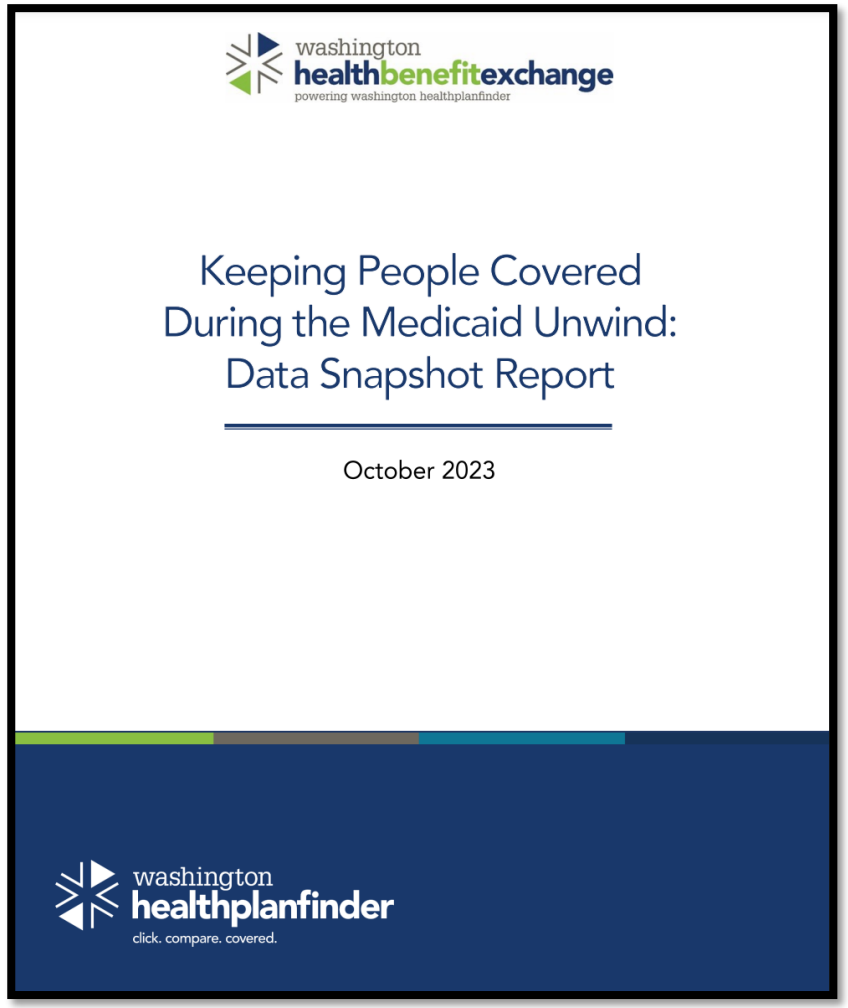
Keeping people covered during the Medicaid Unwind

Connecting customers to coverage

- 107,000 of those who lost Apple Health from April 1 through Aug. 31 have regained coverage through *Washington Healthplanfinder*
- 90% of those who returned to Apple Health or transitioned to QHP coverage had no gap in coverage.

Historically High uptake among QHP eligible customers

- Customers selecting a QHP following the end of their Apple Health coverage is nearly 60% higher than pre-public health emergency
    - Higher QHP uptake among customers who are younger, Hispanic, and non-white, compared to existing QHP customers



Keeping People Covered During the Medicaid Unwind: Data Snapshot Report (October 2023)

What is behind the successful coverage transitions during the Unwind

Integrated platform for Apple Health and QHP keeps people in coverage

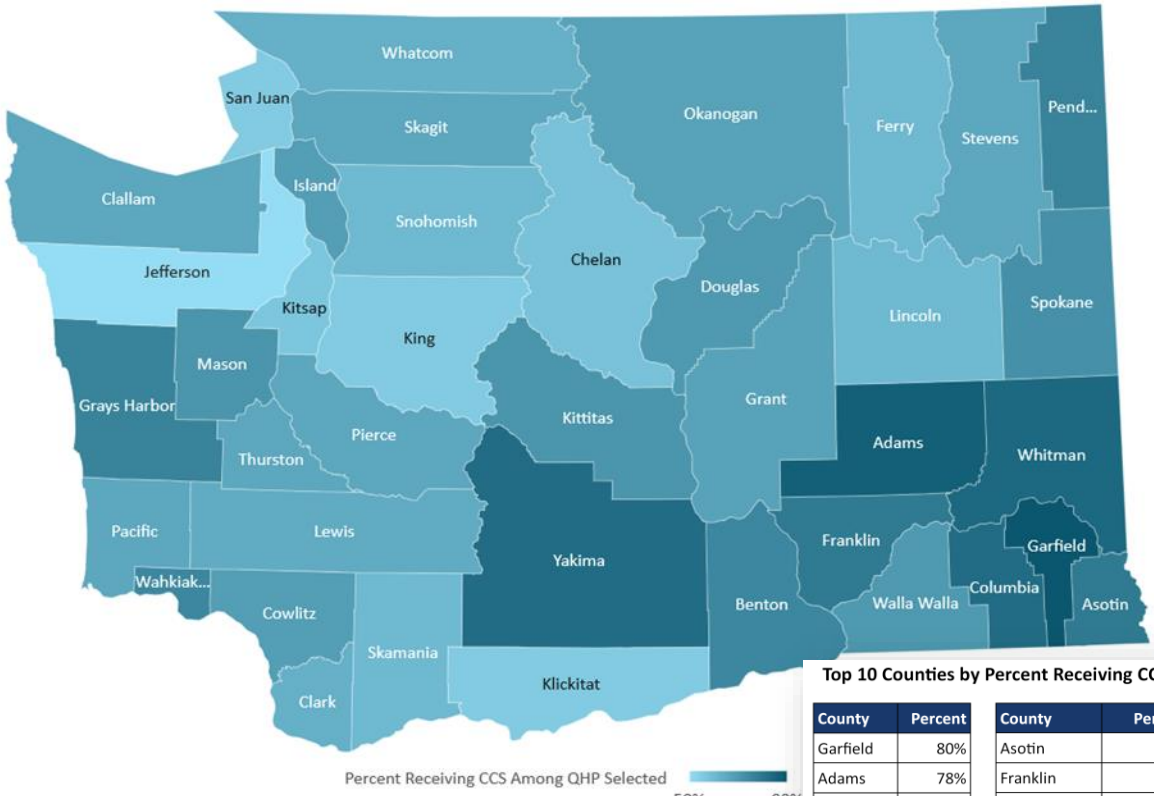
Federal and state premium subsidies help customers transition from Apple Health to QHPs

- 87% are receiving federal subsidies to reduce cost of coverage
- Over 60% are receiving Cascade Care Savings (state subsidies for those <250% FPL).

Data-driven outreach generating significant increases in call center and website activity

- *Washington Healthplanfinder* web traffic up 50% compared to August – April 2022
- Call Center volume up 50%
- Grassroots assister network of over 3,000 brokers, navigators and Tribal assisters across the state

Cascade Care Savings helps former Apple Health Customers



Top 10 Counties by Percent Receiving CCS

County	Percent
Garfield	80%
Adams	78%
Whitman	76%
Columbia	75%
Yakima	75%

County	Percent
Asotin	72%
Franklin	72%
Grays Harbor	70%
Pend Oreille	70%
Benton	69%

Questions?

Joan Altman
Director of Government Affairs & Strategic Partnerships
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Washington Healthplanfinder

waplanfinder

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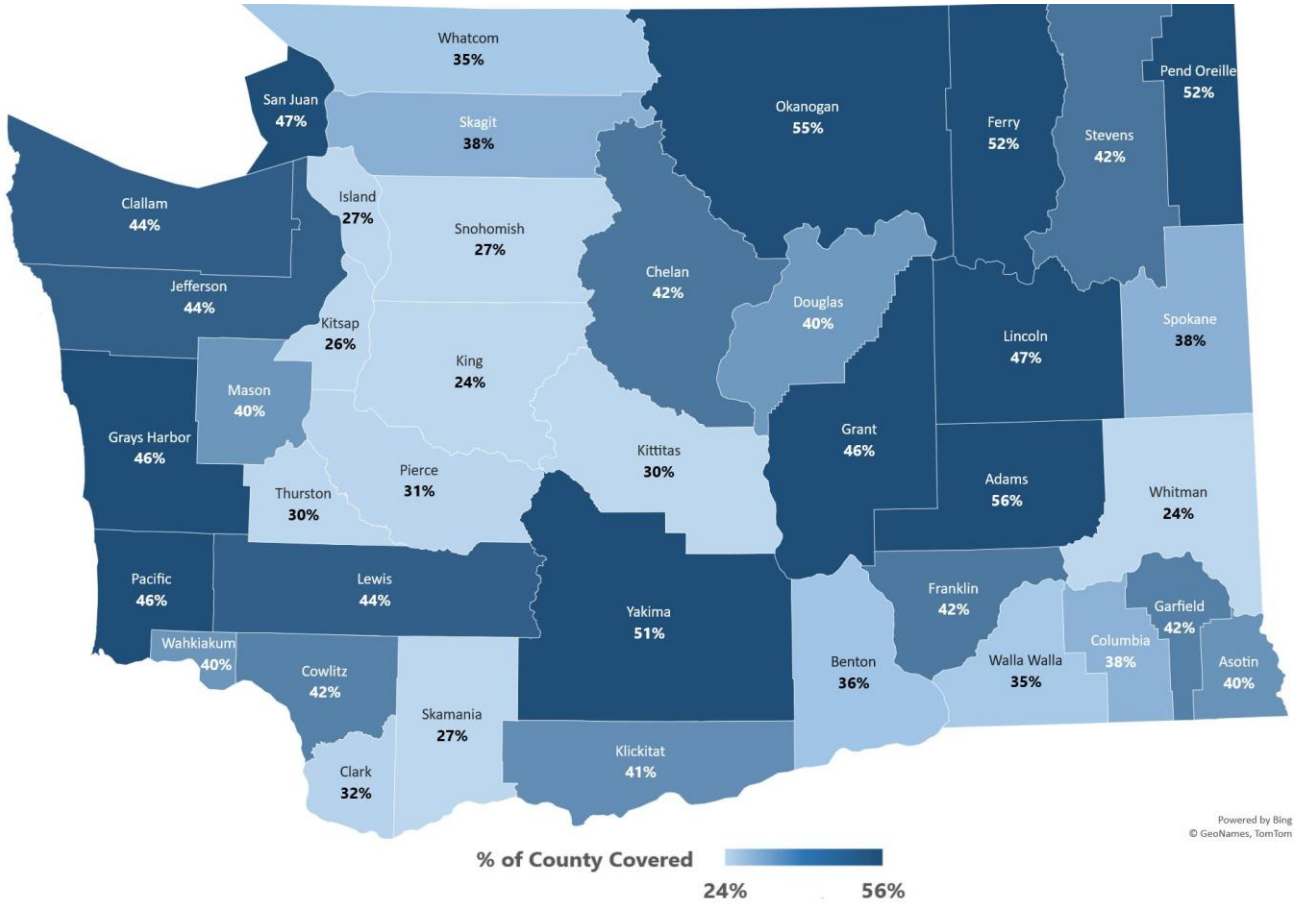
Appendix

