Subject: FW: Tribal Consultation

Hello all – I am attaching a letter that is being sent out to tribal leaders electronically and hard copy along with several update materials. The consultation with tribes on August 2, 2010 is a follow up meeting to the March 9, 2010 consultation on the "bridge waiver". The Bridge Waiver was the request Medicaid Purchasing Administration (formally Health & Recovery Services Administration) at the request of the Governor to request federal assistance from the Centers for Medicare and Medicaid Services to sustain the Basic Health program and Medicaid Care Services (ADATSA & GA).

If you have questions regarding this waiver please contact Jennie Hamilton at 360-725-1101, HAMILJ1@dshs.wa.gov or Deb Sosa at 360.725.1649 or sosada@dshs.wa.gov.

All offices of the Medicaid Purchasing Administration will be closed for state government Temporary Layoff Days- scheduled for Friday, August 6, 2010; Tuesday, September 7, 2010; Monday, October 11, 2010; Monday, December 27, 2010; Friday, January 28, 2011; Tuesday, February 22, 2011; Friday, March 11, 2011; Friday, April 22, 2011; and Friday, June 10, 2011. ***Self service options through the Internet and phone systems will be operative, just as they would for a holiday.***

Deborah A. Sosa
Native Health Program Manager
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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Medicaid Purchasing Administration
626 8th Avenue, SE • P.O. Box 45502
Olympia, Washington 98504-5502

July 7, 2010

Cindy Mann, Director
Centers for Medicare and Medicaid Services (CMS)
7500 Security Boulevard
Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Dear Ms. Mann:

Enclosed is a proposal for an 1115 demonstration waiver to allow Washington State to draw upon the early Medicaid expansion option afforded under the Patient Protection and Affordability Act (PPACA) to sustain our Basic Health (BH) and Medical Care Services (MCS) programs until National Health Reform (NHR) is fully implemented in 2014. As we have discussed, the future of these two programs is in jeopardy without the waiver. With the waiver, Washington State has increased fiscal flexibility to extend a critical coverage bridge to some 90,000 individuals, with about 69,000 financed through the waiver. In 2014, these individuals will transfer to the Medicaid program, or have subsidized access through the Exchange or the PPACA Basic Health option. When that happens, we do not expect any need to continue the waiver.

I believe we have been clear in our view of the bridge period as a "dynamic transition" until full expansion of Medicaid in 2014. We understand that approval of Washington's proposed demonstration will require the state to increasingly align both the BH and MCS programs with the 2014 Medicaid requirements. To this end, our proposal includes realistic "transitional bridge" milestones, with timing constraints where movement towards PPACA compliance requires statutory and/or regulatory changes or must adapt to the contractual obligations of our managed care procurement cycles. The waiver proposal also includes key issues that Secretary Sebelius and Governor Gregoire recently discussed.

Although the pace of change primarily hinges on the state's challenging fiscal recovery, I want to emphasize that we are not looking to supplant or backfill the state's budget gap. We offer a natural operating environment for informing and demonstrating applicable new NHR standards and requirements as they evolve and for addressing potential administrative and systems challenges during the transition to NHR. I am certain this would benefit CMS and other states as we all prepare to implement NHR.

Governor Gregoire and I look forward to continued technical assistance from you and your staff so we can reach agreement on our 1115 demonstration waiver this summer and successfully complete the formal approval documents as soon as possible.

Sincerely,

Doug Porter
Assistant Secretary

Enclosure

cc: Susan Dreyfus, Secretary, Department of Social and Health Services
Roger Gantz, Director, Medicaid Purchasing Administration
Jenny Hamilton, Program Manager, Medicaid Purchasing Administration
Kelly Heilman, CMS Central Office
Thuy Hua-Ly, Director, Medicaid Purchasing Administration
Susan Johnson, CMS Regional X Office
Nick Lutes, Governor's Office of Financial Management
Richard Onizuka, Director, Health Care Authority
Heidi Robbins Brown, Deputy Assistant Secretary, Medicaid Purchasing Administration
Mark Rupp, Governor's Office
Jonathan Seib, NHR Policy Advisor, Governor's Office

WASHINGTON STATE 1115 DEMONSTRATION WAIVER PROPOSAL
TRANSITIONAL BRIDGE FOR LOW-INCOME ADULTS

A. Background

Since Washington State's initial January 19, 2010 concept paper, federal and state level fiscal and policy dynamics have resulted in a series of course adjustments. The opportunity to review these with the Centers for Medicare and Medicaid Services (CMS) has allowed us to clarify the need for an 1115 demonstration waiver and develop the details of Washington's proposal. This section recaps our path to this point.

Initial Concept Anticipating Enactment of National Health Reform:

In January 2010, we submitted a concept paper to Secretary Sebelius requesting a federal financing partnership to help sustain two separate state-funded programs, Basic Health (BH) and Medical Care Services (MCS), as a bridge to National Health Reform (NHR). Our assumption at that time was that NHR enactment was imminent using the framework defined by the Patient Protection and Affordable Care Act, (PPACA). Under the PPACA, individuals with family incomes up to 133 percent of the federal poverty level (FPL) were expected to be covered through Medicaid; those with incomes between 133 and 200 percent of the FPL would receive subsidized coverage available in a Health Insurance Exchange or state Basic Health option. Relative to this NHR framework, our concept was seen as a bridge for individuals who would ultimately become "*new Medicaid eligibles*" but who were facing a potential loss of coverage in the BH and MCS programs as a result of Washington's continuing fiscal crisis[1].

Revised Focus on Parents/Caretaker Relatives:

Working with the Centers for Medicare and Medicaid Services to understand the possibilities and challenges when NHR appeared stalled, we diverted Washington's concept to target only *"parents/caretaker relatives"* enrolled in BH, with incomes up to 200 percent of the FPL, the upper program limit. We believed that this group, approximately 20,000 citizens, could potentially be eligible for Medicaid financing under a Section 1931 State Plan Amendment (SPA) today. We set about revising our concept paper to target this group, respond to CMS's questions, and remain nimble should NHR actually be enacted.

State Budget Complications:

A new state revenue forecast indicating a $2.8 billion gap further intensified the state's fiscal crisis beyond that anticipated in our original concept paper. Mid-March, the 2010 Legislature was called back for a Special Session to finalize the 2010 Supplemental budget, which was delivered to the Governor on April 13, 2010 for signature. Following debate on a variety of options for generating the revenue critical to sustaining the BH and MCS programs and funding the budget in general, the current budget (ESSB 6444) includes explicit proviso directives for the Department of Social and Health Services (DSHS) and Health Care Authority (HCA) to seek federal matching funds for the BH and MCS programs through an 1115 demonstration waiver. State funding for both programs is currently assumed through June 2011, with the caveat that the MCS program will have to adopt enrollment duration limits and if federal funding is not approved, the BH program will reduce enrollment below its 65,000 enrollment target[2].

Enactment of National Health Reform:

Enactment of NHR brought us full circle. Beginning April 2010, NHR allows states to expand their Medicaid coverage to 133 percent of the FPL. However, for the foreseeable future (through June 2013) Washington State will not have sufficient state funds to support a full Medicaid entitlement expansion. Envisioning that our future coverage infrastructure would build on the platform defined by NHR, we submitted a revised concept paper in April 2010, applying the opportunities available through NHR (and existing SPA expansion options) to sustain the BH and MCS programs as originally conceived.

Proposal for an 1115 Demonstration Waiver - Transitional Bridge to NHR:

Our current proposal requests an 1115 demonstration waiver to implement a transitional bridge to NHR based on the existing BH and MCS programs. As described in our previous concept papers, this would allow low-income individuals enrolled in these programs to sustain coverage until the full expansion of the Medicaid program takes effect in 2014. At that time, individuals with family incomes up to 133 percent of the FPL would be covered under the Medicaid State plan; those with incomes between 133 and 200 percent of the FPL could receive subsidized coverage available in a Health Insurance Exchange, state Basic Health option or via a further Medicaid expansion. Relative to this NHR platform, our proposal is an effective bridge for "new eligibles" who otherwise could be uninsured as a result of Washington's fiscal crisis.

By definition, Washington's demonstration is time-limited – it ends in January 2014 and effectively covers only about three years. During that time, we propose to use Medicaid funds to support coverage for eligible adults with family income up to 133 percent of the FPL - based on the TANF methodology for income determination. This would allow us to continue the BH program at its current coverage maximum of 200 percent of the FPL - based on the BH gross income methodology for program eligibility- and also sustain the separate MCS program. Subsidies for BH and MCS individuals who do not qualify for federal support from Medicaid matching funds would continue to be fully state funded.

The demonstration is integral to our ability to contemplate a role for the NHR state Basic Health option[3] in Washington's future. As described above in *State Budget Complications*, the 2010 Legislative budget directs BH to reduce enrollment if the transitional bridge proposal is not approved. If that occurred, the BH program's ongoing viability would be jeopardized[4], and we would likely face the prospect of dismantling and subsequently having to rebuild the program and its administrative infrastructure to support a state Basic Health option as part of NHR implementation in 2014. Retaining the MCS program ensures that, even with limited state resources, Washington can continue to provide coverage for its most medically and behaviorally vulnerable adults who are currently not otherwise eligible for Medicaid and Supplement Security Income (SSI).

From a *state* perspective our proposal gives Washington the flexibility to sustain coverage for at least 90,000 individuals and prepare to implement the *full* range of coverage options under NHR during the transitional bridge.

From a broader *national* perspective our proposal offers an early-learning laboratory to identify and resolve issues that many states will face in preparing for a smooth transition to NHR. It clearly demonstrates the value of NHR as the vehicle for coverage expansion. And it facilitates resolution of operational and system challenges involved in linking multiple options for subsidized coverage, an expectation of NHR in 2014. States have little more than three years to get ready. At the same time, most are faced with ongoing enormous fiscal challenges and resource constraints. Washington's demonstration jumpstarts the process with planning milestones that begin the transition to NHR as standards are developed and implemented.

B. Revised Transitional Bridge Proposal

This document combines relevant portions of earlier concept papers and clarifies Washington's proposed demonstration in response to discussions, questions raised, and critical changes required by CMS. Assuming readers are familiar with Washington's previous concept papers, transitional milestones are presented first to confirm that this is not a static demonstration. Remaining sections emphasize where federal authority still appears necessary with additional details provided to answer CMS' questions. And financial details of the proposal are now included in sections 9-10.
Contents of the revised proposal include:

1. Transitional bridge milestones
2. Maintenance of effort
3. Demonstration programs overview
4. Management of enrollment levels
5. Eligibility determination
6. Benefits and cost sharing
7. Managed care requirements
8. Tribal consultation and public notice
9. Budget neutrality
10. Standard funding questions.

1. Transitional Bridge Milestones:

With federal approval, implementation of our transitional bridge will begin no later than January 1, 2011. We would actually like to implement in 2010 if possible; our Congressional delegates have set October 2010 as their target. We have described our proposal as a "dynamic" transition, recognizing that although the demonstration purpose is to help stabilize both BH and MCS programs for the foreseeable future, it covers the period in which Washington will need to prepare for implementation of NHR in 2014. Transitional bridge milestones therefore expedite our readiness for NHR. They begin on January 1 of the year noted unless statutory authority or a managed care contracting update is needed, which would potentially delay implementation until July 1. Milestones include:

2011:

- Citizenship determination based on data matching through the social security verification system. This includes development of an automated interface for childless adults and parents/caretaker relatives which will inform the potential interface requirements among coverage options for low income populations in 2014.
- Elimination of MCS time limits (i.e., maximum eligibility period of 24 months in a 5 year period). Because current statutory direction does not end this restriction until June 2013 and the current budget will need revisions, this will require legislative action which cannot be accomplished until the 2011 session.
- Screening of new BH applicants for Medicaid eligibility and enrollment. This will require regulatory changes and may need additional statutory authority.
- Income determination for identification of BH and MCS individuals eligible for federal match claim based on the Family Medicaid (TANF) methodology as allowed in the CMS guidance letter of April 9, 2010.
- Rollback of monthly premium cost sharing to 2009 levels for the lowest income BH enrollees (i.e., individuals with family income from 0-65 percent of the FPL) from $34 to $17.
- Mental health parity for Basic Health. Statutory and regulatory changes have been completed.

- Basic Health currently meets ~90% of the relative value of Medicaid coverage (i.e., scope of benefits). The level of BH and MCS scope of services would not be reduced nor cost sharing increased before 2014.
- No cost sharing for preventive care.
- Elimination of pre-existing condition waiting period for BH children (limited numbers).
- Fair hearings for Basic Health (denials of service) processed through Medicaid systems once the formal Independent Review Organization (IRO) process is exhausted. Regulatory changes will be needed.
- Administrative and information system challenges and enhancements identified *(if any)* to:
    - track out-of-pocket charges and determine 5% aggregate cost sharing cap for low income population coverage options in 2014;
    - ensure that no federal financing support is claimed for services provided in Institutions for Mental Disease (IMDs) – currently this is approximately 2% of expenditures for the MCS program, 0% for BH; and
    - Allow a smooth interface among coverage options that support low income populations. Manual administrative controls may initially be necessary, with automated processes developed over time to meet PPACA compliance in 2014.

2012:

- Competitive purchasing efficiencies including joint BH/Medicaid procurement (with standardized quality and performance measures, application streamlining, common Basic Health/Medicaid managed care delivery system) and delivery system streamlining to fully support mental health parity for all MCS enrollees. These will require regulatory and managed care contract changes.
- Methodology implemented for determining and capturing demographic data to identify American Indian/Alaskan Native (AI/AN) tribal membership. This will inform the potential interface requirements among coverage options for low income populations in 2014 to support cost sharing restrictions for AI/AN individuals.
- Elimination of pre-existing condition waiting period for BH adults.

2013:

- Modified adjusted gross income (MAGI) calculation for Basic Health program eligibility (assuming details known) as an opportunity to work out any administrative challenges prior to PPACA compliance in 2014.
- Cost sharing evaluation findings (and implications) available.

2014:

- Prepared to adopt PPACA requirements for Medicaid.
- Single contract (to be considered if state Basic Health option offers best continuity of coverage/cliff avoidance for 133-200% FPL individuals).

