Washington State Health Care Authority

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

January 12, 2024
Virtual meeting held electronically (Zoom)
2–4:30 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
Eddy Rauser
Pam MacEwan
Robert Murray
Roger Gantz

Members absent

Esther Lucero
Ian Doyle
Kai Yeung

Call to order

Pam MacEwan, FTAC Liaison, called the meeting to order at 2:01 p.m.

Agenda items

Welcoming remarks

Pam MacEwan began with a land acknowledgement, welcomed members to the seventh meeting, and reviewed the agenda.

Meeting summary review from the previous meeting

The Members present **voted by consensus to adopt the November 2023 meeting summary**.

Public comment

Kathryn Lewandowsky, Co-Chair, Whole Washington, encouraged FTAC to look at Connecticut's work to transition their Medicaid program from managed care to fee-for-service. This has generated administrative savings and reduced administrative costs.

Jen Nye, Whole Washington, expressed concerns over the current pace of decision-making for the future system, and encouraged a more urgent, tangible, and transparent choice be given for a "real" alternative.

Commission updates

Liz Arjun, Health Management Associates (HMA)
In December, the Commission re-grouped and sequenced transitional solution topics. The Commission agreed that in 2024, FTAC should continue their focus on universal health care system design topics, the first of which is benefits and services. The Commission's 2024 work plan will be approved at their February meeting.

Presentation: Understanding Medicaid waivers in a universal coverage context

Dan Meuse Deputy Director, State Health and Values Strategies, Princeton University
1115 waivers give states broad authority to waive Medicaid requirements to carry out a demonstration project. Waivers must be "budget neutral" (costs to the federal government must be the same with or without the waiver) and promote the objectives of the Medicaid program. Waivers are tools to obtain policy goals.
Like waivers, state plan amendments (SPA) allow states to choose new populations to serve or new benefits to provide, but don't require budget neutrality. Expanding coverage through a SPA will open federal financial participation (FFP) funds but will require state match, whereas waivers allow states to receive matching funds for otherwise unallowed expenses and to use indirect spending as match for Medicaid FFP. SPA expansions will also require specific mandatory and optional benefits to be provided based on the expansion, whereas waivers allow states to design different benefit packages for expanded populations. A SPA is relatively permanent. A waiver covers a five-year period. Other states have used SPAs or waivers to eliminate asset tests for Classic Medicaid, e.g., via SPA in Arizona and via waiver in California.

A waiver implementation of expansion advantages the state's general revenue compared to a SPA. In a waiver negotiation, Washington would have to prove to the federal government that a unified system meets federal requirements, or that a certain requirement(s) does not need to be met and why.

Presentation: Washington's experience with 1115 demonstration waivers

Mich'l Needham, Chief Policy Officer, Health Care Authority (HCA)
Washington has a long history of using demonstration waivers to achieve policy goals. The waiver development process is extensive, involving concept design, data collection, CMS completeness review, tribal consultation, public comment and transparency, and CMS negotiations (which can range from three months to two years). There are many steps after waiver approval and hundreds of deliverables due to CMS. These include protocol documents and implementation plans for each program, legislative authorization/spending authority, quarterly and annual reports, and external evaluation reports. Program implementation may also take several years depending on design complexity. Implementation of a waiver is much more administratively burdensome than a SPA. It can be beneficial to the state to examine what parts of a waiver can "graduate" to permanent authorities (SPA) to reduce administrative burdens. Demonstrating budget neutrality is an extended process and negotiation is not a straightforward process.

Presentation: Avoiding Medicaid - characteristics of primary care practices with no Medicaid revenue

Steven Spivack, PhD., MPH, Director of Quality Measurement and Data Analytics, Lewin Group
Prior research has demonstrated that up to one-third of all physicians refuse to accept new Medicaid patients. Commonly cited reasons for this include low reimbursement rates and burdensome administrative and billing requirements. This study examined the proportion of primary care practices with no Medicaid revenue and how

those practices compare to practices with Medicaid revenue across key organizational characteristics and population health capabilities.
Practices were categorized based on their Medicaid revenue as a proportion of total revenue, including zero percent, between zero and 10 percent, and more than 10 percent. Out of 1,731 practices, 17 percent had zero Medicaid revenue. Practices with no Medicaid revenue were on average smaller, independent, had a higher proportion of primary care physicians, and were more likely to be urban, in low poverty areas, and in states that have not expanded Medicaid. Some reasons for not accepting Medicaid patients may be a lack of organizational capabilities and infrastructure, access to a large enough patient base outside of Medicaid, or less advanced population health and IT capabilities. Possible interventions to increase uptake in Medicaid participation include increasing reimbursement rates (most challenging to implement) or focusing efforts on smaller, independent practices and what they need. Practices residing in areas with more Medicaid-eligible individuals may be more likely to move from the zero percent category to between zero and 10 percent. It may be helpful to engage practices in areas with higher proportions of Medicaid-eligible individuals but who aren't accepting as many patients as they could.

Discussion and votes on Medicaid guidance to the Commission

Washington's Medicaid program provides the richest benefit of any payer and could be something to aspire to for coverage under Washington's universal health care system (though members largely agreed, that(?) including long-term care services as a covered benefit is not likely – at least not at the start). Administrative processes would need to change to integrate Medicaid into a unified financing system. Members agreed that both 1115 waivers and SPAs should be considered as vehicles to achieve this and other policy goals.

FTAC members voted to recommend that the Commission consider pursuing, when appropriate, waivers or SPAs as needed to include Medicaid enrollees in Washington's universal health care system, details of which will need to be developed once benefits and services are determined. Members agreed that it's not possible at this time to provide more specific guidance until benefits and services are determined.

Members agreed that access to care issues persist for Medicaid patients, though it would be a mistake to recommend targeted provider rate increases without first understanding where the issues are and why, and potential unintended consequences of increasing rates. **FTAC members voted to recommend that the Commission pursue analysis to understand Medicaid provider reimbursement in Washington and how it impacts provider willingness to accept Medicaid enrollees.**

Different administration across payers can be burdensome for providers. **FTAC members voted to recommend that in their transitional solutions work, the Commission consider paths to simplify administration for the Medicaid program which may help motivate provider participation in Medicaid.**

These votes are intended to provide guidance to the Commission on Medicaid options that allow the design process to advance. This guidance is not binding indefinitely, and Medicaid will be revisited. FTAC members will develop a Medicaid Memo to the Commission that will be shared with the Commission at their February meeting.

Adjournment

Meeting adjourned at 4:46 p.m.

Next meeting

March 14, 2024
Meeting to be held on Zoom
2–4:30 p.m.