Washington Healthplanfinder Customers by County

Top 10 Counties	**Adams**	**56%**
	Okanogan	**55%**
	Pend Oreille	**52%**
	Ferry	**52%**
	Yakima	**51%**
	Lincoln	**47%**
	San Juan	**47%**
	Pacific	**46%**
	Grant	**46%**
	Grays Harbor	**46%**



31% of Washingtonians (<65 years old) receive their health coverage through *Washington Healthplanfinder (*Medicaid + QHP*);* in several counties it is closer to 50%

Washington Healthplanfinder Customers

Through *Washington Healthplanfinder* the Exchange:

- Connects customers to OIC approved and Exchange Board certified health and dental plans (QHPs/QDPs) and available federal and state financial assistance
  - Strong and stable carrier participation (12 health carriers and 5 dental carriers for 2023)
  - QHP enrollment primarily occurs during annual open-enrollment period (Nov 1 – Jan 15)
- Helps facilitate continuous coverage for those who churn between individual market and Apple Health coverage
- Refers potentially eligible customers to other available social service programs

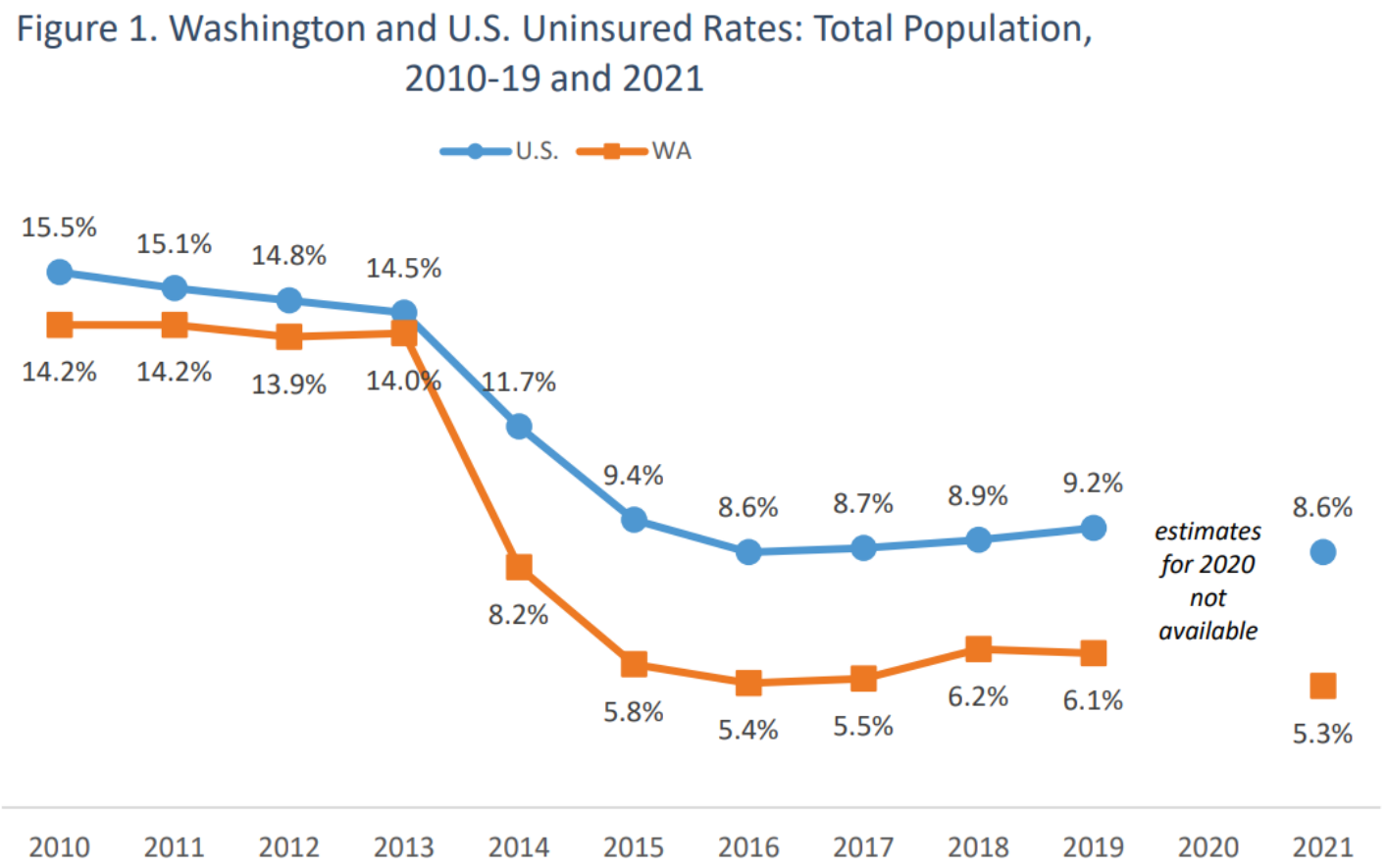
bridgespan
MOLINA HEALTHCARE
Regence
United Healthcare
PREMERA BLUE CROSS
LifeWise
COMMUNITY HEALTH PLAN of Washington™
KAISER PERMANENTE®
coordinated care
PacificSource HEALTH PLANS

Washington Apple Health

Washington Healthplanfinder (HPF)

What is Washington Healthplanfinder and how do I use it? - YouTube

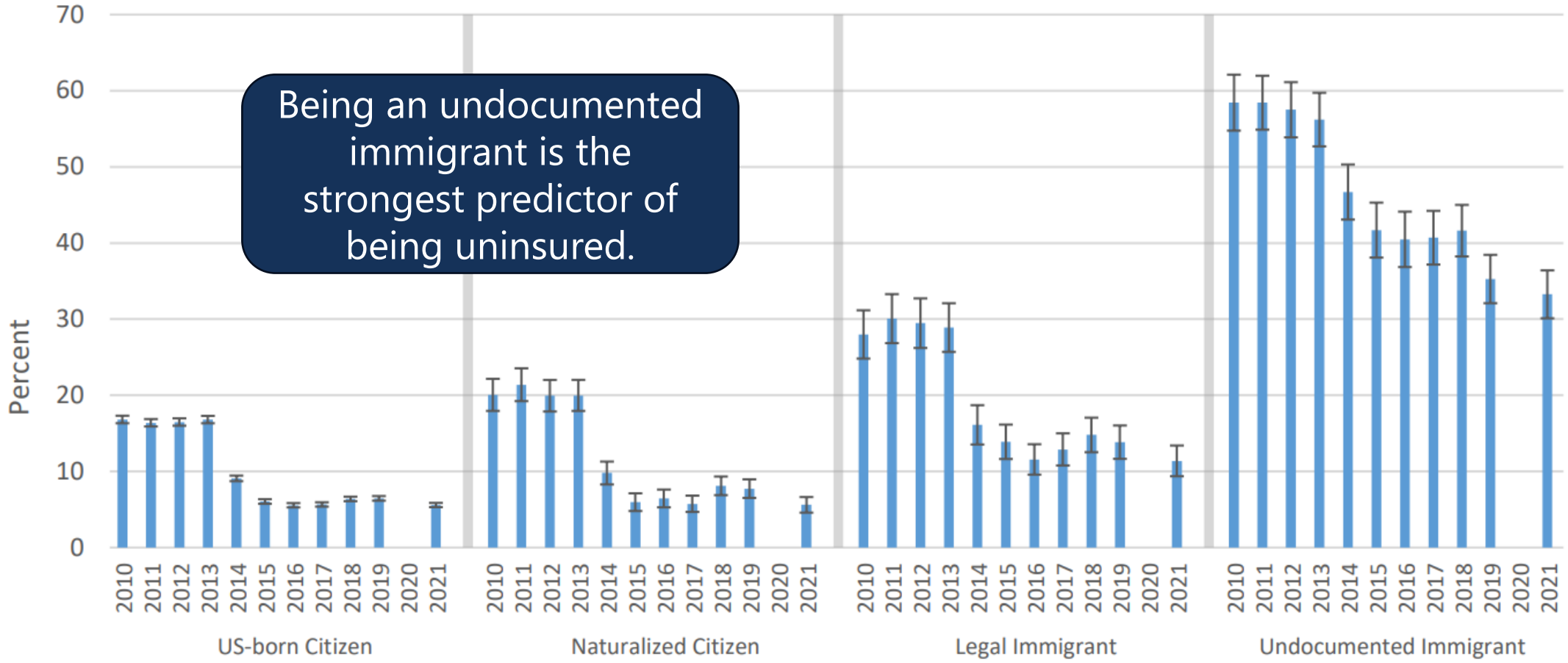
Significant Reduction in Statewide Uninsured Rate Since Exchange Launch



Source:
OFM Health Care Research Center (Brief No.108): https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief108.pdf

Who are the remaining Uninsured in Washington?

Figure 2. Percentage uninsured in population age 18-64 by immigration status: 2010-21, Washington



Data Source: Office of Financial Management Research Brief No. 112 (August 2023), Washington's non-citizen immigrant population continued to experience disparities in health coverage available at: https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief112.pdf

Official Website: wahealthplanfinder.org (English & Spanish)

Customer Support

Call us at

1-855-923-4633
1-855-WAFINDER

Support in 200+ languages

Visit us at

wahealthplanfinder.org

Download the

WAPlanfinder app

Free Enrollment Assistance Available Statewide

To connect with an **Assister**, visit Wahealthplanfinder.org and click "Help Center."
From here, you can search for a navigator or broker in your community

To connect with the ***Washington Healthplanfinder*** **Customer Support Center,**
call: 1-855-923-4633; TTY: 855-627-9604 (language assistance available in 240+ languages)

750+ Navigators & Certified Application Counselors

90+ Tribal Assisters

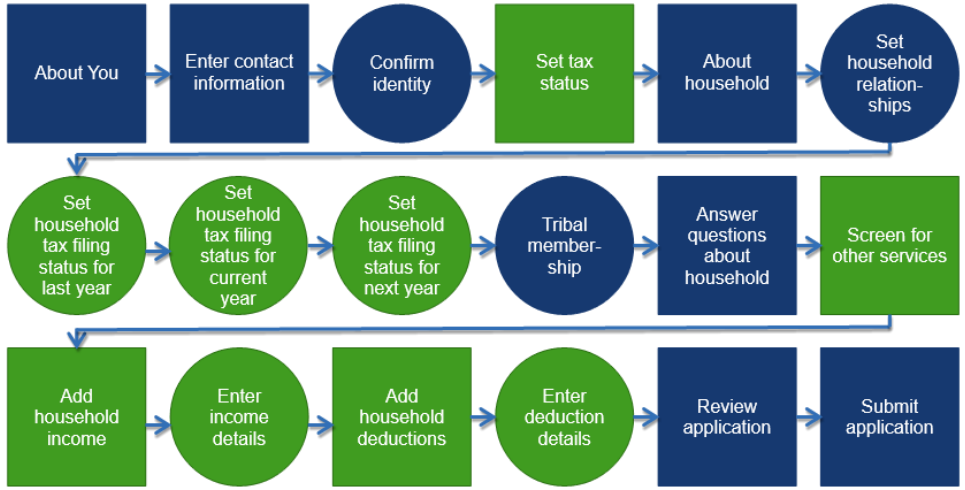
2000+ Certified Producers

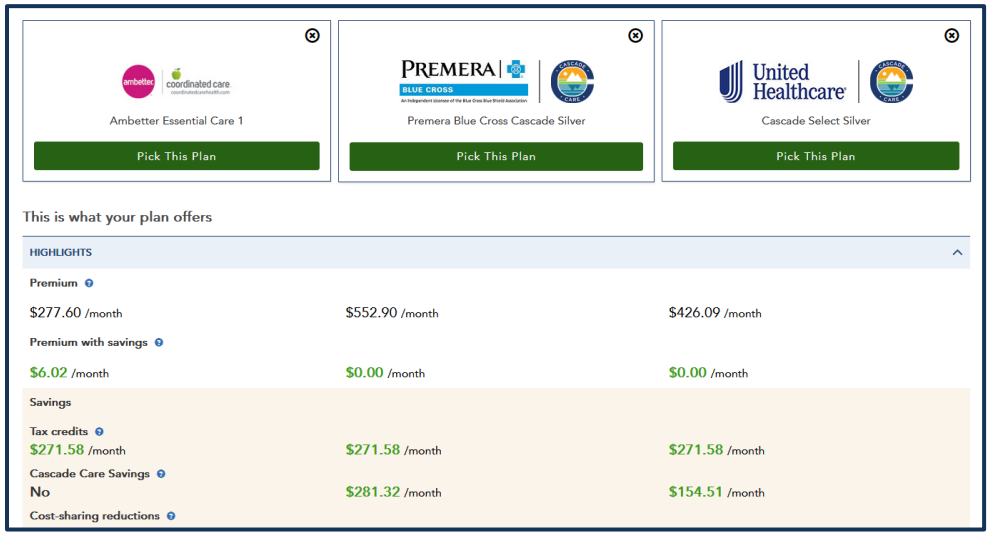
10 Enrollment Centers

Shopping for Coverage

- **Applying for health coverage can be challenging – on screen prompts, field level help, and decision support tools are provided, in addition to free 1-1 assistance.**