The state is currently collaborating with managed care carriers to develop payment reforms based on development of medical home and accountable care organization pilots. Implementation timing has not yet been determined but is likely to occur during the transitional bridge period; benefits will potentially accrue to the demonstration population since health plans engaged include those that contract with the BH and MCS programs. Furthermore, the state is engaged in ongoing efforts to more fully integrate behavioral and medical health to expand the concept of a medical home to a "*person-centered health home*" and to allow for more efficient and effective management of the highest risk individuals.

2. Maintenance of Effort

Anticipated Need for Federal Authority:

Since the February Revenue Forecast, Washington has experienced 3 months of under-performance with revenues less than projected. While Washington currently has a balanced state budget with state funding for the BH and MCS programs assumed through June 2011, the state's June 17, 2010 Revenue Forecast projects ongoing fiscal constraints[5]. The director of the state Economic and Revenue Forecast Council reports that job growth has slowed and will remain slow; recovery is hampered by tight credit for small businesses and the vulnerability of regional banks that have greater exposure risk in the commercial real estate sector. The continued "restrained recovery" is compounded by the uncertainty surrounding federal approval of a 6 month extension of the ARRA FMAP enhancement that provides aid to state Medicaid programs. Furthermore, as Washington begins work on its 2011-13 budget, the state's Office of Financial Management projects a $3 billion shortfall for that period and the Governor has announced a rigorous new budget-building process, available at: http://governor.wa.gov/priorities/budget/transformbudget.pdf.

Under this backdrop Washington cannot guarantee a certain level maintenance of effort in its proposal for a demonstration waiver. We are not looking to backfill the state's budget gap. Instead we propose a shared risk approach that limits federal exposure in proportion to the level of funding the state is able to spend on demonstration populations. Rather than traditional aggregate federal spending we propose the "per capita client spending" approach described in detail in section 8, *Budget Neutrality.* To implement this shared-risk approach we would need federal authority to allow Washington to adjust the BH and MCS program projected expenditures based on available revenues, with a reciprocal adjustment in the federal contribution to avoid any sup plantation effect. Our fiscal situation at this time does not allow us to promise otherwise.

3. Demonstration Programs Overview

Anticipated Need for Federal Authority:

- **Separate Programs:** Washington's demonstration supports 2 separate coverage options for low income individuals, Basic Health and Medical Care Services, which are maintained as separate programs because their risk profiles are very different. To combine them under the BH program as CMS has asked about, would increase the BH program's risk profile and result in premiums that are no longer affordable for BH enrollees. For example, the projected 2011 member premium for the MCS program[6] (approximately $1,041) nearly quadruples the projected average premium for the BH program (approximately $275). Based on discussions with CMS we understand that federal authority *may* be needed to continue operating BH and MCS as separate demonstration programs.

To put the demonstration in context, a current snapshot of the broad array of Washington public coverage programs is provided in Appendix 1, excerpted from our original concept paper. Here we describe only those programs supported by Washington's proposed transitional bridge demonstration.

Basic Health (BH):

The BH began in the late 1980's, designed as a state subsidized pool emphasizing affordable coverage for low-income working adults in families with incomes up to 200 percent of the FPL[7]. Operating statewide since 1993, BH requires enrollees to make premium contributions based on a sliding scale and point-of-service cost sharing. Standardized benefits are available statewide and delivered through 5 state-contracted managed care plans that currently also provide coverage for the Medicaid program or

we anticipate will do so after the next procurement cycle. A fairly detailed chronological history of changes to the program is available at http://www.basichealth.hca.wa.gov/about.html.

Washington's transitional bridge demonstration supports **citizen adults in families with income up to 133 percent of the FPL** based on the TANF methodology for determining income. Estimates indicate this is approximately 70 percent of the current BH enrollment. (Use of the TANF income determination methodology for federal financing purposes is described further in section 5, *Eligibility Determination*.) As planned, these individuals (and remaining BH enrollees) would continue to receive the current scope of benefits and make premium and point-of-service cost-sharing contributions until full implementation of NHR in 2014. Our goal is to continue to provide coverage for as large a BH pool as possible as Washington transitions to NHR.

Medical Care Services (MCS):

MCS provides medical coverage to some of the state's most vulnerable adults who are not otherwise eligible for Medicaid. These individuals can be grouped into 2 key programs, Disability Lifeline and Alcohol and Drug Addiction Treatment Support Act (ADATSA), which we propose will be supported by federal financing of our transitional bridge. As described below, a subset of the Disability Lifeline caseload can transfer to existing Medicaid Categorically Needy coverage instead, and receive general assistance through SSI. Washington's transitional bridge demonstration also supports all **citizen adults** in the MCS program based on the TANF methodology for determining income. Estimates indicate this is just over 90 percent of the current enrollment since all MCS enrollees have **incomes well below the threshold of 133 percent of the FPL.**

- **Disability Lifeline – *previously known as General Assistance***

  Washington is one of only 12 states that provide both medical coverage and cash grants - collectively known as general assistance - to very low-income adults without dependents. These individuals are physically or mentally incapacitated and expected to be unable to work for at least 90 days. Some have temporary conditions that enable them to exit general assistance and return to work after a short time; others have chronic conditions and need medical coverage for an extended period. Of this latter group, one-third eventually applies and qualifies for Medicaid and SSI.

  During the 2010 Legislative session, major revisions to general assistance were adopted in statute through enactment of E2SHB 2782[8]. Not all changes anticipated in our original concept paper were included; however important changes to manage enrollment were enacted and are described fully in section 4, *Management of enrollment levels*. Programs originally titled "General Assistance" were renamed "Disability Lifeline" to better reflect their intent.

  "Disability Lifeline" (DL) – previously known as General Assistance Unemployable (GA-U): Adults under age 65 who do not meet SSI criteria as disabled or blind, and whose primary incapacity is not substance abuse or chemical dependency, receive medical coverage through the MCS statewide contract for managed care[9]. Our transitional bridge demonstration includes this population of **"incapacitated" adults** whose income is generally **no more than ~38 percent of the FPL**. As a result of E2SHB 2782, their managed care contract must provide for integrated delivery of medical and mental health services.

  An additional group of adults who are legal residents, age 65 or older, and would meet SSI criteria as either blind or disabled but for their current citizenship status, also receive medical coverage delivered primarily via fee-for-service. This group was ***previously known as General Assistance Aged, Blind and Disabled (GA-ABDR).*** Our original concept papers suggested that a small number of these individuals, whose income is generally **no more than 75 percent of the FPL,** would be included in our transitional bridge financing. This is no longer the case.

"Disability Lifeline Expedited" (DL-E) - previously known as General Assistance Expedited (GA-X):
DL adults with the most serious impairments who are likely to meet the disability criteria for SSI (based on an assessment by a contracted physician) are *required* to apply for SSI[10]. Upon application to SSI, these individuals transition to DL-E status where they are presumed eligible for Medicaid coverage while their SSI application is reviewed. As a result, our transitional bridge also does not include this population. However, if DL-E individuals are ultimately determined ineligible for SSI they would return to the DL program, continue medical coverage through the MCS delivery system and "rejoin" the transitional bridge demonstration. E2SHB 2782 directs a more systematic screening to identify all individuals likely eligible for SSI to ensure those eligible for full Medicaid coverage receive their entitlement and those with no other options enroll in the DL program.

- **Alcohol and Drug Addiction Treatment Support Act (ADATSA)**

  Individuals precluded from gainful employment due to a primary incapacity of drug or alcohol addiction receive chemical dependency (CD) treatment delivered via fee-for-service under the ADATSA program rather than DL. Individuals must comply with requirements for treatment to remain eligible for services and they typically remain on the ADATSA program about 10 months.

Exhibit 1 summarizes the assistance programs with health coverage for transitional bridge demonstration groups shaded in green.

Exhibit 1: Overview of Medical Coverage for Incapacitated Adults

Program	Medical Coverage Delivery System (Transitional Bridge Populations Shaded)	*Average* State FY09 Monthly Count
Disability Lifeline *(previously GA-U)*	Medical Care Services - Managed Care	15,948
Disability Lifeline *(previously GA-ABDR)*	Medical Care Services – Fee-for-service	Less than 1,000
Disability Lifeline – Expedited *(previously GA-X)*	Presumptive Medicaid - Fee-for-service	13,982
Alcohol and Drug Treatment (ADATSA)	Medical Care Services - Fee-for-service	4,490

4. Management of Enrollment Levels

Anticipated Need for Federal Authority:

- **Enrollment limits:** Since the inception of the BH program, enrollment has been managed within *fiscal limitations*. Since 2009 an *approximate enrollment cap of 65,000* has been defined in statute. The MCS program has traditionally been treated as a caseload-driven program. Recent clarification of the impact of E2SHB 2782 confirms that it continues to be based on a caseload forecast, but its status has changed so that like the BH program it too must now be administered within funds appropriated for the biennium. If the actual caseload were to exceed projections, either a statutory request would be necessary to spend the additional funds required to sustain the increased enrollment or the program might need to initiate enrollment limits.

  The BH program has never been a caseload driven program and while the state faces a likely budget shortfall for the next biennial budget that is not likely to change.

  To implement our transitional bridge demonstration, Washington would need federal authority to reserve the ability to implement enrollment caps for the BH and MCS programs should that be necessary until NHR implementation in 2014.

- **Medical Care Services time limits:** In an effort to limit expenditures for the few individuals who did not transition back to work but were not disabled enough to qualify for SSI, E2SHB 2782 imposed time limits on enrollment in the Disability Lifeline (DL). From September 1, 2010 until June 30, 2013, medical coverage for those who remain on DL will be limited to 24 months in a 60 month period, pending a review of likely eligibility for SSI and therefore transfer to the DL-E program. CMS reiterated that time limits are a major stumbling block for Washington's demonstration and stakeholders have expressed similar concerns. Although current statute ends time limits in July 2013, we propose to eliminate them altogether for the MCS program; however, this will require a change in appropriation authority that could not occur before the 2011 Legislative session. We will therefore need federal authority to continue time limits until Legislative action can occur for implementation in July 2011.

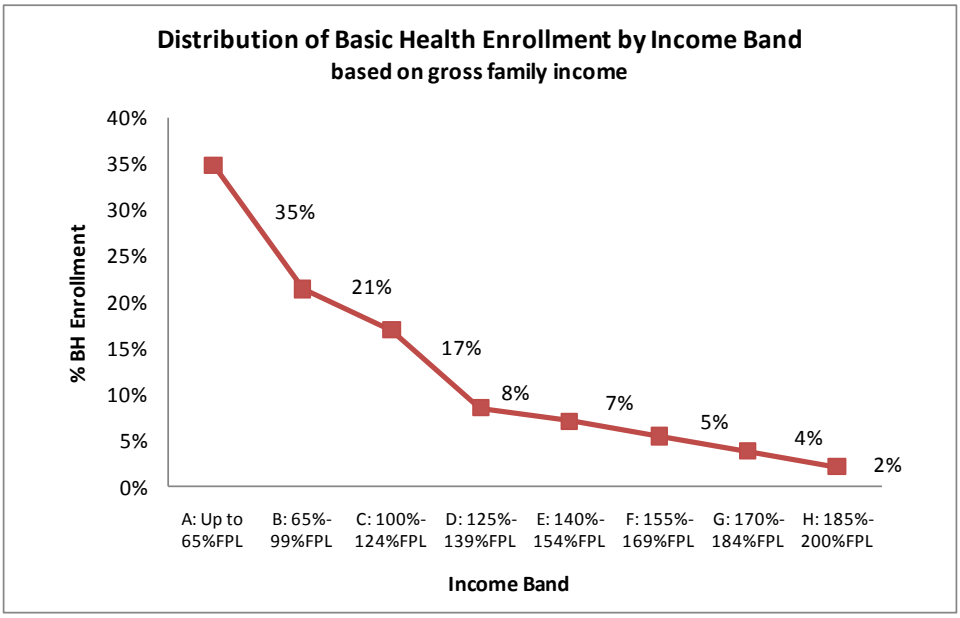
The remainder of this section provides background details on enrollment trends, estimates of uninsured Washingtonians who could potentially be eligible for BH or MCS coverage, and the estimated impact of time limits as currently directed in statute for the MCS program.

Enrollment Trends and Prioritization:

- ***Basic Health:***

  BH enrollees fall into 8 groups, or bands, defined by income. Exhibit 2 shows that enrollment is skewed toward families with the lowest incomes. More than a third of the total enrollment falls in the lowest income band A, with gross family incomes up to 65 percent of the FPL, currently $1,194 per month for a family of four.

Exhibit 2:



If our proposed demonstration is approved, the 2010 Legislative budget allows expansion of the BH program *beyond* its current limit of "approximately 65,000". However, particularly given our ongoing fiscal challenge, we still will need to manage BH enrollment within available funding. In recent years this has necessitated the adoption of a wait list, which has grown to well over 100,000 since our original concept paper. Statutorily defined groups[11] are given enrollment priority and bypass the wait list; these are the *only* applicants who have actually been enrolled since the current list was implemented in May 2009[12]. For the most part enrollment follows a policy of *first-come first-served.* This has always been the case.

CMS has expressed concern that in times of fiscal austerity this may disadvantage the lowest income applicants and skew enrollment towards higher income bands. What we have seen is that the policy effectively sustained a consistent distribution that mirrors the pattern shown in Exhibit 2 - for years. From January-June 2010, when we might have expected a difference as a result of changes in cost sharing, the distribution of new enrollees paralleled that of existing enrollees. Because BH enrollees have few other affordable coverage options, enrollment has remained very stable – monthly exits have now slowed to around 1%. Recent analysis of the change in enrollment over the last year shows extraordinarily little churn – in general, enrollees are one year older and their duration of BH coverage is one year longer. In spite of increased cost sharing (see section 6, *Benefits and Cost Sharing)* we have no indication that the lowest income band enrollees are leaving the program to be replaced by individuals in higher income bands.

