5596-S2.E AMH HCW BLAC 042

E2SSB 5596 - H COMM AMD
By Committee on Health Care & Wellness

NOT CONSIDERED 04/22/2011

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** The legislature finds that mounting budget pressures combined with growth in enrollment and constraints in the medicaid program have forced open discussion throughout the country and in our state concerning complete withdrawal from the medicaid program. The legislature recognizes that a better and more sustainable way forward would involve new state flexibility for managing its medicaid program built on the success of the basic health plan and Washington's transitional bridge waiver, where elements of consumer participation and choice, benefit design flexibility, and payment flexibility have helped keep costs low. The legislature further finds that either a centers for medicare and medicaid services' innovation center project or a section 1115 demonstration project, or both, with capped eligibility group per capita payments would allow the state to operate as a laboratory of innovation for bending the cost curve, preserving the safety net, and improving the management of care for low-income populations.

NEW SECTION. **Sec. 2.** A new section is added to chapter 74.09 RCW to read as follows:

(1) By October 1, 2011, the department shall submit a request to the centers for medicare and medicaid services' innovation center and, if necessary, a request under section 1115 of the social security act, to implement a medicaid and state children's health insurance program demonstration project. The demonstration project shall be designed to

achieve the broadest federal financial participation and, to the extent permitted under federal law, shall authorize:

(a) Establishment of base-year, eligibility group per capita payments, with maximum flexibility provided to the state for managing the health care trend and provisions for shared savings if per capita expenditures are below the negotiated rates. The capped eligibility group per capita payments shall: (i) Be based on targeted per capita costs for the full duration of the demonstration period; (ii) include due consideration and flexibility for unforeseen events, changes in the delivery of health care, and changes in federal or state law; and (iii) take into account the effect of the federal patient protection and affordable care act on federal resources devoted to medicaid and state children's health insurance programs. Federal payments for each eligibility group shall be based on the product of the negotiated per capita payments for the eligibility group multiplied by the actual caseload for the eligibility group;

(b) Coverage of benefits determined to be essential health benefits under section 1302(b) of the federal patient protection and affordable care act (42 U.S.C. 18022(b)) with coverage of benefits in addition to the essential health benefits as appropriate for distinct categories of enrollees such as children, pregnant women, individuals with disabilities, and elderly adults.

(c) Limited, reasonable, and enforceable cost sharing and premiums to encourage informed consumer behavior and appropriate utilization of health services, while ensuring that access to evidence-based, preventative and primary care is not hindered;

(d) Streamlined eligibility determinations;

(e) Innovative reimbursement methods such as bundled, global, and risk-bearing payment arrangements, that promote effective purchasing, efficient use of health services, and support health homes, accountable care organizations, and other innovations intended to contain costs, improve health, and incent smart consumer decision making;

(f) Clients to voluntarily enroll in the insurance exchange, and broadened enrollment in employer-sponsored insurance when available and deemed cost-effective for the state, with authority to require clients to remain enrolled in their chosen plan for the calendar year;

(g) An expedited process of forty-five days or less in which the centers for medicare and medicaid services must respond to any state request for changes to the demonstration project once it is implemented to ensure that the state has the necessary flexibility to manage within its eligibility group per capita payment caps; and

(h) The development of an alternative payment methodology for federally qualified health centers and rural health clinics that enables capitated or global payment of enhanced payments.

(2) The department shall provide status reports to the joint legislative select committee on health reform implementation as requested by the committee.

(3) The department shall provide multiple opportunities for stakeholders and the general public to review and comment on the request as it developed.

(4) The department shall identify changes to state law necessary to ensure successful and timely implementation of the demonstration project."

EFFECT: Removes the requirement that the demonstration last for a five year period and that eligibility for Medicaid be verified on a more frequent basis. Removes the requirement that populations receiving additional benefits meet certain clinical criteria, but rather be available for distinct populations as appropriate.

Removes the requirement that the Department of Social and Health Services (DSHS) evaluate the merits of moving to an insurance subsidy model for certain Medicaid populations.

DSHS must provide "multiple" opportunities for input rather than holding "ongoing" discussions with stakeholders.

Removes the specific dates upon which the DSHS must report to the Joint Select Committee on Health Reform Implementation and instead requires DSHS to report at the request of the Joint Select Committee.

Removes the requirement that the Legislature approve any demonstration project prior to implementation.

Revises terminology for consistency.

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