- **Key shopping features**
  - Smart Planfinder (displays ‘Smart Choices’ based on information consumer provides about utilization and preferred providers)
  - Plan Compare (provides side-by-side comparison for up to 3 plans)
  - Cascade Care (logo appears next to relevant plans for easy identification)





Cascade Care is the Exchange's Primary Affordability Initiative

Increase the availability of quality, affordable health coverage in the individual market.

- **Address costs** through lower premiums, lower deductibles, and access to services before having to pay the deductible. This includes leveraging federal and state-based financial assistance, state purchasing power, and provider reimbursement expectations.
- **Encourage meaningful consumer choice** with products of better value and like benefits across all participating carriers.
- **Grow enrollment** by attracting new enrollees and retaining current customers.
- **Ensure continued market health** through stable carrier participation, competitive product offerings, and a larger and more diverse risk pool.

Driving affordability through Cascade Care

2019: Cascade Care 1.0

- Cascade Care is created, providing new coverage options available through *Washington Healthplanfinder*:
  - **Standard Plans** (Cascade) designed by HBE to have the same benefit design & lower cost sharing for easy comparison and better value.
  - **Public Option Plans** (Cascade Select) standard plans procured by HCA that include additional quality, value, and provider reimbursement expectations.
- The Exchange is directed to develop a plan to implement a state premium assistance program and analyze the impact of offering only standard plans beginning in 2025.

2021: Cascade Care 2.0 & 1332 Waiver

- Improvements are made to Cascade Care by:
  - Limiting the number of non-Cascade plans carriers could offer on the Exchange.
  - Requiring public option participation by hospital systems participating in other public programs.
- The Exchange is directed to establish a state premium assistance program (Cascade Care Savings) in 2023, with an initial annual funding level of $50 million.
- The Exchange is directed to explore coverage solutions for individuals without a federally recognized immigration status (1332 Waiver) beginning in 2024.

2023: Sustained CC$ & Waiver Study

- Cascade Care Savings funding is sustained at $50 million annually, with an additional $5 million annually to provide subsidies to new customers under the 1332 Waiver.
- The Exchange is directed to conduct a study on how the 1332 Waiver could be amended to generate federal pass-through funding to support Exchange affordability programs.

Driving affordability through Cascade Care

Maximum PY 2024 Cascade Care Saving Amounts

- Customers that are federally subsidized: $155
- Customers that are not federally subsidized: $250

Illustrative Examples - PY 2024 Cascade Care Savings Amounts

	Federally Subsidized	Not Federally Subsidized
Premium	$378	$378
APTC	$366	N/A
Cascade Care Savings	$12	$250
Net Premium	$0	$128

- 35-year-old customer.
- Their annual income of $24,588 makes them eligible for state subsidies.
- Enrolled in a CHPW Silver Public Option plan.

Driving affordability through Cascade Care

Upcoming Legislative Reports

Public Option Impacts

- Exchange report about the impact of public option on hospital financial sustainability.
- Health Care Cost Transparency Board report about the impact of public option on consumers.
- Based on above analyses, Exchange recommendations to the Legislature about how to address public option financial or other issues.

Offering Only Cascade Care Plans

- Analyze impact to Exchange customers of offering only Cascade Care (standard & public option) plans on the Exchange starting in 2025.

1332 Waiver Pass Through Study

- Assess waiver amendment(s) to capture federal pass-through funding to support affordability programs, focusing on methods being used in other states that could be most readily leveraged in Washington.

Subsidies Support Customer Transitions to Marketplace

A 32-year-old Spokane resident makes $31,320 a year (230% FPL). They were on an Apple Health Coordinated Care plan and enrolled in Coordinated Care Public Option plan when their eligibility was redetermined.

2024 Public Option Silver Plan	Customer Out-of-Pocket Costs
Total Premium	$356
Federal premium subsidies (APTC)	-$289
State premium subsidies (Cascade Care Savings)	-$63
Monthly Net Premium	**$4**
Deductible	$2,500
Primary Care Visits (4; copay before deductible)	$62
Generic Medication Annual Supply (12 fills; copay before deductible)	$288
Total customer out-of-pocket costs in 2024	**$398**

Customer also qualifies for federal cost-sharing reduction subsidies for those up to 250% FPL that help lower out-of-pocket costs.

WWW.WAHEALTHPLANFINDER.ORG | WWW.WAHBEXCHANGE.ORG

Health Care Authority
Medicaid (Apple Health) Enrollment

November 09, 2023

Washington State Health Care Authority

Washington Apple Health

- Health Care Authority (HCA) is the state agency for the policy and purchasing of all Apple Health (Medicaid) programs in Washington State.
- For the purposes of eligibility, Apple Health is divided into Classic Medical Programs and MAGI-based Medical Programs.
- MAGI stands for modified adjusted gross income. This is how income is calculated to determine eligibility.

Application processes
MAGI-based and classic Medicaid

- No wrong door
- Calls can be transferred w/in HCA and HBE
- Systems communicate w/in DSHS/HCA/HBE

Criteria	MAGI-Based	Classic
AGE	0 – 64 years	65 years and older, Medicare, disability or blindness
How to apply	Online through: • Washington Healthplanfinder or; • By phone • In-person w/Navigator	Online through: • Washington Connections or; • In person at a local DSHS office or; • Call and request an interview over the phone
Eligibility process	• Real-time results • Can choose Manage Care Plan or system auto-enrolls • Client can call or go online to change plan	Data entry done by DSHS staff: • Can get real time results • If more information is needed case will pend.
Call Center	• HBE trouble shoot online application • Eligibility questions, calls are transferred to HCA • Can call HCA directly and get answers on billing, eligibility, resources	DSHS

Washington State Health Care Authority

MAGI application process

- Eligibility for MAGI-based programs is determined by client attestation with a post-eligibility review.
- Eligibility criteria are cross-matched with state and federal data sources.
- Clients will need to verify criteria that is unverified or income that is found non-compatible.
  - HCA eligibility staff manually verify eligibility.

MAGI application process

- Applications accepted year-round.
- Individuals who are found eligible for Apple Health are approved for a one-year period unless they are:
  - Found ineligible during a post-eligibility review
  - Turning 19 years or 65 years old or start to receive Medicare
  - Eligible for less than 12 months of After-Pregnancy Coverage
  - Eligible for a Classic Medicaid program
  - Not a Washington State resident; or meet specific eligibility criteria for the program they were approved.

Apply for MAGI Apple Health

- Most individuals applying for Apple Health coverage apply for a MAGI-based medical program:
  - Adults age 19 to 64 years old
  - Children
  - Parent or caretaker with children
  - Pregnant or applying for someone who is pregnant
- Applications for these programs can be submitted:
  - Online: wahealthplanfinder.org;
  - Phone: 1-855-923-4633;
  - Mobile application: WAPlanfinder;
  - Fax: 1-855-867-4467; or
  - Mail: PO Box 946, Olympia WA 98507.
- Eligibility criteria varies for each program and is based on household size, tax filing status, and income (not resources).

Classic Apple Health

Washington State Health Care Authority

Apple Health Classic

- HCA contracts with the Department of Social and Health Services (DSHS), to administer some Apple Health programs for individuals who are age 65 and older or have blindness or a disability. These programs are referred to as Apple Health Classic (Medicaid) programs.
- Individuals applying for Apple Health Classic programs submit applications through the Washington Connection application portal.
- Eligibility criteria varies for each program and is based on household size, income, and meeting the resources requirement.
  - Medicare Savings Programs (MSP) does not have a resource or asset test.

Apply for Apple Health Classic

- Individuals 65 years or older, who have blindness or a disability, and receive Medicare, apply for Apple Health Classic coverage:
  - Online: Go to washingtonconnection.org/home/ - select the "Apply Now" button.
  - Paper: Submit an *Application for Aged Blind Disabled or Long-Term Services and Support (HCA 18-005).
  - Phone: Request an application by calling 1-877-501-2233.
  - In-person: local community services office.
  - Free interpreter services are available.