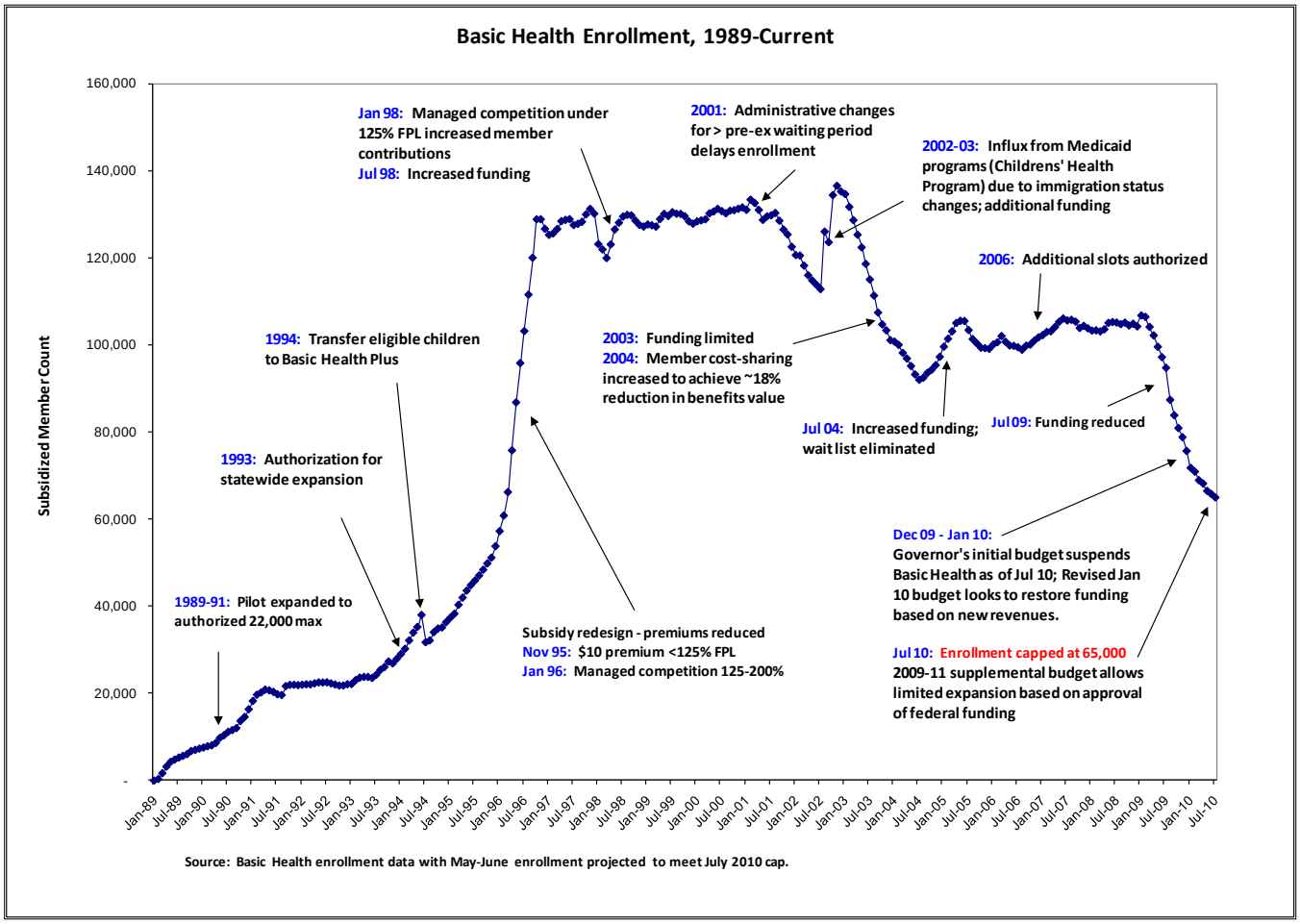
To avoid the need for limitations on BH enrollment, CMS suggested that Washington identify a level of federal poverty below which enrollment could be an automatic entitlement. Given its budget constraints, the state appears unable to set a level of entitlement low enough to be affordable. Estimates of Washington's uninsured population likely to be eligible for BH coverage are shown in Exhibit 3, from analysis of the latest (2008) state biennial population survey. These individuals are concentrated in families with the lowest incomes. More than half this group appears to have not been working at the time of the survey, consistent with prior survey results, and likely to be a growing number as a result of recent economic challenges. Estimates of **citizen** adults with incomes up to 25% of the FPL, who could potentially be eligible for BH coverage, (i.e., approximately 114,000 childless adults and 13,000 parents) would nearly triple the size of the program[13]. At this time the state simply could not afford this, with or without federal financial support.

Exhibit 3: Overview of 2008 Washington State Population Survey Estimates of Uninsured Citizens Under Age 65

Washington's Uninsured Population	Total
Total citizens under age 65	645,000
Of these citizens: – the number of parents and childless adults	570,000
Of these parents and childless adults: - the number with income less than 133% of the FPL (based on gross income)	253,000 childless adults 58,000 parents
- the number with income less than 25% of the FPL	114,000 childless adults 13,000 parents

Exhibit 4 graphically presents BH's enrollment history over the past two decades - fluctuations have always been tied to legislative appropriation. Based on enrollment that from the mid 1990s rarely waivered below 100,000, reached a cap of 130,000 in 2003, and then declined during the 2003-05 and current recessions, it is clear that low income Washingtonians find BH coverage critical.

Exhibit 4:



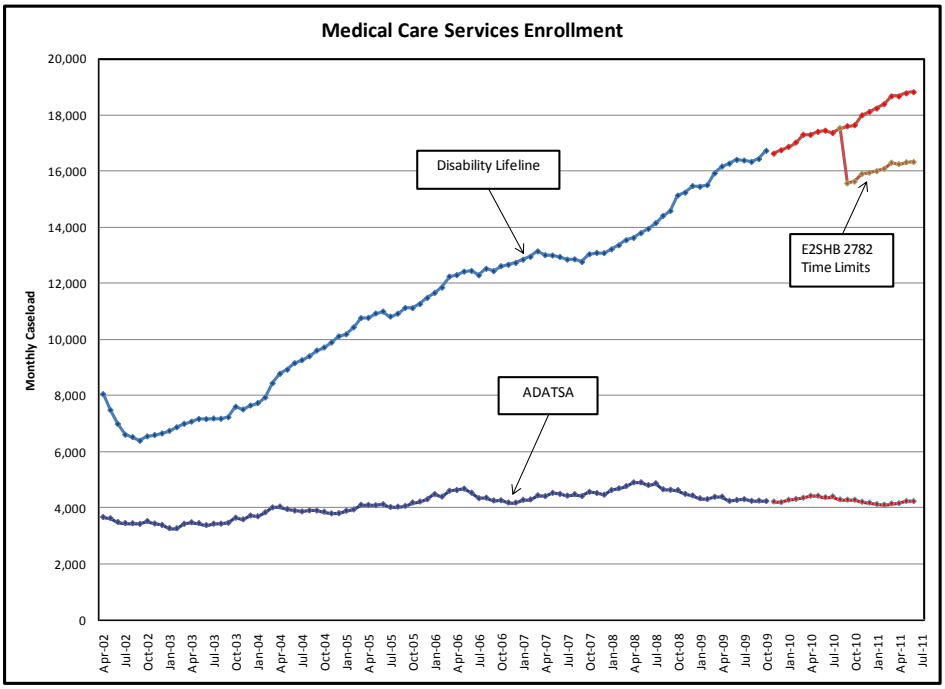
Source: Basic Health enrollment data with May-June enrollment projected to meet July 2010 cap.

- ***Medical Care Services:***

  Exhibit 5 updates the graphic history of the MCS caseload since July 1993. Most notable trends are (a) a steep decline in 2002, the result of an intensified effort to identify GA-U (now DL) recipients likely to be eligible for SSI and thus transferred to GA-X (now DL-E) where they would receive Medicaid coverage[14], (b) the recent surge in enrollment during the recession to over 18,000 individuals receiving MCS coverage today, and (c) the potential impact of the E2SHB 2782 time limits, which effectively set enrollment counts and trends back a year. The ADATSA caseload has remained fairly constant, at around 4,000 for the last 8 years.

  Without MCS coverage, these individuals have few options. Unless their incapacity would make them eligible for DL-E and Medicaid coverage they would not be eligible for Medicaid until their incapacitating condition deteriorated. While they may be eligible for BH, the current wait list makes that a distant option.

Exhibit 5:



As described, the MCS program has been directed to adopt time limits in September 2010 and to ensure that DL clients engage in prescribed treatment and services that will set them on a path back to employment, those that refuse without good cause[15] will be disenrolled. Time limits, a maximum of 24 months over a 5 year span, would retroactively apply to DL clients currently receiving MCS coverage but do not apply to individuals applying for SSI who are eligible for Medicaid during their application period. In addition, time limits do not apply to the previously GA-ABDR population of elderly and disabled individuals who are not eligible for Medicaid due to their immigration status.

Based on current case reviews, which are ongoing, approximately 4,400 individuals have been receiving services for at least 20 months and a further 3,500 have been receiving coverage for at least 12-19 months. By September all these individuals are to be reviewed to determine their eligibility to transfer to SSI. No one can be disenrolled from DL due to time limits until a review of their disability and determination of their potential eligibility for SSI is made.

Based on the status of reviews completed by June 7, 2010, about half the individuals on DL for 20 months, nearly 1,000 individuals have been referred to a SSI facilitator. The remainder will continue to receive MCS coverage for the time being. Projected impacts of MCS time limits are shown in Exhibit 6. While ***caseload growth will continue to occur even with time limits***, for the full period in which time limits have been directed, we project an average reduced caseload of approximately 10 percent, close to 1,800 individuals per month. By June 2013 when time limits end, the forecasted caseload of about 20,000 individuals would have been reduced to about 18,000.

Exhibit 6: Overview of Projected Impact of MCS Time Limits (based on current caseload forecast)

Forecast Period	Enrollment Impact
September 2010	
Forecast without time limits	17,412
Forecast with time limits	15,396
Impact of the instigation of time limits	~12% reduction in Sep 2010
January – December 2010 (first year with time limits)	
Average forecast without time limits	17,358
Average forecast with time limits as of Sep 2010	16,706
Impact of time limits CY10 (first year with limits)	~3% increase over CY2009 (~7% increase was forecast) without time limits)
January – December 2013 (last year with time limits)	
Average forecast without time limits	20,053
Average forecast with time limits in place from Jan-Jun and eliminated July 2013)	19,076
Impact of elimination of time limits as of Jul 2013	~13% increase over CY2012 (~7% increase was forecast without time limits)
September 2010 – June 2013 (full period during which time limits directed to be in place)	
Average forecast without time limits	18,336
Average forecast with time limits	16,560
Overall impact on MCS enrollment	~10% reduction Sep 10 – Jun 13

E2SHB 2782 allows MCS coverage to be extended beyond 24 months if Washington's transitional bridge demonstration is approved. "*To the extent authorized in the operating budget*", MCS coverage may also be reinstated for individuals terminated from DL as a result of exceeding the time limits prior to federal approval of the transitional bridge demonstration. There is no explicit reference to this in the 2010 supplemental budget and funding that would allow the removal of time limits was not included.

Discussions with CMS have required us to take a closer look at the impacts of alternatives on Washington State and on low income vulnerable adults who face potential termination from the MCS program. We compared the outcomes of (a) a federally approved demonstration waiver with no time limits and (b) no waiver with continued time limits. The results of anticipated federal financial support were compelling. **We now propose to obtain statutory authority to eliminate time limits for MCS coverage as soon as possible rather than waiting until they expire in June 2013 per current statute.**

5. Eligibility Determination

Anticipated Need for Federal Authority:

- **Use of early Medicaid expansion:** Under Washington's current Medicaid State plan, eligibility is limited to individuals who fall into specified categories which historically included five broad coverage groups – children, pregnant women, adults in families with dependent children, individuals with disabilities, and the elderly. Additional eligibility determination is a function of income, resources, immigration status, and residency. The passage of NHR now adds "childless adults" to

the eligible coverage groups and allows an "early Medicaid expansion" to include them after April 1, 2010. Unfortunately, as we have reiterated, Washington cannot afford a traditional early Medicaid expansion at this juncture. Instead, we will need federal approval of our proposed transitional bridge demonstration to apply the "early Medicaid expansion" to adults receiving coverage through the BH and MCS programs.

- **Income eligibility:** As a result of the flexibility offered in the PPACA, determination of eligibility for the transitional bridge demonstration has been revised since Washington's previous concept papers. We now propose to:
  1. Maintain the current ***gross income*** test to determine eligibility for initial enrollment in the BH program and;
  2. Use ***Family Medicaid (TANF) income disregards, with no resource test***, to identify BH enrollees eligible for a federal financing claim.
  3. Use ***Family Medicaid (TANF) income disregards*** **with a standard $1,000 resource test**, to determine eligibility for enrollment and federal financings for the MCS program. This is consistent with the program's current operating standards.

  We believe this approach is in accordance with CMS' April 9, 2010 guidance letter in which "countable income" for the Section 1902(k)(2) early expansion can be based on methods that are "reasonable, consistent with the objectives of the Medicaid program and are in the best interest of the [Medicaid] beneficiary." This policy guidance allows states to use an existing income determination method, such as SSI or TANF. We *may* need federal approval to use the TANF methodology from the start of the demonstration.

- **Incarcerated individuals:** While the BH program screens applicants to exclude any who are incarcerated at that time, it does not specifically check for later incarceration. Enrollees whose premiums are paid up-to-date remain on the program. Program administrators are not aware of any currently incarcerated enrollees and believe the likelihood is minimal. We *may* need federal approval, in case the situation ever arises during the demonstration.

- **Medicaid Screening**: CMS has expressed concern that individuals applying for BH are not screened for Medicaid coverage unless they are pregnant or a child likely eligible for BH Plus (i.e., covered by Medicaid). We have also been advised that no current 1115 demonstration waiver has been approved in which Medicaid-eligible individuals are included in the demonstration population. We propose to incorporate screening and enrollment in Medicaid for ***new*** BH applicants beginning with the start of the demonstration. We *may* need federal authority to allow current BH parents/caretaker relatives eligible for Medicaid to remain in BH. Estimates are provided below.

This section provides further details on the estimated demonstration populations. Based on current enrollment in the BH and MCS programs, Washington would be able to claim federal financing support for an estimated 69,000 citizen adults in our proposed transitional bridge population – approximately 48,000 covered through BH and about 21,000 covered through MCS. **This estimate is larger than reported in our previous concept papers as a result of using the TANF income methodology to determine eligibility for federal financing support**.