*Source: hca.wa.gov/assets/free-or-low-cost/18-005.pdf

Enrollment

Washington State Health Care Authority

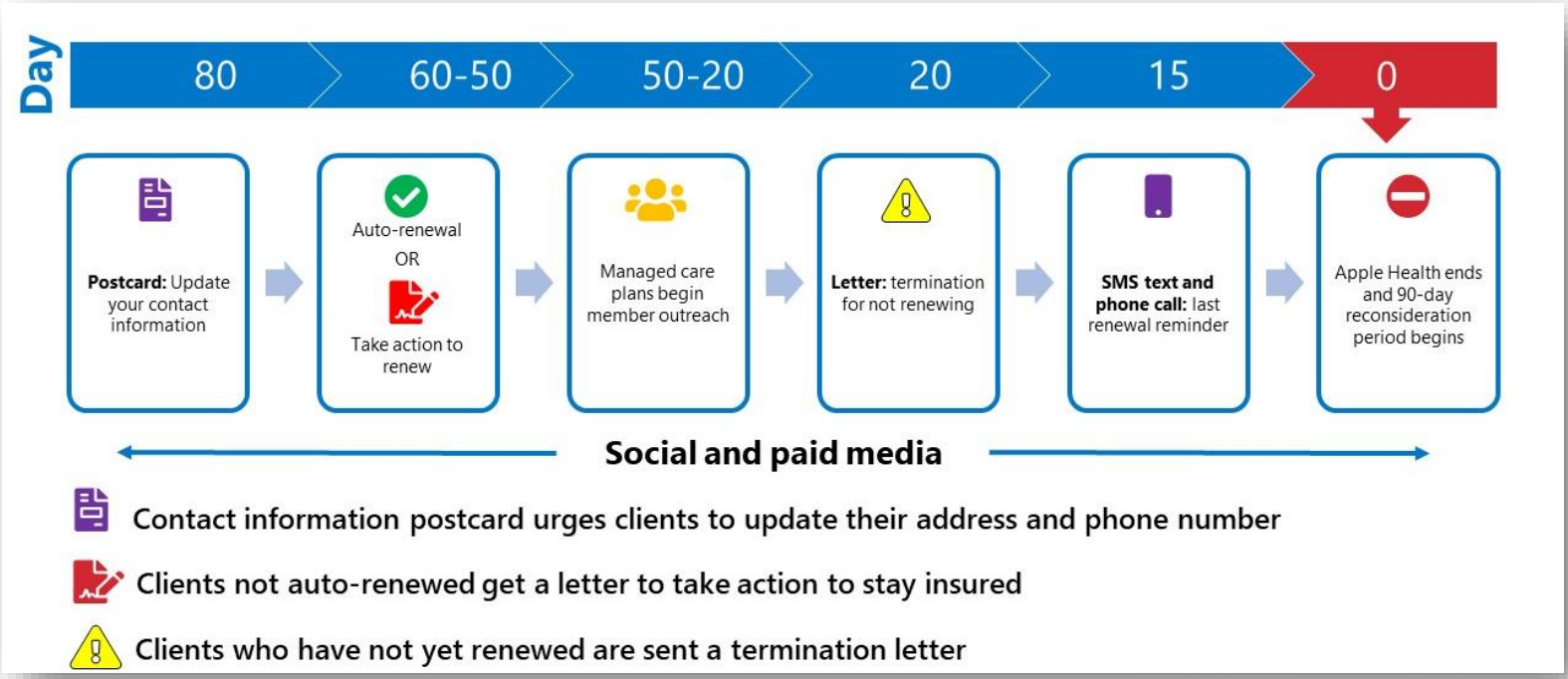
Redeterminations

- Normal operations after the public health emergency began April 1, 2023, notifying clients when it is time to renew their coverage.
- Clients are notified by mail prior to the end of their renewal period.
  - This is an ongoing process.
  - All clients have the opportunity to renew their coverage prior to any closure or transition of coverage.
  - Clients have up to 90 days after coverage ends to complete their renewal and be reinstated without a gap in coverage.

Ongoing redeterminations

- Outreach efforts to reach individuals regarding their coverage starts months ahead by sending them a postcard, letters, phone calls and text messages.
- Individuals terminated may have other coverage options:
  - Qualified Health Plans with financial help to lower their premiums
  - Enroll in Medicare via Special Enrollment Period
  - Employer-sponsored insurance (ESI)
- Data: http://hca.wa.gov/assets/free-or-low-cost/apple-health-phe-unwind-enrollment-data.pdf

Renewal campaign



Questions?

Washington State Health Care Authority

Tab 6

Washington State Health Care Authority

Understanding Washington's Medicaid Program & Opportunities for Universal Health Care

Presentation to the November 9, 2023, FTAC Meeting

Roger Gantz
Finance Technical Advisor Committee Member

[This overview brief draws upon the author's analysis and other sources noted. All conclusions and opinions are those of the author, and not the Universal Health Care Commission's Finance Technical Advisory Committee.]

Overview of Presentation

- Medicaid Program Overview
- Federal & Washington State Medicaid Eligibility
- Federal & Washington State Medicaid Benefits
- Medicaid Premiums & Point-of-Service Cost Sharing
- Federal & Washington State Medicaid Reimbursement
- Washington's Medicaid Service Delivery Systems
- Key Takeaways

- Appendix 1 – Washington State Program Eligibility
- Appendix 2 – Washington's Medicaid By Service Expenditures
- Appendix 3 – 1915 Type Waivers
- Appendix 4 – Washington's 1915 Waivers
- Appendix 5 - 1115 Demonstration & Research Waivers
- Appendix 6 – Washington's 1115 Waivers
- Appendix 7 – Payment Rate Comparisons

Washington's Medical Assistance Programs

Federally Funded

- **Medicaid (Title XIX): Federal** program that provides health coverage to low-income adults, children, pregnant women, elderly adults, and people with disabilities. Long-term care services are also available to elderly adults, and people with disabilities.
- **Children's Health Insurance Program (CHIP): Federal** program that provides health coverage for children in families with incomes above a state's Medicaid coverage for children.

State Funded

- **Children's Health Program (CHP):** State-funded program that provides health coverage for children who are not eligible for Medicaid or CHIP due to their citizenship status.
- **Immigrant Health Program:** New state-funded program that will provide health coverage for adults who are not eligible for Medicaid due to their citizenship status.
- **Medical Care Services (MCS):** State-funded program that provides coverage to adults who are not eligible for Medicaid but otherwise meet eligible for either Aged, Blind or Disabled coverage, housing assistance needs program, or survivors of certain crimes programs.

Apple Health is the name of Washington's Medicaid and CHIP programs.

Medicaid Program[1]

- The nation's publicly-funded health insurance program for people with low income
- Covers more than 1 in 5 Americans and covers 21% of all health insured enrolled Washingtonians.
- Principal source of long-term care coverage for people in the U.S.
- Provides coverage for low-income Medicare beneficiaries to help pay for premiums, cost sharing, and provides wraparound coverage for services not covered by Medicare, e.g., long-term services and supports.[1]
- Enacted as part of the Social Security Amendments of 1965 (P.L. 89-97), the same legislation that created Medicare.
- Like Medicare, Medicaid is an entitlement program.
- A voluntary program – All 50 states, 5 US territories and DC participate.
- Eligible individuals have rights to payment for medically necessary health care services defined in statute; the federal government is obligated to fund a share of the outlays for those services.

1 Rudowitz, Garfield, Hinton, "10 Things to Know about Medicaid: Setting the Facts Straight", Kaiser Family Foundation (June 30, 2023).

[2] For nearly 1 in 5 Medicare beneficiaries.

Medicaid Program

Joint Federal/State Administered Program – Federal Gov't has a Role

- Medicaid is jointly financed by the federal government and states and administered by states within broad federal guideline.
- The Centers for Medicare & Medicaid Services' (CMS) Center for Medicaid and CHIP Services is the lead federal agency.
    - CMS provides administrative guidance to states through the State Medicaid Manual, State Medicaid Director and State Health Official Letters, and other materials.
- The Single State Agency (SSA) is the lead agency in each State or jurisdiction responsible for managing federal funds dedicated to addressing substance use prevention, treatment, and recovery. In Washington, that agency is the Health Care Authority.
- Contract between CMS and states is called the State Plan which contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for federal financial participation (FFP) in the state program.

Medicaid Program

Financing through Matching Funds

- The federal government reimburses states for a percentage of Medicaid allowable costs.
- The basic percentage of federal financial participation is the "Federal Medical Assistance (FMAP).
- The FMAP is computed by a formula that considers the average per capita income for each State relative to the national average.
- By law, the FMAP cannot be less than 50% nor more than 83%.
- Washington's current FMAP is 50%.

Special Medicaid Federal Financial Participation Rates	
Medicaid Activity	Federal Matching Rate
Indian Health Services & Tribal Clinic Services	100 percent
ACA expansion for adults up to 138 percent FPL	90 percent
Family Planning Services	90 percent
Breast & Cervical Cancer Program	65 percent
General administration [1]	50 percent
General Medicaid eligibility determination [1]	50 percent
Activates conducted by skilled medical personal [1]	75 percent
Operations of Medical Management Information System (MMIS) [1]	75 percent
Implementation of an MMIS [1]	90 percent
Source: The adminstrative FMAP rates are from MACPAC's Federal Match Rates for Administrative Activies chart. https://www.macpac.gov/federal-match-rates-for-medicaid-administrative-activities/	

This table shows other matching rates that apply to certain program and administrative costs.

Medicaid Program
Eligibility

To receive federal funding, states must cover certain "mandatory" populations:

- Children through age 18 in families with income below 138% FPL;
- Certain parents or caretakers with very low income;
- People who are pregnant and have income below 138% FPL;
- Seniors and people with disabilities who receive cash assistance through the Supplemental Security Income (SSI) program.

States may also receive federal Medicaid funds to cover "optional" populations. These include:

- Adults and children in the groups listed above whose income exceeds the limits for "mandatory" coverage;
- Seniors and people with disabilities not receiving SSI and with income below the poverty line;
- "Medically needy"[1] people and other people with higher income who need long-term services and supports;
- With the ACA expansion, non-disabled adults with income below 138% FPL,, including those without children.

[1] Those whose income exceeds the state's regular Medicaid eligibility limit but who have high medical expenses, such as for nursing home care, that reduce their disposable income below the eligibility limit.

Washington's Medicaid Program

Eligibility[1]

- Appendix 1 is a detailed list of Washington's 22 Medicaid eligibility and non-Medicaid programs eligibility standard.
- Washington's asset/resource eligibility requirements only apply to Categorically Needy (CN) and Medically Needy (MN) aged, blind and disabled coverage for long-care and support services. [1]
- Washington has the 15th highest income level (215% FPL) for Medicaid eligible children among states and the 4th highest (317% FPL) for CHIP children.[2]
- Washington has the 38th highest income level (198% FPL) for pregnant women, third highest (138% FPL) for adults, and 26th highest (75% FPL) for elderly and disabled adults. [3]

MEDICAL ASSISTANCE ELIGIBILITY CATEGORY COUNT - AUGUST 2023

Medical Assistance Eligibility Category	Non-Duals	Duals	Total	%Total
Medicaid Program				
CN Children	805,919	28	805,947	38.3%
ACA Expansion Low Income Adults	726,182	1,388	727,570	34.6%
CN Family Medical	145,004	1,061	146,065	6.9%
CN Blind/Disabled	85,491	48,061	133,552	6.3%
CN Aged	4,964	92,497	97,461	4.6%
Medicare Savings Program/QMB Only	0	35,060	35,060	1.7%
Medicare Savings Program/QDWI, QI, SLMB Only	0	33,374	33,374	1.6%
CN Pregnant Women	14,147	24	14,171	0.7%
MN Aged	120	3,843	3,963	0.2%
CN Children Other - Foster Care @ Ages 18 < 26	2,659	11	2,670	0.1%
Family Planning Services Only; Not Federally Qualifie	2,205	0	2,205	0.1%
CN HWD (Ticket to Work)	391	1,430	1,821	0.1%
MN Blind/Disabled	47	1,657	1,704	0.1%
Alien Emergency Medical (AEM)	956	15	971	0.0%
Take Charge Family Planning	691	2	693	0.0%
CN Breast & Cervical Cancer (BCCT)	337	1	338	0.0%
MN - Other Disabled (Family/Pregnancy)	9	0	9	0.0%
Family Planning Services Only; Federally Qualified	5	0	5	0.0%
Children's Health Insurance Program				
CHIP	52,913	1	52,914	2.5%
Pregnant Women; Not Federally Qualified	14,531	1	14,532	0.7%
Children's Health Program				
CHP - State Only < 18	27,173	0	27,173	1.3%
Medical Care Services Program				
MCS - A/B/D/ADATSA; Not Federally Qualified	1,294	3	1,297	0.1%
Other				
Involuntary Treatment Act	237	0	237	0.0%
Refugees	11	0	11	0.0%
TOTAL	**1,885,286**	**218,457**	**2,103,743**	**100.0%**

Source: DSHS, Research & Data Analysis Division, ProviderOne Client by Month

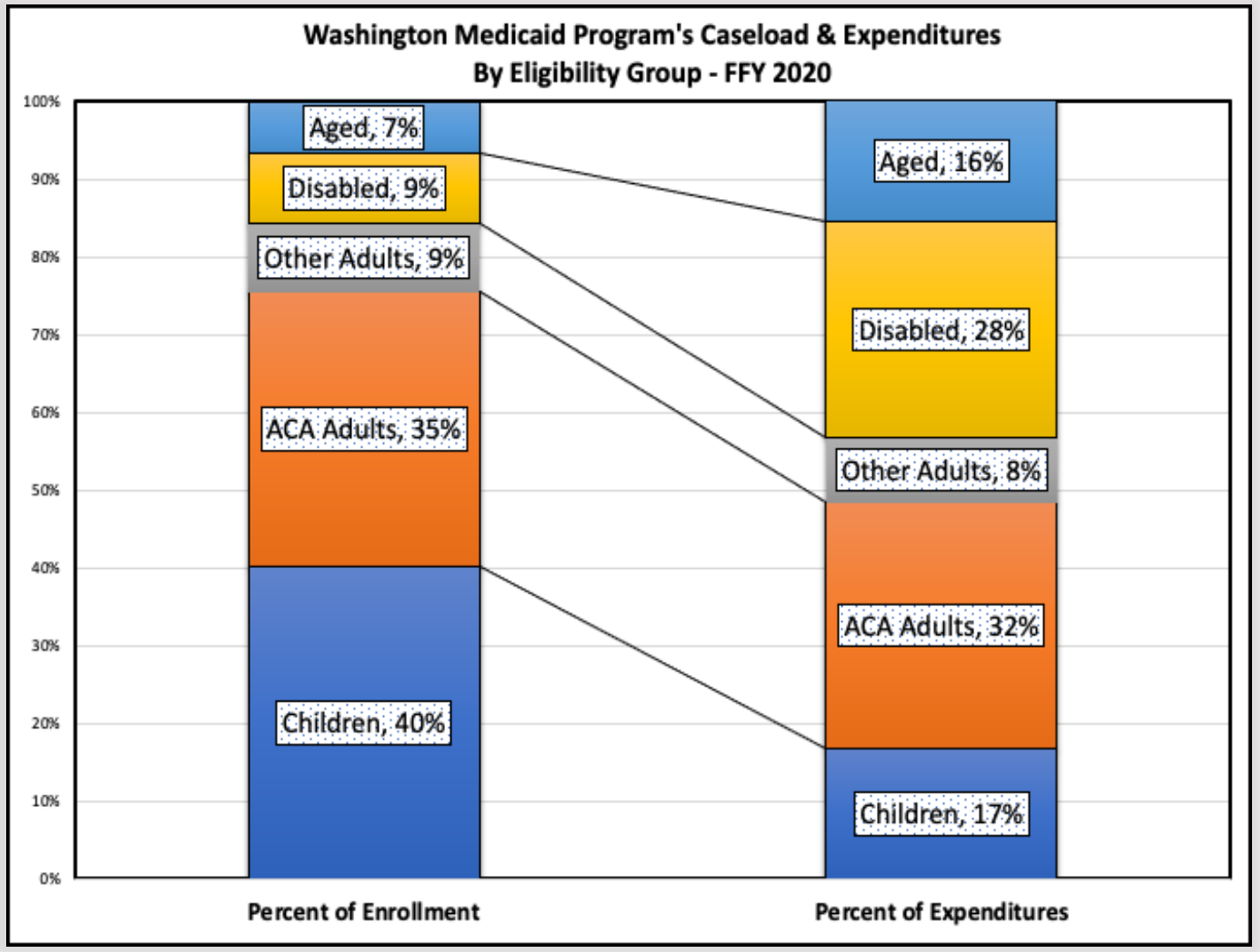
Medicare-Medicaid Duals include both full and partial dually eligibles. Full duals are eligible for full scope Medicaid services. Partial duals are individuals in which Medicaid pays only Medicare premiums (either both part A & B, B only, or A only depending upon the partial dual category).

[1] Categorically Needy is a phrase describing certain groups of Medicaid eligibility groups that sates are required to cover to participate in the Medicaid program. Medically Needy is phase used to describe optional coverage for persons who do not quality for Categorically Needy due to income.

[2] Kaiser Family Foundation, Medicaid & CHIP Indicators, https://www.kff.org/state-category/medicaid-chip/trends-in-medicaid-income-eligibility-limits/

Washington Medicaid Program

Enrollment & Expenditures By Eligibility Groups [1]



[1] MACPAC, MACStats: Medicaid and CHIP Data Book (December 2022), Exhibit 14 and 21.

Medicaid Program

Mandatory & Optional Medicaid Benefits

- There are 15 mandatory benefits, which states are required to provide under federal law and 28 optional services that states may cover if they choose.[1]

[1] CMS Medicaid website, Mandatory a& Optional Medicaid Benefits.

Federal Mandatory Benefits

1. Inpatient hospital services
2. Outpatient hospital services
3. EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services
4. Nursing Facility Services
5. Home health services
6. Physician services
7. Rural health clinic services
8. Federally qualified health center services
9. Laboratory and X-ray services
10. Family planning services
11. Nurse Midwife services
12. Certified Pediatric and Family Nurse Practitioner services
13. Freestanding Birth Center services (when licensed or otherwise recognized by the state)
14. Transportation to medical care
15. Tobacco cessation counseling for pregnant women

Optional Services

1. Prescription Drugs
2. Clinic services
3. Physical therapy
4. Occupational therapy
5. Speech, hearing and language disorder services
6. Respiratory care services
7. Other diagnostic, screening, preventive, and rehabilitative services
8. Podiatry services
9. Optometry services
10. Dental Services
11. Dentures
12. Prosthetics
13. Eyeglasses
14. Chiropractic services
15. Other practitioner services
16. Private duty nursing services
17. Personal Care
18. Hospice
19. Case management
20. Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)
21. Services in an intermediate care facility for Individuals with Intellectual Disability
22. State Plan Home and Community Based Services- 1915(i)
23. Self-Directed Personal Assistance Services- 1915(j)
24. Community First Choice Option- 1915(k)
25. TB Related Services
26. Inpatient psychiatric services for individuals under age 21
27. Other services approved by the Secretary*
28. Health Homes for Enrollees with Chronic Conditions – Section 1945

Medicaid Program in Washington

Benefits

- The Medicaid program has the largest array of health benefits and long-term care and support services.
- Appendix 2 outlines the array of Washington's Medicaid benefits and associated expenditure.
- States may also provide other matchable services through 1915(c) Home & Community-Based Waivers and 1115 Research and Demonstration Waivers.

Washington Medicaid Expenditures - FFY 2022 [1]		
Service Categories	**Amount [2]**	**Percent**
Medicaid & Related Fee for Service	$1,982,374,255	9%
Managed Care (Medicaid & Behavioral Health)	$12,011,010,934	54%
Dental Services	$180,241,195	1%
Medicare Cost Sharing Programs	$530,626,417	2%
Behavioral Health Services	$1,437,010,234	6%
Long-Term Care & Support Services	$5,035,204,493	23%
Total Services	$21,176,467,528	95%
Administration	$1,072,546,047	5%
Total Medicaid	$22,249,013,575	100%

[1] Source: Washington's CMS-64 Report for federal fiscal year (FFY) 2022. The form CMS-64 is used by state Medicaid agencies to report actual benefit costs and administration to the Centers for Medicare & Medicaid Services (CMS). CMS uses this information to compute federal financial participation.

[2] Expenditures are reported on a month of payment (cash) basis, and not on a month of service (accrual) basis.

This table summarizes Washington's Medicaid FFY 2022 total expenditures by-service expenditures.

Medicaid Program

Premiums & Point-of-Service Cost Sharing[1]

- States can require certain groups of Medicaid beneficiaries to pay enrollment fees, premiums, deductibles, coinsurance, copayments or similar cost-sharing amounts, including[2]
  - Pregnant women and infants with family income at or above 150% FPL
  - Qualified disabled and working individuals with income above 150% FPL
  - Disabled working individuals eligible under the Ticket to Work and Work Incentives Improvement Act of 1999
  - Disabled children eligible under the Family Opportunity Act (FOA)
  - Medically needy individuals.

- The total amount of premiums and cost sharing incurred by all individuals in a Medicaid household may not exceed 5% of the family's monthly or quarterly income.

- States also experiment with different approaches to the use of premiums and cost sharing for Medicaid beneficiaries under Section 1115 waivers. [3]

- Washington's Medicaid program does not have any premium or point-of-service cost-sharing requirements. The CHIP program, for children in households greater than 210% FPL, imposes modest premiums.

[1] MACPAC (Medicaid and CHIP Payment and Access Commission)
[2] Specific guidelines on who may be charged these fees, the services for which they may be charged, and the amount allowed in 42 CFR Parts 447 and 457.
[3] Kaiser Family Foundation, "Medicaid Waiver Tracking: Approved and Pending Section 1115 Waivers by State." (September 29, v2023).

Medicaid Program Payments - Federal

- The Medicaid program has a federal payment requirements and states, such as Washington, have adopted other payment requirement to support access to care.
- Federal payment requirements include:
  - Hospital and nursing home fee for service payments must be consistent with efficiency, economy, and quality of care, and are sufficient to provide access equivalent to the general population.
  - Medicaid payments for hospitals, nursing homes and other “institutions” cannot exceed in aggregate the amount that would be paid by Medicare for the same services.
  - States are required to make additional disproportionate share hospital (DSH) payments to hospitals that serve a disproportionate share (defined in law) of low-income patients.
  - Physician related payments are to promote efficiency, economy, quality, access, and safeguard against unnecessary utilization.
  - Federally Qualified Health Care (FQHC) and Rural Health Clinic (RHC) payments are based on the average of the center’s costs incurred during fiscal years (FYs) 1999 and FY 2000.
  - Managed care rates be developed in accordance with generally accepted actuarial principles and practices, appropriate for the population and services, and certified by qualified actuaries as being actuarially sound.

Medicaid Program Payments - Washington

- Washington's special payments include:
  - Participating government-operated hospitals payments are based on the full cost of medically necessary services and requires the expenditure of local funds in lieu of state funds to qualify for federal matching funds.
  - Multiple DSH payment programs.
  - Critical Access Hospital (CAH) payments are cost-based.
  - Tribal (IHS clinic, tribal 638 clinic or tribal FQHC) clinics are reimbursed on the Indian Health Services' all-inclusive encounter rate.
- In general, Medicaid payment rates for the same services are lower than Medicare and commercial payment rates.[1]
- However, for certain provider types (CEP/DSH hospitals, FQHCs, RHCs, CAHs, and tribal clinics) Medicaid payment rates may be higher.

[1] See Appendix 7 for payment rate comparisons.

Medicaid Program – Largely Administered through Medicaid Managed Care Organizations (MCOs).

Medicaid Managed Care Delivery System

- In the early 1990s, states began major initiatives to enroll most of their Medicaid clients into in comprehensive, risk based managed care arrangements.

- States have incorporated managed care into their Medicaid programs for several reasons, including
  - Control and predictability over future costs
  - Compared to FFS, can allow for greater accountability for outcomes and can better support systematic efforts to measure, report, and monitor performance, access, and quality
  - May provide an opportunity for improved care management and care coordination

- While the shift to MCOs has increased budget predictability for states, the evidence about the impact of MCOs on access to care and costs remains limited.