Estimated Transitional Bridge Demonstration Population:

- ***Basic Health:***

  Analysis of BH enrollment confirmed just over **18,000 "parents/caretaker relatives"** whose income and citizenship status would make them a target for federal financing support in our transitional bridge demonstration. Parent status and citizenship were confirmed through a match process that first checked against Washington State's public assistance files for the presence of a household

member (child) receiving assistance, and then verified associated social security numbers using the automated federal social security system.

The lowest income adults in BH are predominantly those without dependents and without an "incapacity" that would make them eligible for MCS coverage. As a result, they have very limited access to affordable coverage options – BH is it. ***Estimated* at about 30,000, these citizen "childless adults**" would make up the bulk of the transitional bridge demonstration population eligible for federal financing support. As with the parents/caretaker relatives, citizenship would be determined through the automated federal social security system. A system interface for this process would be formalized by the start-up of the demonstration and automated as soon as possible thereafter. None of these individuals is assumed to be eligible for current Medicaid coverage.

In 2014, we anticipate that most (if not all) of the proposed demonstration BH population would transition to Medicaid; the remainder (if any) would transition to subsidized coverage in either the state Basic Health option or an Exchange. Coverage post NHR would therefore be either consistent or even more robust than that received during the demonstration.

- ***Medical Care Services:***

  Given their low incomes, most individuals eligible for MCS coverage under the DL and ADATSA programs will also transition to a Medicaid entitlement in 2014[16]. We anticipate a partnership of state and federal financing through the transitional bridge demonstration would sustain coverage for about **20,900** of these individuals, a slight decrease in estimates given in our previous concept papers as a result of the citizenship verification interface with the automated federal social security system. Most come from the DL population, as shown in Exhibit 7.

Exhibit 7: Estimated MCS Transitional Bridge Population Eligible for Federal Financing Support

Program	Medical Care Services Delivery System	*Estimated Transitional Bridge Population*
Disability Lifeline (DL)	Managed Care	*At least* **17,000** (approximately 89% of the total DL population is presumed eligible based on citizenship verification processes – the denominator includes the previous GA-ABDR population that will not be part of the demonstration)
Alcohol and Drug Treatment (ADATSA)	Fee-for-service	*At least* **3,900** (approximately 98% of this population is presumed eligible based on citizenship verification processes)

Medicaid and Transitional Bridge Eligibility Interface:

The MCS program uses existing Medicaid eligibility determination to ensure that individuals have exhausted all Medicaid avenues before they can be made eligible for coverage through MCS. Like the SSI program these individuals are reassessed periodically to identify ongoing incapacity that would trigger transfer to DL-E and potentially SSI where coverage is provided through Medicaid.

In response to CMS's questions, Exhibit 8 presents elements of current eligibility determination for the BH program in comparison with Medicaid. During our analysis we could not complete the full formal screening process for all BH parents/caretaker relatives to determine Medicaid eligibility; however, based on income and confirmed citizenship status we estimate that between **9,000-12,000 individuals** could potentially be eligible for Medicaid.[17] The lower number includes citizens only, the larger number includes legal residents who appear likely to have met their 5 year Medicaid bar.

BH and Medicaid programs currently coordinate to ensure that no one is dually enrolled in both programs. Where the situation arises, individuals are disenrolled from BH and retain coverage solely through Medicaid. To adopt full Medicaid screening and enrollment for all 65,000 currently enrolled BH members would require statutory authority and a subsequent *mammoth* administrative effort. It would also require a Legislative commitment to retain financing in BH to support new membership as Medicaid-eligibles are transferred, otherwise BH enrollment would be reduced to a level at which managed care contracting could be jeopardized. Our actuarial consultants have noted that a substantial influx of new enrollees within current enrollment constraints could result in risk pool degradation and increased uncertainty for managed care contractors whose response to dwindling market share would likely be to drop out. We are concerned that this would seriously compromise competitive purchasing and plan choice that have been hallmarks of the BH program.

Given the current fiscal, political and administrative circumstances we propose to **screen *new* BH applicants for Medicaid eligibility and enrollment during the transitional bridge period**. We understand that PPACA compliance in 2014 will require us to screen all low income individuals for Medicaid eligibility.

The transitional bridge takes advantage of standard Medicaid processes where possible. The information exchange between BH and Medicaid is flowcharted in Exhibit 9. It capitalizes on systems that have linked BH and Medicaid since the mid-1990s, for BH children who are enrolled in "Basic Health Plus" and low income pregnant women. These individuals receive Medicaid coverage but remain linked to family members enrolled in the BH program to ensure the family's continuity of coverage. For the transitional bridge, a pre-enrollment process in BH would take advantage of the Medicaid citizenship verification function which currently is able to locate and confirm social security numbers and citizenship using an automated federal system that links across multiple data sources. Our analysis of "*parents/caretaker relatives"* tested this process.

This same process will be applied to all adults, however, it may need to be partially manual rather than fully automated until systems changes can be implemented. This is an opportunity for Washington to test eligibility determination interface requirements and uncover challenges that will need to be addressed for streamlined coverage to low income individuals in general and PPACA compliance in 2014.

Exhibit 8: Determination of Eligibility under Basic Health, Medicaid and the Transitional Bridge

Process	Basic Health (BH)	Medicaid/MCS	Approach for Transitional Bridge
Categorical Determination			
SSN requirement	BH has not been defined as "public assistance" so the collection of SSN is *voluntary,* although approximately 70 percent of applicants provide an SSN.	Medicaid requires all applicants to provide a SSN.	Washington would maximize availability of SSNs using the standard Medicaid match process that first checks against Washington State's public assistance files and then verifies associated SSNs using the automated federal social security system. This process was successfully tested on BH parents/caretaker relatives. (see citizenship)
Assignment of Medical Support Rights	Not required or identified	Medicaid applicants assign their rights for medical support to the state via an electronic interface with the Division of Child Support. Linked to this is the following "paternity" process.	BH would continue to operate with no changes until details surrounding NHR implementation for "new eligibles" require otherwise.
Cooperation in Establishing Paternity for children	Not required	Required for family medical coverage.	BH would continue to operate with no changes – transitional bridge financing does not apply to children.
Cooperation in securing medical support (third party liability)	Managed care plans are required to conduct and report on their coordination of benefits so that benefits from other coverage take precedent.	Requires client to cooperate in securing medical support through other third party payers if available.	BH currently consistent with Medicaid – further changes would be adopted as details surrounding NHR implementation for "new eligibles" require otherwise.
Application for and enrollment into Medicare	Not required for applicants under age 65 but applicants over age 65 must submit proof of Medicare **in**eligibility. BH will disenroll a client later found eligible for Medicare but does not require application to Medicare as a condition of enrollment in BH.	Required under Medicaid IF the state will pay the required cost sharing expenses for the client. We do not delay opening Medicaid for clients otherwise eligible but may terminate coverage if client does not cooperate in establishing entitlement and enrollment in Medicare.	BH would continue to operate with no changes.

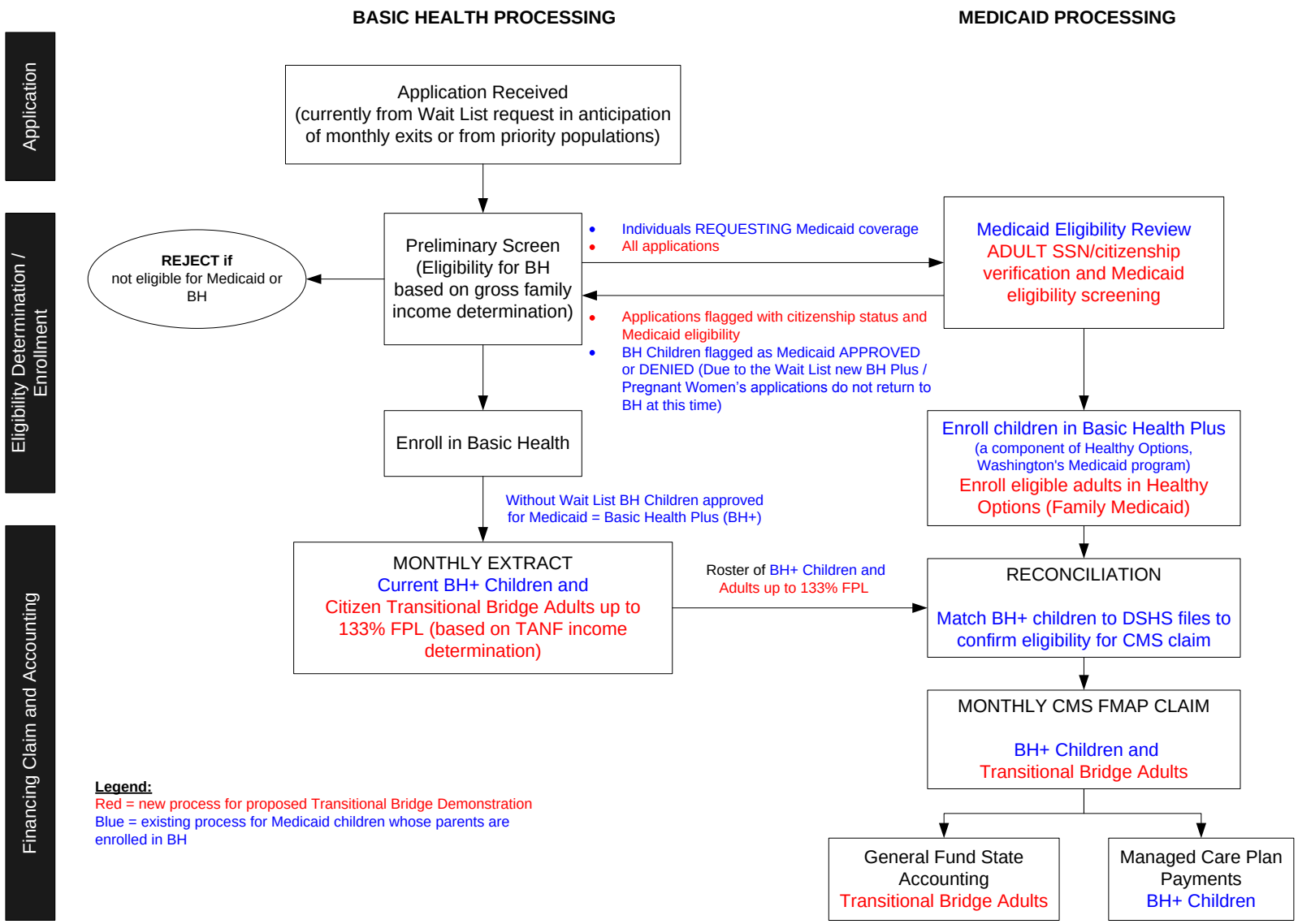
Process	Basic Health (BH)	Medicaid/MCS	Approach for Transitional Bridge
Household composition – dependents	A child may be considered to be a dependent whether they live in the BH applicant's household or not. A subscriber could pay for coverage for a dependent living in another person's home and count that child's unearned income as part of their household income. BH currently allows a child to be dependent through age 22 if they are a full-time student.	Dependents must be in the same household to be included in the Medicaid assistance unit. For Family Medical a dependent is only allowed through the end of the month in which the child graduates from high school. The child could still be eligible for Medicaid through age 19 but their parents would not be.	All citizen adults (parents or otherwise) enrolled in BH would become eligible for transitional bridge financing so long as they meet income requirements – under 133% FPL – as determined using Family Medicaid (TANF) income disregards.
Household composition – spouse	Spouses are not required to receive coverage and be enrolled but their income is counted and they are included in household size for determination of premium contributions.	Spouse's income must be included in the medical assistance unit.	
Domestic partners	Currently not eligible for BH until 2014.	Not eligible for Medicaid as a spouse.	BH would continue to operate with no changes until details surrounding NHR implementation require otherwise.
Estate Recovery 1917(b) SS Act	Not subject to Estate Recovery	Any expenses paid by Medicaid dollars for clients 55 and older are subject to Estate Recovery.	BH would continue to operate with no changes until details surrounding NHR implementation require otherwise.
Institutionalization	BH does not enroll individuals who are institutionalized at the time of application. Existing members who are incarcerated are not disenrolled or suspended as long as their premiums remain current. Based on actuarial analysis BH enrollees do not receive services in Institutions for Mental Disease - costs accounted for less than 0.1% of total costs of BH services provided.	Medicaid does not allow federal financing for institutionalized individuals or for those (age 22-64) in an Institution for Mental Disease (IMD). Clients are not eligible for federal financing from Medicaid when they are institutionalized.	BH would continue to operate with no changes until details surrounding NHR implementation require otherwise.

Process	Basic Health (BH)	Medicaid/MCS	Approach for Transitional Bridge
Resource Determination			
Asset Test	Information on family resources not collected.	Resource information required and verification mandatory for all programs other than for children and pregnant women. Family Medical limits assets to $1,000 per assistance unit but increases in assets after enrollment in Medicaid are disregarded.	BH would continue to operate with no changes until details surrounding NHR implementation require otherwise – asset/resource tests under NHR appear limited and the Family Medicaid (TANF) income determination would exclude assets for current enrollees.
Income Determination			
Income limits	Based on a gross family income test the upper program limit is 200% of the FPL.	Family Medicaid limits are based on a test which is approximately 35% of the FPL applied to net income after a 50% earned income deduction. In general, this results in income limits for the program of about 75% of the FPL. NHR allows this limit to be increased to about 133% of the FPL.	Income limits for BH enrollment would continue to be based on gross income up to 200% of the FPL. For determination of federal match Family Medicaid (TANF) income determination would be adopted. **As details regarding NHR income determination using Modified Adjusted Gross Income (MAGI) become available, BH may be a reasonable vehicle for demonstrating MAGI prior to its adoption by all states in 2014.** We would like to consider an opportunity like this but could likely not implement until 2013.
Income exclusion	Similar exclusions as Medicaid (e.g., tribal income, adoption supports, crime victim's compensation) but not all federal exclusions apply.	All income excluded under a federal law not counted toward family income.	See income limits.
Income deductions	BH allows child care deduction when both parents are working or in school. No other income deductions allowed.	Family Medical allows for a 50% earned income disregard, plus allowance for dependent care costs and child support payments.	See income limits.
Income allocation and deeming	Allocations and deeming do not apply.	Allocations may be made to children in separate medical assistance units to reduce income to 100% FPL for adults. Income deeming and allocation could lower parent income below 200% of the FPL using current Medicaid rules.	See income limits.

Process	Basic Health (BH)	Medicaid/MCS	Approach for Transitional Bridge
Income determination methodology	Similar to Medicaid when using averaging methodology to calculate income. However, BH does not use any prospective budgeting and does not estimate income based on future pay dates.	Medicaid requires either averaging or anticipated monthly (AM) budgeting. All income budgeting is based on a prospective best estimate. AM budgeting is mandated when the household includes a disabled or aged individual.	See income limits.
Immigration Status Determination			
Citizenship and identity	No citizenship verification or restrictions on enrollment due to citizenship with the exception of students studying in the US full-time students under temporary visas. These students are not eligible for BH.	Must meet US citizenship criteria or be a qualified alien and have served 5-year ban on Medicaid to qualify.	Fully consistent with current Medicaid requirements – **individuals who do not meet Medicaid immigration status requirements would not be eligible for the transitional bridge financing**. Determination of citizenship was initially thought to be a major operational challenge. However, DSHS recently implemented a "citizenship-match model" that successfully links with the automated federal social security system to achieve match rates in excess of 90%. We used this model to test BH parents/caretaker relatives who could be eligible for the transitional bridge and found that it validated SSNs and confirmed citizenship.
Residency Determination			
Residency	Must provide verification of current WA address.	Must provide verification of current WA address.	Fully consistent with current Medicaid requirements

Exhibit 9

OVERVIEW OF MEDICAID /BASIC HEALTH LINKAGE FOR PLANNED TRANSITIONAL BRIDGE DEMONSTRATION



6. Benefits and Cost-Sharing

Anticipated Need for Federal Authority:

In response to our original concept paper, CMS raised several questions related to benefits and cost sharing. This is a key area on which Washington will need federal authority.

- **Pre-existing condition exclusions:** MCS has no pre-existing condition exclusions per se but does impose an incapacity standard to a lesser degree than that imposed for SSI eligibility. BH requires a 9 month pre-existing condition waiting period, except for maternity and prescription drugs.[18] Enrollment in BH has been managed via a wait list for some time, and applicants transitioning off the list receive credit against their pre-existing condition waiting period based on time on the list. In our previous concept paper we neglected to report that applicants currently receive a maximum of 3 months credit, leaving an effective 6 month pre-existing condition waiting period in practice. While this will be PPACA compliant in 2011 for children, a regulatory and managed care contracting change will be needed to eliminate the waiting period for adults. Actuarial estimates by Milliman indicate that this could drive a modest 5 percent premium increase, depending on the rate of growth in BH and the corresponding risk selection impact[19]. Federal authority *may* be required until a regulatory change can be made to bring BH to PPACA compliance for the 2012 managed care contracting cycle.
- **Mental health parity:** Implementation of mental health parity in the BH program has been phased in based on state law[20] that began with the 2006 BH managed care contract. The final step to reach full parity requires a change in the managed care contracts and cannot be implemented until the next contract cycle begins, January 1, 2011. This enhancement will ensure that any treatment limitations or financial requirements related to coverage for mental health services will be consistent with limitations imposed on coverage for medical and surgical services. Federal authority *may* be required to approve implementation of our transitional bridge prior to January 1, 2011. Our actuarial consultant recently estimated that on average, full mental health parity would add about $8.36 to current premiums.
- In our April 23, 2010 revised concept paper we noted that "*The MCS program parallels mental health parity requirements defined under the current Medicaid managed care contract, with mental health services coordinated across multiple delivery systems*". This is accurate for individuals enrolled in the Disability Lifeline but we have determined that this is not the case for individuals enrolled in ADATSA - mental health benefits are not covered through that program at this time because CD treatment is the focus. However, individuals for whom a secondary mental health condition is uncovered during CD treatment are subsequently transferred to the DL program for full coverage. Transfer rates are relatively low – historical data show that only a few (about 5%) individuals transferred to the previous GA-U or GA-X programs within a 12 month window of starting on ADATSA coverage. The ADATSA program has been widely viewed as a very successful and efficient model for CD treatment. As a move toward PPACA compliance, we will make coverage changes that address full mental health parity for these individuals as part of the procurement strategy for 2012. (See section 7, *Managed Care Requirements).* In the meantime, federal authority *may* be required to support the delivery of mental health benefits for ADATSA enrollees through their transfer to DL.
- **Benefits equivalence:** We believe that the scope of benefits for our BH transitional bridge population currently compares favorably with the definition of a "Benchmark Benefits Package" established in Section 1937 of the Social Security Act and with Medicaid. Comparing the 2010 BH scope of services (including mental health parity) with Medicaid, our actuarial consultant Milliman has estimated a relative value of 90.3 percent. Federal authority *may* be required to accept BH as either benchmark coverage or Secretary approved coverage for our transitional bridge demonstration.

- **Cost sharing:** Given that the Bridge is a temporary, approximately three year endeavor, our goal has been to avoid programmatic changes that would result in the need for increased financial appropriation by the Legislature, enrollment reductions, or a challenging operational design with multiple cost sharing options for sub-groups of the BH membership. To implement Washington's proposal under current fiscal constraints, we will need federal authority to continue cost sharing during the transitional bridge demonstration.

  However, as described further below, we propose rolling back enrollee premium contributions to 2009 levels for individuals in the lowest income band A, 0-65% of the FPL. Beginning January 1, 2011, with approval for Washington's demonstration, monthly premium contributions for this population would be reduced from $34 to $17.

- **Non-emergent transportation:** The BH program covers emergency transportation, including approved ambulance services to transfer individuals from one facility to another. Other non-emergent transportation has never been a covered service and not an expressed issue for enrollees. Federal authority *may* be required to continue the standard BH transportation benefit.

The remainder of this section describes (a) the current benefits covered under the BH and MCS programs, and (b) cost sharing requirements under the BH program.

Covered Benefits:

A comparison of the current BH, MCS, state employees Uniform Medical Program (UMP) and Medicaid covered benefits is shown in Exhibit 10. The focus is on benefits available to adults. At this time, there is no intent to reduce benefits offered to enrollees – our goal is to sustain and if possible improve benefits during the demonstration to support a smooth transition to NHR implementation in 2014.

Exhibit 10: Comparative Summary of 2010 Public Program Benefits for Adults

MEDICAID, MEDICAL CARE SERVICES (MCS), UNIFORM MEDICAL PLAN (UMP) & BASIC HEALTH (BH) *COVERAGE FOR ADULTS*					
Legend: Y = Covered Service; L = Limited Coverage; N = Not Covered (see comments for additional information)					
Services	**Medicaid CN**	**Medical Care Services**	**Uniform Medical Plan**	**Basic Health**	**Comments**
Advanced RN Practitioner Services	Y	Y	Y	L	BH - covered at the discretion of Health Plans
Ambulance/Ground and Air	Y	Y	Y	Y	
Anesthesia Services	Y	Y	Y	Y	
Audiology	Y	Y	Y	N	
Blood/Blood Administration	Y	Y	Y	Y	
Case Management	L	Y	L	N	Medicaid - maternity and pre-approved clients in pre-bariatric surgery
Chiropractic Care	N	N	L	L	BH – covers maximum of 6 visits annually; must be tied to reconstructive joint surgery. UMP - 10 visits per calendar year.

MEDICAID, MEDICAL CARE SERVICES (MCS), UNIFORM MEDICAL PLAN (UMP) & BASIC HEALTH (BH) *COVERAGE FOR ADULTS*					
Legend: Y = Covered Service; L = Limited Coverage; N = Not Covered (see comments for additional information)					
Services	**Medicaid CN**	**Medical Care Services**	**Uniform Medical Plan**	**Basic Health**	**Comments**
Dental Services	Y	L	L	L	Limited to emergency dental services UMP - Limited to certain oral surgeries, trauma, services provided in hospital or surgical center.
Dentures Only	L	N	N	N	
Detox Alcohol (3 days) Detox Drugs (5 days)	Y	L	Y	Y	UMP - No $ limits after 1/1/10; subject to medical necessity. MCS – restricted coverage limitations
Diabetes Education	Y	Y	Y	Y	BH – up to 10 hours per year UMP - up to 10 hours per calendar year; diagnosed diabetics only.
Drugs and supplies, prescription	Y	Y	Y	Y	UMP - Most drugs covered; some are excluded.
Emergency Room Services	Y	Y	Y	Y	UMP - $75 ER copay (in addition to facility/professional charges)
Emergency Surgery	Y	Y	Y	Y	
Eyeglasses and Exams	Y	Y	Y	N	UMP - Not subject to deductible; exams one per year; hardware $150 per 2 calendar years. Note: Vision services are often riders in the private insurance market.
Family Planning Services	Y	Y	Y	Y	
Hearing Aids	Y	N	Y	N	UMP - Up to $800 per 3 calendar years Note: Hearing aids are often riders in the private insurance market.
Home Health Services	Y	Y	Y	Y	
Hospice	Y	N	Y	Y	
Inpatient Hospital Care	Y	Y	Y	Y	
Interpreter Services	Y	Y	N	Y	
Maternity Support Services	Y	Y	Y	N	BH – Pregnant women covered through Medicaid / CHIP and return to BH post-partum UMP – Exception - lactation services covered only for medical condition of mother or baby; doula not covered.

MEDICAID, MEDICAL CARE SERVICES (MCS), UNIFORM MEDICAL PLAN (UMP) & BASIC HEALTH (BH) *COVERAGE FOR ADULTS*					
Legend: Y = Covered Service; L = Limited Coverage; N = Not Covered (see comments for additional information)					
Services	**Medicaid CN**	**Medical Care Services**	**Uniform Medical Plan**	**Basic Health**	**Comments**
Medical Equipment	Y	Y	Y	L	BH - covered only during inpatient hospital stay.
Neurodevelopmental Centers	N	N	L	N	UMP - Depends on type of services offered and provider types; some aren't covered. Primarily a service for children not adults.
Nursing Facility Services	Y	Y	Y	L	Medicaid - provides both short and long-term nursing facility services. BH - alternative to hospitalization in an acute care facility at health plan's discretion.
Nutrition Therapy	L	N	L	N	Medicaid– approved only for bariatric surgery. UMP - Only certain diagnoses; see current COC.
Optometry	Y	Y	Y	N	
Organ Transplants	Y	Y	Y	L	BH - must be enrolled for 12 consecutive months before service is covered, unless newborn, or if condition is contracted while enrolled in BH.
Orthodontia	N	N	N	N	
Outpatient Hospital Care	Y	Y	Y	Y	
Oxygen/Respiratory Therapy	Y	Y	Y	Y	
Pain Management (chronic)	Y	Y	Y	Y	BH - may be covered by Health Plan as cost containment mechanism. Medicaid - considered a professional rather than specific "pain management" service.
Personal Care Services	L	N	N	N	Medicaid– provided only through LTC programs.
Physical/Occupational/Speech Therapy	L	L	Y	L	Medicaid - Covered when client is receiving home health services. BH - covers physical or occupational therapy for maximum of 6 visits annually-tied to reconstructive joint surgery.
Physician-Related Services	Y	Y	Y	Y	

MEDICAID, MEDICAL CARE SERVICES (MCS), UNIFORM MEDICAL PLAN (UMP) & BASIC HEALTH (BH) *COVERAGE FOR ADULTS*					
Legend: Y = Covered Service; L = Limited Coverage; N = Not Covered (see comments for additional information)					
Services	**Medicaid CN**	**Medical Care Services**	**Uniform Medical Plan**	**Basic Health**	**Comments**
Private Duty Nursing	L	N	L	L	Medicaid– provided only through LTC programs. BH - covered at the discretion of managed care plans. UMP - Subject to pre-authorization, medical necessity
Prosthetic Devices & Mobility Aids	Y	L	Y	N	
Psychological Evaluations	N	Y	Y	N	
Inpatient Mental Health	Y	Y	Y	L	BH - covers up to 10 inpatient days; Medicaid has no inpatient limits. **Parity by January 1, 2011**. UMP - Must be preauthorized; no day limits.
Outpatient Mental Health	L	L	Y	Y	BH - 12 visits per calendar year. Medicaid – adults up to 12 visits per calendar year. **Parity by January 1, 2011**. Medicaid clients have access to mental health services provided by RSNs. UMP - No visit limits as of 1/1/10.
Substance Abuse/Outpatient (Detox Drugs)	Y	Y	Y	Y	BH - up to $5,000 in 24 consecutive month period or $10,000 lifetime maximum. Medicaid - up to 5 days for Detox Substance Abuse. UMP - No $$$ limits as of 1/1/10.
Total Enteral/Parenteral Nutrition	Y	Y	Y	L	BH - covered at the discretion of Health Plans. UMP- Subject to pre-auth; usually handled through case mgmt.
Transportation Other Than Ambulance (**non-emergency transportation**)	Y	Y	L	N	UMP- Subject to medical necessity; see current COC for guidelines.
X-ray and Lab Services	Y	Y	Y	Y	

PPACA compliance requires the benefits design for the state Basic Health option to meet a definition of "essential health benefits" that includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.

Washington State's current BH and MCS scope of benefits appear to encompass most of these "essential health benefits" categories with the exception of vision and *comprehensive* dental benefits (which are

currently optional for Medicaid adults and have been reduced in recent years.) Other BH benefits differences include durable medical equipment, limitations on physical and occupational therapies and non-emergent transportation. Consistent with NHR expectations, BH managed care plans are already required to follow the United States Preventive Services Task Force (USPSTF) guidelines for immunizations that must be covered when administered as part of a preventive care visit. A full description of the BH schedule of benefits is included in the "*2010 Basic Health Member Handbook*" available at: http://www.basichealth.hca.wa.gov/documents/22-405.pdf.

Benefits Equivalence Analysis:

Generally BH and MCS programs cover specific services comparable to Medicaid (delivered through the Healthy Options system of managed care) and the Uniform Medical Plan (UMP), which is the state's self-insured plan (a Preferred Provider Organization) for public employees. Actuarial estimates of current benefits equivalence show that the scope of benefits for our transitional bridge compares favorably with the definition of a "Benchmark Benefits Package" established in Section 1937 of the Social Security Act and with the current Medicaid and state employees' health coverage benefits package.