- As of 2021, all but six states had Medicaid beneficiaries enrolled in MCOs.[1] Over 75% of all Medicaid clients are enrolled in MCOs.

[1] Data. Medicaid.gov. Managed Care Enrollment Summary.

Washington's Medicaid Program

Medicaid Managed Care Delivery System

- Washington currently has 1.8 million beneficiaries enrolled in MCOs.
- 12th highest percent of MCO enrollment in the country.[1]

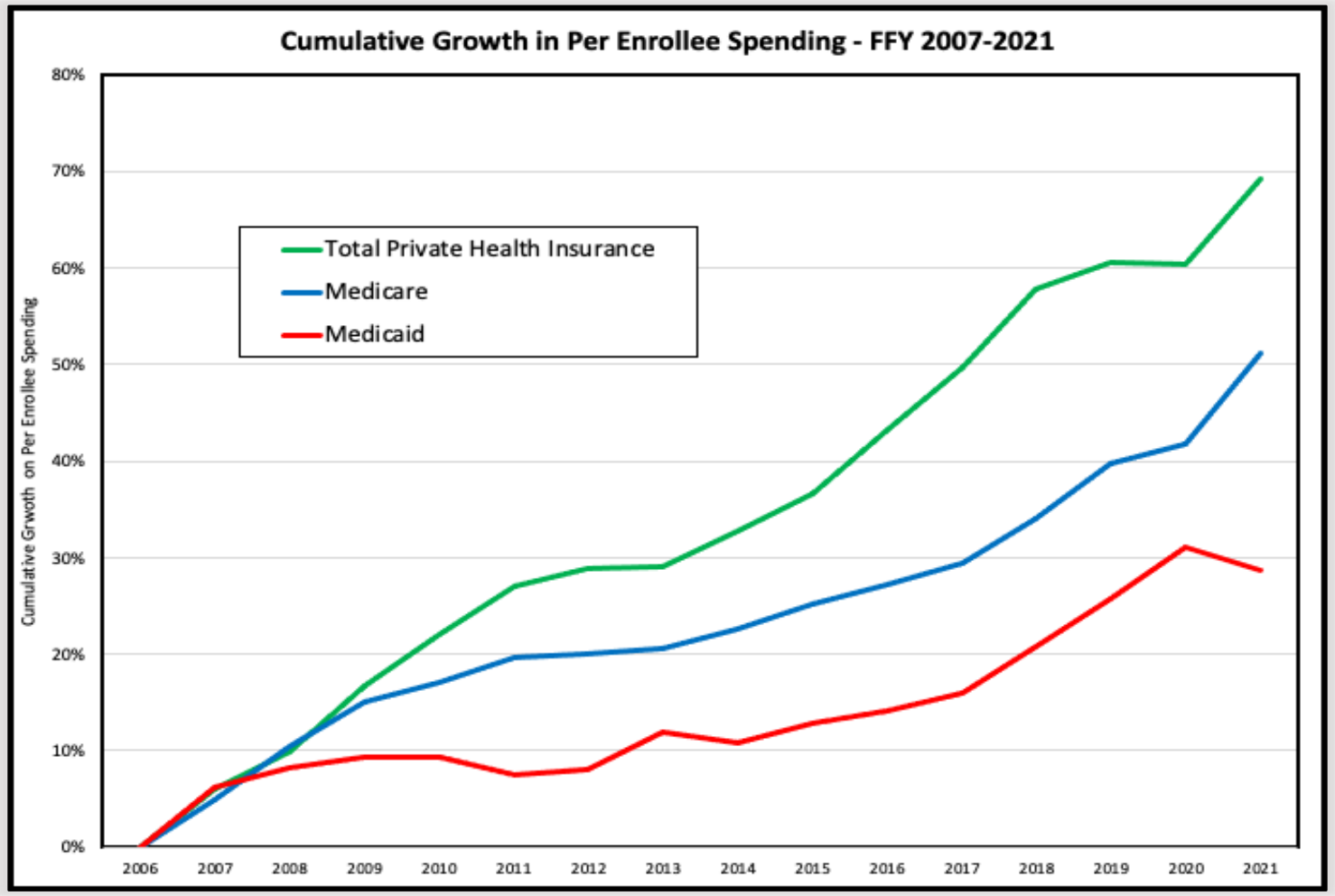
Percentage of Washington's Medicaid Enrollees in Managed Care by Eligibility Group, FFY 2020	
Eligibility Group	Precent Enrolled in MCO
Children	96.6%
ACA Adults	96.5%
Other Adults	86.4%
Disabled	53.0%
Aged	5.7%
Total	85.6%

Source: MACPAC, MACStats: Medicaid and CHIP Data Book, (December 2022), Exhibit 30

[1] MACPAC, MACStats: Medicaid and CHIP Data Book, (December 2022), Exhibit 30

Medicaid Expenditure Growth Rate

On a per-enrollee basis, Medicaid spending has experienced slower cumulative growth since 2007 compared to Medicare and private insurance, although there has been variations particularly in more recent years on a year-to-year basis.[1]



[1] National Health Expenditure (NHE) data and Kaiser Family Foundation, "Medicaid Financing: The Basics." (April 13, 2023)

Key takeaways

- Unlike Medicare, there is a potential pathway to incorporate Medicaid and into a state administered, unified financing system through Section 1115 demonstration and research waivers. (see Appendices 5, 6 and 7)
  - However, there are budget neutrality requirements.

- While Medicaid eligibility is categorical (e.g., age, income, resource, disability status), there are waiver and eligibility strategies that would allow for Medicaid eligibility to be seamless within a unified system.
  - Currently, Medicaid eligibility is processed through the state's *Healthplanfinder.*

- Medicaid has broad benefit coverage, including dental, vision, hearing and long-term care and support services.
  - Those services not covered in a state uniform benefit design can be treated as supplemental coverage and provided through separate delivery systems.

- Washington's Medicaid program does not impose premium or point-of-service cost sharing.
  - There are federal limits on premiums and cost sharing that would likely not be waivable.

- Washington's Medicaid program has a complex array of payment systems that should be analyzed to determine the cost and impact of "rate normalization".

- Like nearly all states, Washington's Medicaid program employs a managed care delivery system for most of its beneficiaries.

Questions?

Appendix 1

Washington's Medicaid Program Eligibility[1]

Washington's Medicaid Program – Eligibility [1]	
Modified Adjusted Gross Income (MAGI) Programs	
Adult Medical (N05)	This program provides ABP coverage to adults with countable income at or below 133 percent of the FPL who are ages 19 up to 65, who are not incarcerated, and who are not entitled to Medicare. No resource limits.
Family Medical (N01)	This program provides CN coverage to adults with countable income at or below the applicable Medicaid standard (38 percent - 42 percent FPL) and who have dependent children living in their home who are under the age of 18. No resource limits.
Health Care Extension (N02)	This program provides CN coverage to individuals who lost eligibility for Family Medical because of an increase in their earned income after they received Family Medical coverage for at least 3 of the last 6 months. These individuals are eligible for up to 12 months extended CN medical benefits
Apple Health for Newborns (N10):	This program provides 12 months of CN coverage if the mother was enrolled in an Apple Health program when the child was born. There is no resource or income limit for this program.
Apple Health for Kids (N11, N31)	This program provides CN coverage to children under age 19 whose families have income at or below 210 percent of the FPL. Children who would have been eligible for Apple Health for Kids had they met immigration status requirements receive CN coverage under state-funded Apple Health for Kids.
Apple Health for Kids with Premiums (N13, N33) ***(NOTE: Title XXI CHIP program)***	This program provides CN coverage to children under age 19 whose families have income above 210 percent and at or below 312 percent of the FPL. Participants pay a low-cost monthly premium.
Pregnancy Medical (N03, N23)	This program provides CN coverage to pregnant individuals with countable income at or below 193 percent of the FPL without regard to citizenship or immigration status. Once enrolled in Apple Health for Pregnant Individuals, the individual is covered regardless of any change in income for 12 months after the pregnancy ends through the After- Pregnancy Coverage (APC) program.

[1] Health Care Authority, "Eligibility Overview: Washington Apple Health (Medicaid) Programs", October 2023, https://www.hca.wa.gov/assets/free-or-low-cost/22-315.pdf

Appendix 1
Washington's Medicaid Program Eligibility[1]

Washington's Medicaid Program – Eligibility [1]	
Medically Needy Pregnant Individuals (P99	This program provides MN coverage to pregnant individuals with income above 193 percent of the FPL. Individuals who qualify are eligible for MN coverage after incurring medical costs equal to the amount of the household income that is above the 193 percent FPL standard.
Family Planning Only (P06)	This program provides coverage for pre-pregnancy family planning services to help participants, regardless of gender, take charge of their lives and prevent unintended pregnancies
After Pregnancy Coverage (N04, N24, N07,N27)	After-Pregnancy Coverage (APC) is comprehensive Apple Health coverage for individuals to access health care services any time in the 12 months after their pregnancy ends. This program provides CN coverage to individuals with income at or below 193 percent of the FPL, regardless of immigration status
Classic Medicaid Programs	
Breast and Cervical Cancer Treatment Program (BCCTP) (S30)	This federally funded program provides health care coverage for individuals diagnosed with breast or cervical cancer or a related pre-cancerous condition. Eligibility is determined by the Breast, Cervical, and Colon Health Program (BCCHP) in the Washington State Department of Health (DOH).
Foster care and adoption support (D01, D02, D26)	This program provides CN coverage to children receiving foster care and adoption support. This program also provides CN coverage to individuals from the age of 18 up to 26 who age out of foster care in Washington State
Non-Citizen Program	
Alien Emergency Medical (AEM) (K03, N21, N25, S07)	This program covers health care services to treat qualifying emergency medical conditions. The person must be otherwise eligible for Medicaid solely due to immigrant requirements. Have a qualifying emergency medical condition as described in WAC 182-507-0115, or 182-507-0120, that is approved by HCA's medical consultant team.

Appendix 1
Washington's Medicaid Program Eligibility[1]

Washington's Medicaid Program – Eligibility [1]	
Supplemental Security Income (SSI) Related Program	
SSI Program (S01)	This program provides CN coverage to individuals receiving SSI (Supplemental Security Income) cash benefits.
SSI-Related Program (S02	This program provides CN coverage to individuals who meet the SSI (75 percent for one person and 83 percent for a couple) income and resource limits ($2,000 for an individual and $4,000 for a couple) and at least one of the following requirements: • 65 years old or older (aged). • Blind (as defined by the Social Security Administration and determined by DSHS). • Disabled (as defined by the Social Security Administration and determined by Disability Determination Services (DDS)).
SSI-Related MN Program (S95, S99)	This program provides MN coverage to individuals with income above the SSI income limits. Individuals who qualify and enroll in the Apple Health SSI- Related MN Program become eligible for MN coverage after incurring medical costs equal to the amount of the household income that is above the SSI income standard.
Apple Health for Workers with Disabilities (HWD) (S08)	**This program provides CN coverage to adults with blindness or a disability (aged 16 and above) who are employed with earnings. HWD has no asset test and no upper income limit. Health care premiums are based on a sliding income scale.**

Appendix 1
Washington's Medicaid Program Eligibility[1]

Washington's Medicaid Program – Eligibility [1]	
Medically Needy (MN) and Spendown	
Medically Needy (F99, G95, G99, K95, K99, L95, L99, P99, S95, S99	The Medically Needy (MN) program is a federal and state-funded Apple Health program for individuals who are aged, blind, disabled, pregnant, or a child with income above the applicable CN limits. MN provides slightly less health care coverage than CN and requires greater financial participation by the individual. An individual with income above the limits for the applicable CN program may enroll in the MN program. An enrollee is given a base period, typically three or six months, to spend down excess income— in other words, to incur financial obligations for medical expenses equal to their spenddown amount. Spenddown is the amount of the individual's income minus the income limit for their particular program. The enrollee is responsible for paying these medical expenses.
Medicaid Saving Programs (MSP)	
Qualified Medicare Beneficiaries (QMB) (SO3)	For Medicare beneficiaries with income up to 100 percent of FPL, this MSP pays for Medicare Part A and B premiums, deductibles and copayments except for prescriptions.
Special Low-Income Medicare Beneficiaries (SLMB) (SO5)	For Medicare beneficiaries with income up to 120 percent of FPL, this MSP pays for Medicare B premiums.
Qualified Individuals (QI-1) (SO6)	For Medicare beneficiaries with income up to 135 percent of FPL, this MSP pays for Medicare B premiums
Qualified Disabled Working Individuals (QDWI) (SO4)	For Medicare beneficiaries with income up to 200 percent of FPL, this MSP pays for Medicare A premium.