- Comparing the 2010 BH scope of services (including mental health parity) with Medicaid, our actuarial consultant Milliman estimated a relative value for BH of 90.3 percent. Including cost sharing in the comparison reduces the relative value of BH to 77.1 percent of Medicaid coverage. The analysis adjusted for specific Medicaid benefits not covered by BH – durable medical equipment, vision hardware, hearing aids, more extensive physical therapy, and non-formulary drugs. These are all identified in Exhibit 10.
- Comparing the 2010 BH scope of services (including mental health parity) with the state employees' Uniform Medical Plan (UMP), Milliman estimated a relative value for BH of 89.8 percent. Including cost sharing in the comparison reduces the relative value of BH to 88.2 percent of UMP coverage. The UMP includes coverage for the additional benefits noted for Medicaid and also covers chiropractic care, which is not covered under Medicaid (or MCS) and is extremely restricted in BH.

In performing the benefits equivalence analysis, a detailed summary of utilization and unit costs was constructed for the Basic Health subsidized population. That summary was then placed into the structure of the Milliman Health Cost Guidelines, which established use rates of services and the cost per service relative to standard benchmarks. The model was then adjusted to include only adults, to represent the transitional bridge population.

The utilization and unit cost comparisons were held constant throughout the analysis, other than for modifications in covered services. When additional covered services were included in the model, the Health Cost Guidelines allowed for consistent utilization and unit cost assumptions to be developed. These additional amounts were checked for reasonableness against actual Healthy Options adult and UMP experience.

Cost-Sharing Overview:

No cost sharing is required for the MCS program.

Consistent with coverage in the broad commercial market, cost sharing in BH comes in the form of standardized premium contributions, copayments, coinsurance, and deductibles up to an out-of-pocket maximum. Enrollees in BH with comparable incomes and family size have always contributed comparable cost share, regardless of their race or ethnicity. We would expect this to continue through the transitional bridge period.

No distinction is made to exempt American Indians/Alaskan Natives (AI/AN) as will be the expectation in 2014. For many BH AI/enrollees, premium cost sharing is covered by Tribal sponsors, so the only contribution made by these individuals is at the point-of-service. Because provision of race and ethnicity data is voluntary, BH cannot identify each AI/AN enrollee who joins the program. This

sometimes is a problem for states *today* with respect to Medicaid coverage for Tribal members. We would use the transitional bridge demonstration to develop (and implement in 2012) a workable method for capturing race/ethnicity information. This is a key opportunity for Washington State and CMS to partner in helping states support PPACA compliance in 2014. At that time, subsidized coverage in Medicaid, the state Basic Health option, and any Exchange, must be able to identify American Indian/Alaskan Native status to ensure that statutory premium and point-of-service cost sharing obligations can be met and verified.

***Basic Health Premium Cost-Sharing*:**

BH premiums vary by family size, age, income and health plan choice. All enrollees bear the responsibility of contributing toward the cost of their health coverage based on their ability to pay. Enrollee premiums are based on a sliding scale with contributions determined at the mid-point of the income band in which the enrollee's income falls and defined relative to a "benchmark" managed care plan available in all Washington counties. Monthly premium payments made to health plans by the state *average* approximately $250.00 per enrollee (for the period July – December 2009). Current enrollee premium contributions for a BH "benchmark" plan are shown in Exhibit 11. Enrollees with higher incomes pay a higher percentage of the total premium cost. The average monthly state contribution per enrollee for the period July – December 2009 was approximately $214[21]. The average enrollee contribution was approximately $46.

To answer questions about the impact on enrollees of all out-of-pocket expenses, Exhibit 11 also presents current enrollee premium contributions in each income band; Exhibit 12 presents the premium cost sharing for the benchmark 40-54 year old as a percent of income.

Exhibit 11. 2010 Enrollee premium contributions by age range and income band

Age Range	A 0-65 % FPL	B 65-100 % FPL	C 100 –125 % FPL	D 125-140 % FPL	E 140-155 % FPL	F 155-170 % FPL	G 170-185 % FPL	H 185-200 % FPL
0-18[22]	$0-$34	$0-$45	$0-$60	$0-$60	$0-$60	$0-$60	$0-$60.55	$0-$72.19
19-39	$34	$45	$60	$70.66	$88.32	$108.20	$131.20	$156.41
40-54	$34	$45	$60	$90.59	$113.24	$138.72	$168.20	$200.52
55-64	$34	$45	$60	$154.91	$193.63	$237.20	$287.63	$342.90

Exhibit 12. Benchmark 40-54 year old premium cost sharing as a percent of median income

Income band	FPL	Median Income	Enrollee Premium	Premium as % of *Median* Income	Premium as % of *Maximum* Income
A	0 - 65%	$293.31	$34	11.6%	5.8%
B	65 - 100%	$744.56	$45	6.0%	5.0%
C	100 - 125%	$1,015.31	$60	5.9%	5.3%
D	125 - 140%	$1,195.81	$90.59	7.6%	7.2%
E	140 - 155%	$1,331.19	$113.24	8.5%	8.1%
F	155 - 170%	$1,466.56	$138.72	9.5%	9.0%
G	170 - 185%	$1,601.94	$168.20	10.5%	10.1%
H	185 - 200%	$1,737.31	$200.52	11.5%	11.1%

On January 1, 2010, premium contributions increased significantly. For individuals in the lower income bands A-C, who make up over 70 percent of the BH membership, premium contributions doubled. Monthly contributions for income band A increased from $17 to $34; income band B increased from $22.50 to $45; and income band C increased from $30 to $60.

Basic Health Point of Service Cost-Sharing:

Cost sharing responsibilities are described in detail in the "*2010 Basic Health Member Handbook*" (pages 24-37) available at: http://www.basichealth.hca.wa.gov/documents/22-405.pdf. Cost sharing at the point-of-service has been an explicit policy decision since the inception of the program, designed to encourage efficient utilization of appropriate services and shared financial responsibility. For example, in 2010:

Copayments:

- A $15 copayment applies to office visits but no copay is required for preventive services, to encourage routine physicals, immunizations, PAP tests, mammograms and other screening and testing provided as part of a preventive care visit. These services are not subject to the deductible.
- A $100 copayment applies to non-emergent use of hospital emergency rooms or out-of-area emergency services, but there is no copayment if the individual is admitted. These services are also not subject to the deductible.
- A $10 pharmacy copayment (or less where drug costs are lower) applies to the utilization of generic drugs in each managed care plans' preferred drug list (formulary). For brand name drugs the copayment is 50 percent of the drug cost. This encourages the utilization of cost-effective generic drugs that are therapeutically equivalent to more expensive brand name drug options. This service is also not subject to the deductible.

Additional coinsurance, deductibles and annual out-of-pocket maximum:

- Enrollees are responsible for a 20 percent coinsurance payment on select services, for example, inpatient and outpatient hospital services, inpatient mental health, ambulance services etc. An out-of-pocket maximum of $1,500 per person applies after a $250 annual deductible has been met.

Point of service cost sharing has changed over time. Exhibit 13 shows the evolution by comparing policy in effect prior to 2004, from 2004-2009, and in 2010. The most significant changes were implemented in 2004 in response to a Legislative directive to reduce the actuarial value of BH by 18 percent as a result of a fiscal shortfall in the 2003-2005 biennial budget. Prior to 2004 copayments were the only out-of-pocket enrollee contribution for services; in 2004 enrollees also were required to meet minimal deductible and coinsurance responsibilities up to an annual out-of-pocket maximum. These continue today, with a minor deductible increase in 2010.

Exhibit 13: Evolution of BH Point-of-Service Cost Sharing

Time Period	No POS Cost Sharing	Copayments (not subject to deductible or OOP Max)	Deductible and Coinsurance up to Annual Out-of-Pocket Maximum
Prior to 2004	• Preventive care • Maternity care (provided through Medicaid) • Oxygen	• $10 – office visits, hospital outpatient visits • $100 per hospital admission (up to $500 annual maximum) • Pharmacy: – tier 1 $3 (e.g., generic in formulary) – tier 2 $7 (e.g., generic alternative) – tier 3 50% drug cost (formulary brand name)	• No deductibles or coinsurance
2004-2009	Same	• $15 – office visits, hospital outpatient visits • $100 per non-emergency hospital visit (i.e., no admission) • Pharmacy - previous tiers 1-2 combined – tier 1 $10 (e.g., generics) – tier 2 50% drug cost (formulary brand name)	• $150 deductible introduced Once deductible met: • 20% coinsurance – hospital inpatient, ambulance, chiropractic/PT, CD, organ transplants • $1,500 Annual OOP maximum
2010	Same	Same	• $250 deductible • Same coinsurance and annual OOP maximum

To answer further questions about the impact on enrollees of out-of-pocket expenses, Milliman conducted an analysis of point-of-service (POS) cost sharing. The average POS cost sharing for the current BH plan design was compared to various income levels. Using a model for calendar year 2010, Milliman estimated an average per member per month POS cost share amount of $45.40, almost the same as the average premium contribution. The model included an adult only population, with adjustments made for mental health parity that will be fully in effect as of January 1, 2011, and otherwise reflected levels of utilization and cost consistent with the current BH program. Exhibit 14 expresses the estimated average POS cost share amount as a percent of income in each of the current BH income bands.

Exhibit 14: BH Point-of-Service Cost Sharing as a Percentage of Income

Income band	FPL	Median Income	POS Cost as % of *Median* Income	POS Cost as % of *Maximum* Income
A	0 - 65%	$293.31	15.5%	7.7%
B	65 - 100%	$744.56	6.1%	5.0%
C	100 - 125%	$1,015.31	4.5%	4.0%
D	125 - 140%	$1,195.81	3.8%	3.6%
E	140 - 155%	$1,331.19	3.4%	3.3%
F	155 - 170%	$1,466.56	3.1%	3.0%
G	170 - 185%	$1,601.94	2.8%	2.7%
H	185 - 200%	$1,737.31	2.6%	2.5%

Basic Health Cost-Sharing Challenge:

Our interpretation of Medicaid law, Exhibit 15, makes it apparent that BH cost sharing is currently beyond the out-of-pocket 5 percent aggregate maximum that CMS has confirmed is intended in Section

1916/1916A of the Social Security Act. CMS has made it clear that cost sharing is a major challenge for our transitional bridge demonstration.

To be consistent with current Medicaid requirements, Washington would have to eliminate premiums and POS cost sharing in the BH program. However, substantial changes either increase the cost to the state to sustain current enrollment, or reduce potential enrollment to meet fiscal limitations, at a time when Washington can afford to do neither. Even with considerable federal financing support from approval of our proposed demonstration, elimination of cost-sharing to align BH with Medicaid would reduce enrollment to approximately 44,000 individuals. This would be a 36 percent reduction in the Legislature's targeted 69,000 enrollment level for fiscal year 2011, in spite of an estimated influx of about $7 million more than was anticipated in the budget. Such a reduction would likely cause health plans to leave the program because of insufficient market share, and degrade the BH risk pool to a degree that would increase premium rates in general. Without premium and POS cost sharing, Milliman has also estimated a 27.3 percent increase in rates.

The April 9, 2010 CMS guidance letter offered a little leeway for Washington to propose a small step in the direction of reduced cost sharing. Flexibility to determine income eligibility for federal financing support based on the TANF methodology increases estimated federal funding support for the BH program enough to roll back premiums for the lowest income band to 2009 levels. With federal approval of our demonstration we are able to reduce monthly premiums for individuals with incomes between 0-65% of the FPL from $34 to $17.

Basic Health as a NHR Laboratory:

Exhibits 16 and 17 put cost sharing in the BH program in perspective through a comparison with Medicaid, two relatively inexpensive options currently available to individuals trying to find affordable coverage in the private individual market, the Uniform Medical Plan (the largest option available to public employees), and a preliminary interpretation of subsidized options that may become available in a NHR Exchange by 2014. Income clearly influences levels of POS cost sharing allowable in federally subsidized coverage for low income populations.

POS cost sharing options are similar in nature in individual commercial products, the UMP, and BH. In general, cost sharing in BH is considerably lower than similar "affordable" products available in the commercial market. In comparison, BH offers a bridge between public and private coverage that looks much more like Medicaid. As Washington transitions to NHR we would consider BH as a natural laboratory to inform benefit designs that avoid the semblance of a coverage "cliff" for individuals who transition from Medicaid to "commercial" health insurance when their income moves them above the realm of available public subsidies. In addition, BH provides a rich history of consumer behavior in response to cost sharing and informs a broader understanding of the impact of cost sharing on efficient use of appropriate services.

Other than the reduction in premiums for the lowest income band, we propose to leave BH cost-sharing at its current levels until Washington's fiscal recovery allows further transition toward PPACA compliance in 2014. As we believe is required under federal law for an 1115 demonstration waiver, we would include a cost-sharing evaluation in BH. For example we would want to understand how low income enrollees continue to afford cost-sharing, how sponsorship changes in response to increased cost sharing, and how service utilization differs between BH enrollees with cost sharing and comparable Medicaid clients who have no cost-sharing. This information would help both CMS and states in designing benefit coverage for their new Medicaid expansion groups in 2014.

Exhibit 15: Washington Interpretation of Medicaid / CHIP Cost Sharing - Defined by Sections 1916 and 1916A of the Social Security Act

COLLECTABILITY: *In general*, with caveats noted, certain eligibility groups and services are exempt from cost sharing.

a. **Eligibility groups**: pregnant women, individuals receiving hospice care, institutionalized individuals, and *mandatory* Medicaid children under age 18[1] - 1916(a)(2). *However,* through State Plan Amendments limited cost sharing is allowable for these groups for non-preferred drugs and non-emergent use of hospital emergency rooms (shaded below). Subject to income restrictions, copayments are allowed for children not considered *mandatory* Medicaid. American Indian/ Alaskan Natives remain exempt from **all** cost sharing.

b. **Services:** preventive services, emergency services, and family planning services/supplies. Copayments may be applied to preventive services for non-exempt adults.

ENFORCEABILITY: Cost-sharing is not enforceable for any individual with income up to 100% FPL – 1916(e); 1916A(d)(2).