Appendix 1
Washington's Medicaid Program Eligibility[1]

Washington's Medicaid Program – Eligibility [1]
Long-Term Services and Supports (LTSS) and Hospice
Long-term Services and Supports (LTSS) are tailored to fit client individual needs and situations. Services may be authorized through the Department of Social and Health Services (DSHS) by Home and Community Services (HCS) or the Developmental Disabilities Administration (DDA). These services enable people to continue living in their homes with help meeting their physical, medical, and social needs. When these needs can't be met at home, care in a residential or nursing facility is available. Different income standards are used to determine eligibility for CN or MN coverage for LTSS. To be eligible for most LTSS programs, a person must file an application and meet financial eligibility criteria and functional eligibility criteria (based on a comprehensive assessment).
Apple Health benefits include hospice services for people who are eligible under categorically needy (CN), medically needy (MN), or alternative benefit plan (ABP) programs. If a person is not eligible for CN, MN, or ABP, a determination can be made using eligibility rules under a separate Hospice program
[1] SOURCE: Health Care Authority, "Eligibility Overview: Washington Apple Health (Medicaid) Programs", October 2023, https://www.hca.wa.gov/assets/free-or-low-cost/22-315.pdf

Appendix 2

Washington's Medicaid Service Expenditures By CM-64 Reporting Categories

Washington Medicaid Service Expenditures by CMS-64 Report Categories		
CMS-64 Service Categories	**Amount**	**Percent**
Managed Care (Medicaid & Behavioral Health)		
Medicaid - MCO	$11,968,611,707	56.5%
Medicaid MCO - Preventive Services Grade A OR B, ACIP Vaccines and their Admin	$42,399,227	0.2%
Medicaid & Related Fee for Service		
Inpatient Hospital - Reg. Payments	$454,300,025	2.1%
Inpatient Hospital - DSH	$259,105,117	1.2%
Emergency Services for Undocumented Aliens	$208,631,581	1.0%
Outpatient Hospital Services - Reg. Payments	$119,609,745	0.6%
Physician & Surgical Services - Reg. Payments	$87,758,428	0.4%
Clinic Services - Reg. Payments	$212,205,634	1.0%
Federally-Qualified Health Center	$749,591,374	3.5%
Rural Health	$72,262,954	0.3%
Other Practitioners Services - Reg. Payments	$9,282,147	0.0%
EPSDT Screening	$2,712,799	0.0%
Sterilizations	$507,446	0.0%
Laboratory/Radiological	$3,093,915	0.0%
Home Health Services	$9,078,478	0.0%
Hospice Benefits	$17,742,853	0.1%
Physical Therapy	($117)	0.0%
Rehabilitative Services (non-school-based)	($26,032)	0.0%

Washington's CMS-64 Report for FFY 2022. The form CMS-64 is used by Medicaid State agencies to report their actual program benefit costs and administrative expenses to CMS. CMS uses this information to compute the Federal financial participation (FFP) for the State's Medicaid Program costs. Expenditures are reported on a monthly of payment (cash) basis, and not month of service (accrual) basis.

Appendix 2

Washington's Medicaid Service Expenditures By CM-64 Reporting Categories

Washington Medicaid Service Expenditures by CMS-64 Report Categories		
CMS-64 Service Categories	**Amount**	**Percent**
Prosthetic Devices, Dentures, Eyeglasses	$5,149,085	0.0%
Prescribed Drugs	$200,314,438	0.9%
Drug Rebate Offset - MCO & FFS	($1,013,274,531)	-4.8%
Preventive Services Grade A OR B, ACIP Vaccines and their Admin	$722,854	0.0%
ARP Section 9811 COVID Vaccine/Vaccine Administration	$3,588,552	0.0%
Increased ACA OFFSET - Fee for Service	($2,492,178)	0.0%
School Based Services	$11,256,236	0.1%
Medicaid - Other	$4,824,565	0.0%
Other Care Services	$469,856,278	2.2%
Non-Emergency Medical Transportation – Reg. Payments	$96,572,609	0.5%
Dental Services		
Dental Services	$180,241,195	0.9%
Medicare Cost Sharing Programs		
Medicare - Part A	$135,050,578	0.6%
Medicare - Part B	$365,536,841	1.7%
120% - 134% Of Poverty	$17,228,722	0.1%
Coinsurance	$12,810,276	0.1%

Appendix 2

Washington's Medicaid Service Expenditures By CM-64 Reporting Categories

Washington Medicaid Service Expenditures by CMS-64 Report Categories		
CMS-64 Service Categories	**Amount**	**Percent**
Behavioral Health Services		
Mental Health Facility Services - Reg. Payments	$30,507,114	0.1%
Mental Health Facility - DSH	$93,878,926	0.4%
Prepaid Inpatient Health Plan	$720,836,183	3.4%
OUD Medicaid Assisted Treatment – Drugs	$593,007,622	2.8%
OUD MAT DRUG REBATE/National Agreement	($1,219,611)	0.0%
Long-Term Care & Support Services		
Nursing Facility Services - Reg. Payments	$709,892,635	3.4%
Intermediate Care Facility - Public	$199,305,637	0.9%
Home & Community-Based Services - Regular Payment (1915(c) Waiver)	$1,140,345,062	5.4%
Home & Community Based Services State Plan 1915(k) Community First Choice	$2,835,608,017	13.4%
All-Inclusive Care Elderly	$57,930,563	0.3%
Personal Care Services - Reg. Payments	$35,026,210	0.2%
Targeted Case Management Services - Com. Case-Man.	$19,911,269	0.1%
Case Management - State Wide	$89,260	0.0%
Private Duty Nursing	$23,840,157	0.1%
Health Home w Chronic Conditions	$13,255,683	0.1%
Total Services	**$21,176,467,528**	100.0%

Appendix 3
1915 Type Waivers

- **1915(b) Freedom of Choice Waivers**: Permits states to implement service delivery models that restrict choice of providers other than in emergency circumstances. States can also use Section 1915(b) to waive state wideness requirements (e.g., to provide managed care in a limited geographic area) and comparability requirements (e.g., to provide enhanced benefits to managed care enrollees).

- **1915(c) Home & Community Based (HCBS) Waivers:** Permits states to help people who need long-term support services (LTSS) and are Medicaid-eligible by designing its HCBS services based on their needs. Waivers vary from state to state, and many states offer more than one type of 1915(c) waiver.

- **1915(j) self-directed personal assistance services Waivers**: Targets Medicaid enrollees who already receive services under 1915(c) waivers and may want to direct their own care. States can limit the number of people who self-direct their care and decide whether this program will be statewide or limited to certain areas.

- **1915 (k) Community First Choice**: Expands Medicaid opportunities for the provision of home and community based LTSS, facilitates community integration, and provides an enhanced FMAP of six additional percentage points.

1. Appendix 4 has a description of Washington's nine 1915(b) and (c) Waivers.

Appendix 4

Washington's 1915 Waivers[1]

- **1915 (c) Waiver: WA Basic Plus Waiver (0409.R04.00):** Provides community inclusion, individual supported employment/group supported employment, respite, occupational therapy, physical therapy, speech/hearing/language services, assistive technology, community engagement, environmental adaptations, extermination of bed bugs, individualized technical assistance, remote supports, risk assessment, skilled nursing, specialized equipment and supplies, specialized habilitation, stabilization services (staff/family consultation services), stabilization services (crisis diversion bed), stabilization services (specialized habilitation), staff/family consultation services, therapeutic adaptations, transportation, and wellness education services to individuals with autism, intellectual disabilities, or developmental disabilities ages 0 or older who meet an ICF/IID level of care. This waiver operates with a concurrent 1915(b)(4) authority.

- **1915 (c) Waiver: WA Children's Intensive In-Home Behavioral Support Waiver (40669.R03.00):** Provides respite, assistive technology, environmental adaptations, equine therapy, music therapy, nurse delegation, peer mentoring, person-centered plan facilitation, risk assessment, specialized clothing, specialized equipment and supplies, specialized habilitation, stabilization services (specialized habilitation), stabilization services (staff/family consultation), stabilization services (crisis diversion bed), staff/family consultation services, therapeutic adaptations, transportation, and vehicle modification services to individuals with autism, intellectual disabilities, or developmental disabilities ages 8-20 years who meet an ICF/IID level of care. This waiver operates with a concurrent 1915(b)(4) authority.

- **1915 (c) Waiver: WA Community Protection Waiver (0411.R04.00):** Provides individual supported employment/group supported employment, residential habilitation, occupational therapy, physical therapy, speech/hearing/language services, assistive technology, community transition, environmental adaptations, extermination of bed bugs, individualized technical assistance, positive behavior support and consultation, remote supports, risk assessment, skilled nursing, specialized equipment and supplies, specialized evaluation and consultation, stabilization services (crisis diversion bed), stabilization services (specialized habilitation), stabilization services (staff/family consultation services), staff/family consultation services, and transportation services to individuals with autism, intellectual disabilities, or developmental disabilities ages 18 or older who meet an ICF/IID level of care.

[1] Medicaid.gov, State Waiver List.

Appendix 4
Washington's 1915 Waivers

- **1915 (c) Waiver: WA COPES (0049.R08.00)**: Provides adult day health, adult day care, client support training & wellness education, community choice guiding, community support: goods and services, environmental modifications, home delivered meals, skilled nursing services, specialized medical equipment and supplies, and transportation services to individuals ages 65 or older, and individuals with physical or other disabilities ages 18-64 years who meet a nursing facility level of care.

- **1915 (c) Waiver: WA Core Waiver (0410.R04.00):** Provides community inclusion, individual supported employment/group supported employment, residential habilitation, respite, occupational therapy, physical therapy, speech/hearing/language services, assistive technology, community engagement, community transition, environmental adaptations, extermination of bed bugs, individualized technical assistance, remote supports, risk assessment, skilled nursing, specialized equipment and supplies, specialized habilitation, stabilization services (crisis diversion bed), stabilization services (staff/family consultation), stabilization services (specialized habilitation), staff/family consultation services, supported parenting, transportation, and wellness education services to individuals with autism, intellectual disabilities, or developmental disabilities ages 0 or older who meet an ICF/IID level of care. This waiver operates with a concurrent 1915(b)(4) authority.

- **1915 (c) Waiver: WA Individual and Family Services Waiver (1186.R01.00):** Provides respite, occupational therapy, physical therapy, speech/hearing/language services, assistive technology, behavioral health stabilization services (crisis diversion bed), behavioral health stabilization services (positive behavior support and consultation), behavioral health stabilization services (specialized psychiatric), community engagement, environmental adaptations, nurse delegation, peer mentoring, person-centered plan facilitation, positive behavior support and consultation, remote supports, risk assessment, skilled nursing, specialized clothing, specialized equipment and supplies, specialized habilitation, specialized medical equipment and supplies, specialized psychiatric services, stabilization services (crisis diversion bed), stabilization services (specialized habilitation), stabilization services (staff/family consultation), staff/family consultation services, supported parenting, therapeutic adaptations, transportation, vehicle modifications, and wellness education services to individuals with autism, intellectual disabilities, or developmental disabilities ages 0 or older who meet an ICF/IID level of care. This waiver operates with a concurrent 1915(b)(4) authority.

Appendix 4
Washington's 1915 Waivers

- **1915 (c) Waiver: WA New Freedom Waiver (0443.R03.00):** Provides personal assistance services, environmental and vehicle modification, individual directed goods/services/supports, training and educational supports, and treatment and health maintenance services to individuals ages 65 or older, and individuals with physical or other disabilities ages 18-64 years who meet a nursing facility level of care. This waiver operates with a concurrent 1915(b)(4) authority.

- **1915 (c) Waiver: WA Residential Support Waiver (1086.R01.00):** Provides adult day health, adult family home specialized behavior support service, client support training and wellness education, community stability supports, enhanced residential services, expanded community services, nurse delegation, skilled nursing, and specialized medical equipment and supplies to individuals ages 65 or older, and individuals with physical or other disabilities ages 18-64 years who meet a nursing facility level of care.

- **1915 (b4) Waiver: WA Consumer Directed Employer:** The Consumer Directed Employer (CDE) program will transfer the administrative functions and responsibilities of personal care and respite Individual Provider (IP) management from the Department of Social and Health Services (DSHS) and Area Agency on Aging (AAA) staff to a contracted CDE vendor, the Consumer Direct Care Washington, LLC. Participants (also referred to as consumers) will retain the authority to select, supervise, manage, and dismiss their IPs. The CDE must be responsive to the needs of participants, families, the IP workforce, and DSHS. Person-centeredness and self-directed care remains the top priority in the implementation of the CDE. When an IP is chosen by a participant, the participant refers the IP for hiring to the CDE. If qualified, the IP is hired and becomes an employee of the CDE. The CDE is the legal employer and will be responsible for payroll, tax reporting, tracking paid leave, and credentialing of IPs. The CDE is also responsible for electronic visit verification for IPs, billing in the MMIS system, and withholding taxes and garnishments. The CDE will also engage in collective bargaining with the exclusive representative for the IP workforce.

Appendix 5

1115 Demonstration & Resource Waivers

- Section 1115 demonstration waiver authority is broader the Section 1115A (42 U.S.C 1315(a)).
- Section 1115 applies to Medicaid, but not Medicare.
- Section 1115A gives CMS and the Center for Medicare and Medicaid Innovation (CMMI) authority to test innovative payment and service delivery models and applies to Medicare, Medicaid, and CHIP.
- Section 1115 give the Secretary of Health & Human Services (HHS) authorization to “any experimental, pilot or demonstration project likely to assist in promoting the objectives” of the programs.
- Under Section 1115 research and demonstration authority, the Secretary may waive certain provisions of the Medicaid (and CHIP) statutes related to state program design. Such projects are generally broad in scope, operate statewide, and affect a large portion of the Medicaid population within a state.

42 U.S. Code 1315(a). In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of subchapter I, X, XIV, XVI, or XIX, or part A or D of subchapter IV, in a State or States—The Secretary may waive compliance with any of the requirements of section 302, 602, 654, 1202, 1352, 1382, or 1396a of this title, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project.

Appendix 5

1115 Demonstration & Resource Waivers

- The Secretary can also permit federal financial participation for costs not otherwise matchable, allowing states to cover services and populations not included in the Medicaid state plan.

- Congress has limited the Secretary's authority to waive some Medicaid provisions.
  - For example, certain Medicare cost sharing requirements and spousal impoverishment protections cannot be waived.
  - Only limited cost sharing or similar charges may be imposed.[1]

- Generally, 1115 waivers are approved for five-years and can be renewed to continue operations past that period.

- Under 1115 waivers, states **must demonstrate** **"budget neutrality**" in that federal spending under the demonstration cannot exceed projected costs in absence of the demonstration (referred to as the without-waiver baseline).

[1] 42 U.S.C. § 1396o(f). See, e.g., Pharm. Res. & Mfrs. of Am. v. Thompson, 251 F.3d 219, 222 (D.C. Cir. 2001) (stating that Secretary is not authorized "to waive any requirements of section 1396r–8's rebate provision or the requirement that Medicaid beneficiaries contribute no more than a "nominal" amount to the cost of medical benefits they receive").

Appendix 5
1115 Demonstration & Resource Waivers

- 48 states have 68 approved 1115 demonstrations.[1]

- Washington currently has one approved 1115 waiver and one pending:[2]
  - Medicaid Transformation Project
  - Family Planning Only Program for Non-Medicare Beneficiaries.

1115 Waiver Provisions	
Waiver Provision Types	**Number of States [1]**
Expanded Eligibility Groups	31
Other Eligibility/Enrollment Expansions	12
Eligibility/Enrollment Restrictions	13
Select Benefit Expansions	42
Benefit Restrictions & Copays	9
Social Determinated of Health Provisions	19
Other Select Behavioral Health Delivery Reforms and Uncompensated Pools	10
[1] A state's 1115 waiver may include more than one of these categories.	

[1] Kaiser Family Foundation. Medicaid Waiver Tracker: Approved &Pending Section 1115 Waivers by State.
[2] See Appendix 6 for a description of the two waivers.

Appendix 6

Washington's 1115 Demonstration Waivers – Family Planning (pending)

- Washington State's 1115 family planning demonstration waiver was initially approved by the Centers for Medicare and Medicaid Services (CMS) in 2001. The waiver consists of two programs that were implemented and overseen by the Washington's HCA.

- The Family Planning Only Pregnancy-Related (FPO-PR) extension – this program provides family planning services for 10 months to individuals who were on pregnancy Medicaid and do not qualify for other Medicaid programs. This is an automatic transition following the month after the end of the 60 days postpartum coverage.

- Take Charge - implemented in July 2001, offering family planning services to individuals with family income at or below 200 percent of the federal poverty level (FPL). Initially, enrollees on Take Charge could only access care through qualified Take Charge providers. The income increased to 250 percent FPL on October 1, 2012, and again when the ACA was implemented on October 1, 2013, to 260 percent of FPL. On July 1, 2019, the Take Charge provider network was expanded, and the program was renamed from Take Charge to Family Planning Only (FPO).

- The goals of the FPO-PR and the FPO programs are to 1) improve the health of individuals, children, and families by decreasing unintended pregnancies and lengthening intervals between births; and 2) reduce state and federal Medicaid expenditures for births from unintended pregnancies.

Appendix 6

Washington's 1115 Medicaid Transformation Waiver

- **Initiative 1: transformation through ACHs and IHCPs**: Accountable Communities of Health (ACHs) and Indian Health Care Providers (IHCPs) are implementing projects that change the way people receive health care in their region.
- **Initiative 2: supporting older adults and family caregivers**: Expands care options for people, ages 55 and older, so they can stay at home and delay or avoid more intensive services, such as moving to a nursing facility. Provides assistance to unpaid family caregivers, ages 18 or older, who provide care for their loved ones.
- **Initiative 3: Foundational Community Supports (FCS)**: Foundational Community Supports (FCS) provides supportive housing and supported employment services to our most vulnerable Medicaid beneficiaries. These services are designed to promote self-sufficiency and recovery by helping participants find and maintain stable housing and employment. Supportive housing services help individuals get and keep community housing. Supported employment services help individuals with barriers to employment get and keep a job.
- **Initiative 4: substance use disorder (SUD) IMD**: Allows Washington to use federal Medicaid funds to pay for people receiving SUD treatment in a mental health or S UD facility that qualifies as an institution for mental diseases (IMD). IMDs are large facilities dedicated to psychiatric care (more than 16 beds where more than 50 percent of the residents are admitted for psychiatric care).
- **Initiative 5: mental health IMD**: Allows Washington State to purchase (an average of 30 days) acute inpatient services for Medicaid clients between the ages of 21 and 65 who reside in a dedicated large psychiatric facility that qualifies as an "institution for mental diseases" (IMD).

Washington's first transformation waiver ran from January 2017 - June 2023 (with an extension). Washington's new 1115 waiver was approved in June 2023 and will run through June 2028.

Appendix 7
Payment Rate Comparisons

- In general, Medicaid payment rates for the same services are lower than Medicare and commercial payment rates.

- Oregon's Joint Task Force on Universal Health Care "Universal Health Care Financing Modeling" reported:[1]
  - Commercial insurance is approximately 170% of Medicare.
  - Medicaid physician rates are approximately 85% of Medicare.

- Kaiser Family Foundations' comparison of 2019 "Medicaid-to-Medicare Physician Service Fee Index" found that over all physician services, Medicaid pays at .72 of Medicare.[2]
  - Washington had the 35th lowest rates overall in 2019.

- MACPAC found that on average:[3]
  - Medicaid FFS base payments are below hospitals' costs of providing services to Medicaid enrollees and are below Medicare payment rates for comparable services.
  - In 2011, FFS base payment rates were 78% of Medicare for the 18 Medicare-severity diagnostic-related groups studied.
  - Supplemental payments accounted for 49% of FFS inpatient hospital payments nationally and between 0.6 and 97.4% at the state level in fiscal year (FY) 2015 (MACPAC 2016a). Once supplemental payments are taken into account, MACPA found that Medicaid payment were comparable or higher than Medicare.

[1] Oregon's Joint Task Force on Universal Health Care's "Universal Health Care Financing Modeling"(CBIZ Optumas), September 21, 2022, page 24
[2] Kaiser Family Foundation. Medicaid-to-Medicare Fee Index (2019).
[3] MACPAC, Medicaid Hospital Payment: A Comparison across States and to Medicare, Issue Brief (April 2017).

Tab 7

Washington State Health Care Authority

FTAC Discussion

UHC goal: to increase access to quality and affordable health care by streamlining access to coverage, and to reduce fragmentation of health care financing, unnecessary administrative costs, and health disparities.

- Richness of benefits for Medicaid compared to what may be covered under the new system
  - Does a comparison of benefits exist for Medicare, Medicaid, and Public Employee Benefits (PEB)?
- Provider reimbursement
  - What are the main barriers to access and care for Medicaid enrollees, e.g., lower reimbursement rates?
  - What barriers exist with regards to Medicaid provider rate increases, e.g., ongoing work to increase primary care rates? Or, what can be used to increase provider rates?
- Eligibility
  - What federal barriers exist with regards to:
    - Asset limitations for enrollees of classic Medicaid?
- What other information/presentations will FTAC need at their January meeting for further discussion on this topic?
  - What have other states done (if anything) using 1115 waivers to expand eligibility?

Thank you for attending the Finance Technical Advisory Committee meeting!

Washington State Health Care Authority