LIABILITY: Liability for cost-sharing payments is retained by individuals to whom care or services are provided - 1916(e).

CHANGES: Imposition of (a) further cost sharing on generally exempt groups and/or (b) enforceability of copayments for Medicaid populations with income at or below 100% FPL requires CMS approval of a two-year 1115 demonstration waiver – 1916(f).

Cost Sharing Option	Incomes at or below 100% FPL	Incomes 100-150% FPL	Incomes above 150% FPL
Premiums Enforceability	**None allowed**	**None allowed**	**Premiums allowed** if aggregate cost-sharing no more than 5% family income **Enforceable** - Failure to pay premium for 60 days may terminate Medicaid eligibility
Preferred Drugs/ Physician Visits/ DME/ Transportation Enforceability	**Nominal copay allowed** **Not enforceable**	**Copay may not exceed 10% of cost** **Enforceable** - provider can require copayment as condition of receiving service	**Copay may not exceed 20% of cost** **Enforceable** - provider can require copayment as condition of receiving service
Non-preferred drugs Enforceability	**Nominal[2] copay allowed** Medicaid payments to providers must be reduced by amount of cost-sharing whether or not provider collects copay (States can increase rates to maintain same level of state payment when cost sharing introduced) **Not enforceable**	**Nominal copay allowed** Medicaid payments to providers must be reduced by amount of cost-sharing whether or not provider collects copay (States can increase rates to maintain same level of state payment when cost sharing introduced) **Enforceable** - provider can require copayment as condition of receiving drugs	**Copay may not exceed 20% of cost** Medicaid payments to providers must be reduced by amount of cost-sharing whether or not provider collects copay (States can increase rates to maintain same level of state payment when cost sharing introduced) **Enforceable** - provider can require copayment as condition of receiving drugs
Non-emergent use[3] of hospital ER Enforceability	**Nominal copay allowed** **Not enforceable**	**2 times nominal copay allowed** **Enforceable** - Failure to pay may deny full treatment so long as hospital can make a referral to alternative/available non-emergency provider who *cannot* charge additional copay	**Copay may not exceed 20% of cost** **Enforceable** - Failure to pay may deny full treatment so long as hospital can make a referral to alternative/available non-emergency provider who *cannot* charge additional copay
Maximum aggregate	**No more than 5% family income**	**No more than 5% family income**	**No more than 5% family income**

[1] Mandatory Medicaid is defined by age and income to include children under age 1 up to 185% FPL, children aged 1-5 up to 133% FPL and children aged 6-18 up to 100% FPL. At the State's option, children can be defined to include individuals up to age 19, 20, or 21.

[2] Nominal is defined in C.F.R 447.54 to mean a sliding scale maximum of $0.50 when the state's payment is $10 or less; $1.00 when the state's payment is $10.01 - $25; $2.00 when the state's payment is $25.01 - $50; and $3.00 when the state's payment is $50.01 or more.

[3] Non-emergent services include care or services provided in the ER in addition to the screening or stabilizing examination and treatment required by law - 1867.

Exhibit 16: Summary of Cost Sharing in Selected Public Programs and the Private Individual Market

	MORE ENROLLEE COST-SHARING ⟷ *LESS ENROLLEE COST-SHARING*				
INCOME	**Individual Commercial Market Products[23] (2010)**	**Uniform Medical Plan (2010)**	**National Health Reform (Health Insurance Exchange)**	**Basic Health (2010)**	**Current Medicaid (1916/1916A)**
Up to 100% FPL	**Deductibles:** • $1,000 /$1,850 annual (excl. $200 /$0 max. preventive care, copays, Rx drugs) **Copays:** • $100/$100 per non-emergent ER use • $30 per office visit • Rx drugs (Regence) - $10 generic drugs; 30% drug cost – formulary brand name drugs; 50% non-formulary brand name drugs • Rx drugs (LifeWise) - $15 generic drugs only covered • $3,000 /$3,000 Rx drugs annual coverage max **NOTE:** • DME, vision, dental not covered **Coinsurance:** • 30%/25% on select services by preferred providers • 50%/50% on select services by non-preferred providers • *WiseEssentials Rx* excl. 6 office visits/preventive care exams **OOP limit (coinsurance max):** • $5,000 (ind.), $15,000 (fam.)	**Deductibles:** • $250 annual (excl. preventive care) • $100 (ind.), $300 (fam.) Rx drugs (excl. generic drugs) **Copays:** • $75 per non-emergent ER use • $200/day – inpatient services (to max $600) • Rx drugs - $10 (or less) - generic drugs; 50% drug cost - brand name drugs **Coinsurance:** • 0-15% on select services by preferred providers • 40% on select services by non-preferred providers • Excludes preventive care • 15% DME **OOP limit (excl. premiums):** • $2,000 (ind.), $4,000 (fam.) • $600 on inpatient services	N/A	**Deductibles:** • $250 annual (excl. preventive care) **Copays:** • $15 per office visit – excl. preventive care • $100 per non-emergent ER use • Rx drugs - $10 (or less) - generic drugs; 50% drug cost - brand name drugs **NOTE:** • DME, vision, dental coverage generally limited **Coinsurance:** • 20% on select services **OOP limit (excl. premiums):** • $1,500 per person	**Copays:** • Nominal copays allowed but not enforceable **OOP limit (incl. premiums):** • 5% family income
100-150% FPL			**Member Participation:** • 10% of benefit costs (equivalent of "Platinum" plan) **OOP limit (incl. premiums):** • Health Savings Account (HSA) current law limit - $5,950 (ind.), $11,900 (fam.)		**Copays:** • In general, nominal copays allowed and enforceable **OOP limit (incl. premiums):** • 5% family income
150-200% FPL			**Member Participation:** • 20% of benefit costs (equivalent of "Gold" plan) **OOP limit (incl. premiums):** • HSA current law limit - $5,950 (ind.), $11,900 (fam.)		**Copays:** • Allowed up to 20% of cost and enforceable – see overview of further details & restrictions **OOP limit (incl. premiums):** • 5% family income

Exhibit 17: Summary of Enrollee Premium Contributions in Selected Public Programs and the Private Individual Market

MORE ENROLLEE COST-SHARING ⟷ *LESS ENROLLEE COST-SHARING*

INCOME	Individual Commercial Market Products	Uniform Medical Plan	National Health Reform (Health Insurance Exchange)	Basic Health (2010)	Current Medicaid (1916/1916A)
Up to 100% FPL	Age / Breakthru 70 / WiseEss Rx <25 25-29 $175 $109 30-34 $202 $124 35-39 $235 $142 40-44 $277 $170 45-49 $327 $199 50-54 $397 $251 55-59 $471 $307 60+ $554 $357 Child $653 $407 $162 $92	Subscriber: $41 Subscriber + children: $72 Subscriber + spouse: $92 Subscriber + family: $123	N/A	See Exhibit 11 for further benchmark premium details Premiums included here are those applicable to the transitional bridge population. Age Inc*. Band / 19-39 / 40-54 / 55-64 A 34.00 34.00 34.00 B 45.00 45.00 45.00 C 60.00 60.00 60.00 *A: 0-65% FPL B: 65-100% FPL C: 100-133% FPL	None
100-150% FPL			**OOP limit (incl. POS cost sharing):** • HSA current law limit - $5,950 (ind.), $11,900 (fam.)		None
150-200% FPL					Allowable if aggregate cost-sharing no more than 5% income Based on 2010 federal poverty levels (i.e., $10,830 for an individual), 5% of income would be approximately $45 per month for an individual at 100% of the FPL.

7. Managed Care Requirements

Anticipated Need for Federal Authority:

Managed care plans that serve the MCS program operate under a contract that mostly parallels the current Medicaid managed care contract. Through an annual procurement (or contract renewal) process BH currently contracts with managed care plans that serve the Medicaid program as well. The tie between the Medicaid, MCS, and BH managed care contracts is expected to strengthen in the near future. On April 1, 2010, the Governor announced a merger of the Washington Medicaid Administration of the Department of Social and Health Services and the Health Care Authority (HCA), which administers the BH program and health insurance benefits for public employees, and is implementing a small business exchange-like program in January 2011. This merger consolidates the agencies under the HCA umbrella as a further step in the Governor's plan to better coordinate the state's health purchasing practices and policies and facilitate the transition to NHR, with Medicaid now under the Medicaid Purchasing Administration. After preliminary workgroup activities, a formal MPA/BH workgroup will begin in early July 2010 to develop a joint procurement strategy for the 2012 managed care contracts. Goals include the adoption of common Medicaid and BH managed care contractors, standardized quality and performance measurement and other administrative streamlining. Delivery system modifications that transition Washington toward PPACA compliance are expected, including a revised strategy for achieving mental health parity for individuals who currently are served through the ADATSA program and receive subsequent mental health treatment after transfer to DL. In the meantime, we anticipate that federal authority *may* be required in two areas to accommodate:

- Geographic variations in choice of available managed care plans; and,
- Washington regulations that direct the BH fair hearings and consumer appeals process.

***Public and Private Insurance Overview and Plan Choice*:**

Washington's health insurance market place is served by managed care plans that have typically chosen to compete in the public *or* private market place; rarely both.

Two managed care plans dominate provision of public coverage for the low-income population, with Medicaid systems in place and fully operational. They compete for this population *only* and Medicaid is the major financier of their entire book of business. They represent about 22 percent of Washington's total 2008 insured lives[24].

- **Community Health Plan of Washington (CHPW)** provides standardized benefits for about 60 percent of the BH population[25] and is the primary BH managed care plan offering coverage in 37 of 39 counties. It is also the secondary managed care plan for the Medicaid program.

  MCS serves a unique population and substantive expertise is required to provide coordinated services across the multiple delivery systems involved. Because the risk pool has complex health needs and includes only about 22,000 enrollees statewide, this is not a business for which managed care plans actively compete. We would, therefore, need federal authority to limit health plan choice for the MCS program under the transitional bridge to a single managed care contractor.

- **Molina Health Care** provides standardized benefits for just under 20 percent of the BH population, offering coverage in 26 of 39 counties. It is the primary managed care plan for the Medicaid program.

Outside the public sector, three major health plans dominate the individual and group private insurance market place, collectively serving just over 70 percent of Washington's total 2008 insured lives.

- **Group Health Cooperative,** Washington's home-grown health maintenance organization, also provides coverage in a limited geographic area, 5-6 counties, for about 15 percent of the BH program and a portion of the Medicaid program.
- **Regence** mostly provides private coverage but also serves a very small subset of the Medicaid population; and,
- **Premera**, the second largest health plan in the state (in terms of covered lives), has not served the public market in years, including the provision of coverage for public employees.

Other managed care plans operate in Washington with smaller books of localized business. Those that service the BH program include **Kaiser Permanente (KP)** and **Columbia United Providers,** niche players that operate in the southwest corner of Washington State. They provide coverage for about 2-4 percent of the BH program. KP's broader business extends south into the Portland area of Oregon.

Managed care for BH is available in all 39 counties of the state. All counties are served by CHPW, Molina, or both. In a handful of rural counties, where population is limited, only one of these managed care plans is available. To support the transitional bridge for BH adults, we would need federal authority to accommodate the limited health plan choice available in the rural corners of the state.

***Comprehensive Managed Care Statutes*:**

Washington's managed care plans operate within standardized health insurance parameters set in statute and regulated by the Office of the Insurance Commissioner (OIC). These have evolved to provide a comprehensive framework for maintaining high standards of plan performance and consumer protection[26].

Washington's consumer protections are very strong. Effective July 1, 2001, Washington has its own Patient Bill of Rights codified in state law[27]. It guarantees health insurance consumers access to quality health care by providing certain assurances and processes for appealing decisions made by a health insurance company. The Patient Bill of Rights *applies broadly* across Washington's public and private health care coverage markets. It specifically includes:

- Individuals who buy their own health insurance.
- Workers whose employers buy insurance for them.
- People enrolled in Washington's Basic Health Plan.
- People covered through the state's Managed Care Medical Assistance Program, Healthy Options (i.e., Medicaid).
- People covered by state employee health insurance plans.
- School and local government employees whose employers buy health coverage through the state or from an insurance company.

Enacted language is shown in Exhibit 18.

The MCS program comports with the same administrative law appeal rights that are required under federal law and rule for Medicaid clients. As part of our transitional bridge transition, the BH program could be revised to comply with these same federal and state requirements as described in Exhibit 19, F.6. Beginning with the start of the demonstration, the few (if any) BH cases that reach this need could be processed through the existing Medicaid processes.

Exhibit 18: Washington State Patient Bill of Rights

RCW 48.43.500
Intent -- Purpose -- 2000 c 5.

It is the intent of the legislature that enrollees covered by health plans receive quality health care designed to maintain and improve their health. The purpose of chapter 5, Laws of 2000 is to ensure that health plan enrollees:

(1) Have improved access to information regarding their health plans;
(2) Have sufficient and timely access to appropriate health care services, and choice among health care providers;
(3) Are assured that health care decisions are made by appropriate medical personnel;
(4) Have access to a quick and impartial process for appealing plan decisions;
(5) Are protected from unnecessary invasions of health care privacy; and,
(6) Are assured that personal health care information will be used only as necessary to obtain and pay for health care or to improve the quality of care. [2000 c 5 § 1.]

NOTES:

Application -- 2000 c 5: "This act applies to: Health plans as defined in RCW 48.43.005 offered, renewed, or issued by a plan; medical assistance provided under RCW 74.09.522; the basic health plan offered under chapter 70.47 RCW; and health benefits provided under chapter 41.05 RCW." [2000 c 5 § 19.]
Short title -- 2000 c 5: "This act may be known and cited as the health care **patient bill of rights**." [2000 c 5 § 22.]

Managed Care Plan Performance Monitoring:

To evaluate the performance of its managed care plans the BH program uses standards set by the National Committee for Quality Assurance (NCQA). These standards support consumer comparison of plans' service delivery and include:

- Regional and national benchmarks for performance related to delivery of health care services (e.g., patient care, access to care, preventive care).
- HEDIS and CAHPS measures that target business process efficiency and consumer satisfaction.
- Consistent data collection that allows transparency of services delivered, such as immunizations, cervical cancer screening, and antidepressant medication management. This is consistent with the state's ongoing interest in ensuring that purchasing of health coverage emphasizes services with an evidence base.

For contracted plans that are not NCQA accredited, BH has established an interagency agreement with DSHS to obtain the detailed results of audits conducted on these plans that are comparable to the NCQA standards. One of the HCA/DSHS merger workgroup's initial goals is to select common NCQA performance measures and streamline the managed care plan monitoring process.

Exhibit 19 presents the individual components of the Medicaid managed care contract defined to address requirements defined in Section 1932 of the Social Security Act, and explains how they would be addressed in our transitional bridge. The combination of the comprehensive OIC regulation, Patient Bill of Rights, national performance monitoring standards, and the targeting of services to the low income population by two managed care plans, ensures a high standard of performance in serving Medicaid, BH and MCS populations, and thus the transitional bridge. As a result, the managed care requirements that apply to the Medicaid program are either explicitly addressed in the BH managed care contracts or they are accommodated through these broader requirements for all Washington plans. Outside the limitations on choice noted above, the contract for the MCS program parallels the current Medicaid contract.

Exhibit 19: Application of Sec 1932 Medicaid Managed Care Provisions to the Transitional Bridge

Required Medicaid Contract Subpart/Subsection	Key Contractual Requirements for BH Managed Care Plans
A -Standard Medicaid Sec 1932 Contract Provisions	
A.1 Contract Requirement	• Enrollment is voluntary and non-discriminatory – managed care plans must enroll anyone for whom BH makes a premium payment.
A.2 PCCM Contracts	• Not applicable to BH.
A.3 Subcontracts	• Subcontractors must comply with all terms of the contracted managed care plan.
A.4 Choice	• See prior description of public and private health insurance. Standardized benefits are available statewide and delivered through the managed care plans described earlier. In most areas of the state BH enrollees have a choice of multiple plans and BH endeavors to procure contracts with at least 2 managed care plans in all counties. However, in geographically rural/isolated counties, (e.g., Jefferson) where enrollment is small, enrollees have only one managed care plan available. **This may be an area on which federal authority is needed**.
A.5 Information Requirements	• Managed care plan publications describing all benefits etc must be pre-approved by the Health Care Authority which administers the BH program. • The BH member handbook and other publications are available in multiple formats. The Member handbook is available in Braille, audio, hard-copy, and electronically. BH contracts with commercial service to provide language interpretation. • Managed care plans must provide notices of termination. • The member handbook provides details on expectations for enrollees on rights, responsibilities, grievances, complaints and appeals, suspension and disenrollment etc. In addition to compliance with OIC regulation and state law, managed care plans contracting with the BH must support the policies described in the Member handbook.
A.6 Provider Discrimination	• Washington's "every category of provider" statutory mandate requires managed care plans to include all categories of providers in their network. • Managed care plans must comply with state law on provider selection, retention, credentialing and nondiscrimination.
B-Enrollment, Disenrollment and Re-Enrollment	
B.1 Choice and Limitations on Changes Between PCPs	• Managed care plans must comply with the Patient Bill of Rights, OIC regulation, and the standard contract. • Consumer expectations of managed care plans and the BH program are defined in the Member Handbook. • BH is a voluntary program – enrollees can leave at will but cannot be disenrolled because they are sick.
B.2 Disenrollment	
B.3 Procedures for Disenrollment	
C-Enrollee Rights and Protections	
C.1 Enrollee Rights	• Managed care plan publications must be pre-approved by the Health Care Authority.
C.2 Provider-Enrollee Communication	

Required Medicaid Contract Subpart/Subsection	Key Contractual Requirements for BH Managed Care Plans
C.3 Marketing Activities C.4 Liability for Payment	• Managed care plans must comply with the Patient Bill of Rights, OIC regulation, and the standard contract. • Consumer expectations of managed care plans and the BH program are defined in the Member Handbook.
C.5 Cost Sharing	• See earlier description of BH point-of-service and premium cost sharing – this is an area on which federal authority will be needed.
C.6 Emergency and Post-stabilization Services C.7 Emergency Services: Coverage and Payment C.8 Post-stabilization Services: Coverage and Payment	• Managed care plans must comply with the Patient Bill of Rights, OIC regulation, and the standard contract. • Consumer expectations of managed care plans and the BH program are defined in the Member Handbook with systems in place to handle this situation.
C.9 Solvency Standards	• Managed care plans must comply with state solvency standards required in statute (OIC regulations).
D. Quality Assessment and Performance Improvement	
D.1 Access Standards D.2 Structure and Operation Standards D.3 Measurement and Improvement Standards	• Managed care plans must comply with the Patient Bill of Rights, OIC regulation of system capacity, the standard contract quality of care requirements, and expedited authorization of critical health-related decisions. • Consumer expectations of managed care plans and the BH program are defined in the Member Handbook. • Performance monitoring requires reporting of standard NCQA measures. • Contract Quality of Care requirements. • Workgroup efforts to facilitate joint BH and Medicaid procurement are targeting this area for streamlining and consistency.
E. Not Applicable	
F. Grievance Systems	
F.1 Service Authorization and Notice of Action F.2 General Requirements of Grievance Systems F.3 Appeal Process F.4 Expedited Appeals Process F.5 Access to State Fair Hearing	• Managed care plans must comply with the Patient Bill of Rights, OIC regulation and contractual requirements for all BH plans • Consumer expectations of managed care plans , BH program and grievance/appeal filing are explained in the Member Handbook and defined in the Washington Administrative Code chapter 182-25 and the Regulatory Code of Washington chapter 70.47– for issues with health plan services, providers or facilities, health plan decisions or BH administrative/eligibility decisions ○ Access to review process and legal services (free) is clearly described, easy, and promotes a meaningful hearing. • continued next page

Required Medicaid Contract Subpart/Subsection	Key Contractual Requirements for BH Managed Care Plans
F.6 Grievance Process	• As a result of the Patient Bill of Rights, and OIC regulations, formal procedures exist to ensure due process and meaningful review of consumer grievances, complaints and appeals on administrative and health care treatment/services issues for all managed care plans. BH follows the statutory commercial insurance process. • Appeals on administrative decisions related to program eligibility and enrollment (disenrollment for non-payment for example) are defined in WAC 182-25-105 and may be escalated as follows: ○ Step 1: Initial review by BH staff (the first appeal every rolling 12 months for reinstatement as a result of non-payment is always granted if premium payment is made). ○ Step 2: Administrative review by HCA legal authority (for all requests for a review of initial HCA decisions other than those concerning nonpayment, which are reviewed by the Office of Administrative Hearings). ○ Step 3: Independent judicial review by State Office of Administrative Hearings (OAH) - legal representation at no cost to client if requested in accordance with RCW 34.056.542. • State law also requires managed care plans to allow consumers to appeal health care service denials or changes, with strict time limits for process governed by OIC regulation and managed care contracts. The process includes: ○ Managed care plan review - initial decision on BH required within 30 days (expedited where waiting for a decision could put consumer health at risk). ○ Health plan decisions may be challenged through an Independent Review Organization (IRO) with legal representation at no cost to consumers – state law protects consumers' right to decision based on evidence. ○ **While on the surface this may appear to be an area on which federal authority is needed, only 1 BH case in the last 5 years moved beyond the OAH hearing level. If this is viewed as an issue for the transitional bridge, the merger of the HCA and Medicaid would facilitate development of protocols to adopt the Medicaid "fair hearings" process for BH as needed**. • Ultimate appeal stage moves to Article III courts.
G. Not applicable	
H. Certifications and Program Integrity	
H.1 Certification H.2 Program Integrity H.3 Fraud and Abuse	• The Department of Health (DOH) controls all provider and hospital licensing, censoring and revocation of licenses – regular reporting makes information available electronically. • OIC regulates fraud and abuse. • HCA requires compliance with OIC regulations, third party HEDIS audits, Consumer Assessment of Health Plans (CAHPS). • BH plans must provide complaint reporting on denials, appeals, grievances, and independent reviews.
I. Sanctions	
I.1 General	• Managed care plans must comply with OIC regulation of state law.

Required Medicaid Contract Subpart/Subsection	Key Contractual Requirements for BH Managed Care Plans
I.2 Temporary Management	
I.3 Termination	
J. Finance and Payment	
J.1 Federal Financial Participation	• Managed care plans must comply with OIC regulation and the Health Care Authority open access and audit rules.
J.2 Financial Solvency	• Managed care plans must comply with OIC regulation of state solvency standards required in statute.
J.3 Physician Incentive Plan (PIP)	• N/A
X. Procurement Requirements for Managed Care Contracts	
X.1 Contract Provisions	• Standard BH managed care contract covers provisions within this federal sub-category.

8. Tribal Consultation and Public Notice:

Tribal consultation:

- **Initial Concept Consultation:** On March 9, 2010, we conducted an Educational Roundtable and Consultation with the 29 federally recognized Washington State Tribes – 15 representatives were present, some representing Tribal interests in general rather than a specific Tribe. At that time, we were focused on the transitional bridge path that would have requested federal financing for Basic Health parents/caretaker relatives only. However, given the rolling dynamics of the Washington state budget, discussions about the Disability Lifeline, and elements of NHR as we knew it at that time, the actual Tribal presentation was an expansive conversation to clarify the broader historic and policy-making context.

  Every Tribal representative individually expressed support for activities to finance a transitional bridge that would sustain the BH program. One Tribal representative was quoted as saying, "*Being for this is like being for motherhood and apple pie".* Furthermore, the extended discussion clearly indicated that public assistance programs in general are an essential "safety-net" coverage option for the state's most vulnerable low-income adults, Tribal members included. If we had asked whether support would be given for federal financing of the MCS program, it would also have been unanimous.

  A concern expressed, "for the record", was that any authority granted by CMS to allow Washington to implement its transitional bridge until 2014 should not become "precedent-setting" in terms of implications for Tribal coverage in the near future and under NHR. For example, Tribal members who currently receive coverage through BH are not distinguished from other BH members and thus accept the same cost sharing responsibilities, although many[28] are sponsored by the Tribes and do not personally pay premium contributions. Protections for Tribal members are clearly established under Medicaid today and NHR appears to extend these to subsidized coverage in the Health Insurance Exchange(s). Our temporary transitional bridge in no way supersedes or influences those federal expectations. Tribal representatives understood that assumption, but nonetheless wanted to go on record. Minutes of the meeting are included in Exhibit 20.

- **Centennial Accord:** On June 8, 2010, the 21st Centennial Accord meeting was held. This is an annual meeting between the State of Washington and the federally recognized tribes in Washington to develop joint strategies and specific agreements to mutually address goals and obstacles. Discussions and presentations ranged from health care and social services to transportation, jobs and energy, and included brief remarks on the transitional bridge proposal.

- **Further consultation:** Following the Centennial Accord and with consideration of traditional summer events that limit availability of Tribal representation for a further consultation in July, we are scheduling an additional consultation for August 2, 2010. Questions raised at the Centennial Accord made it clear that efforts by the state to prepare for PPACA compliance in 2014 are very important to Washington's Tribes. We are, therefore, planning an agenda that will use this consultation and educational roundtable opportunity to:
  - Review and solicit further input on our proposed transitional bridge demonstration, one element of NHR activity.
  - Share limited additional information we have on the implications of NHR for the AI/AN population and solicit questions.
  - Provide an overview of preliminary planning for a workgroup to focus on the impact of NHR on coverage for low-income populations.

Public Notice:

Discussions on the fiscal implications for the current BH and MCS programs have been ongoing for many months, triggered by the Governor's *original* budget in December 2009, which eliminated both programs. The specter of lost coverage as a result of Washington's fiscal crisis has been seriously considered by Executive and Legislative branch staff, key health care and fiscal policy makers, and a wide variety of consumer advocates, health plans and health delivery system representatives. Discussions during the 2010 Legislative session around development of the Disability Lifeline and the 2010 Supplemental budget have included testimonials at hearings, meetings, discussions with advocates; culminating in a fiscal path intended to maintain the viability of the programs and ultimately tied to this proposal. Newspaper articles have consistently described our discussions with CMS as a federal waiver that will keep the Basic Health and Medical Care Services (focused on Disability Lifeline) programs alive.

The importance of the transitional bridge to Governor Gregoire, the Washington Legislature and Washington's federal delegation, ensures a continuing broad public engagement supporting Washington's proposal. The recent kick-off meeting for the newly established Joint Select Committee on National Health Reform Implementation included a presentation on the proposal with an emphasis on the key outstanding issues and the anticipated timetable for ongoing discussions. Committee and audience members were nothing but encouraging.

Regular bi-weekly conference calls/meetings continue with a coalition of advocates for the BH and MCS programs, to review the development of the proposal and its anticipated alignment with NHR. Advocates discussed a set of guiding principles they delivered to CMS, which represent their desire for a speedier transition to the Medicaid NHR platform, through add-on benefits and elimination of cost sharing. While our goals to sustain the BH and MCS programs during the transitional bridge are aligned, we have expressed caution at the fiscal implications of the desired changes. Until our state's budget improves, changes we can make to the BH program in particular are incremental. This month, our ongoing discussions have targeted advocates' major interest in ensuring that the lowest income vulnerable adults in Washington do not continue to lose ground with respect to coverage options. Their recent engagement has been to encourage compromise on two areas that have also been key for CMS:

- Elimination of MCS time limits; and,
- Reduction in BH cost sharing by rolling back premiums for the lowest BH income band enrollees to 2009 levels.

A centralized web site has been developed to make details on NHR implementation activities more readily available to anyone interested. The proposed demonstration documents are included.

Exhibit 20: Summary of the Tribal Educational Roundtable/Consultation

AGENDA
Tuesday, March 9, 2010
11:00 a.m. – 12:00 p.m.

Proposal for Federal Financing of State-Funded Programs

AGENDA TOPIC	BRIEF SUMMARY OF KEY POINTS AND ACTION ITEMS
Introductions	**Tribal Leaders/Representatives:** **(in person)** Dorothy Hamner, Colville Confederated Tribes; Kerstin Powell, Port Gamble S'Klallam Tribe; June O'Brien, Ed Fox, Squaxin Island Tribe; Bill Riley, Jamestown S'Klallam Tribe; Rick George, Nooksack Tribe; Kim Zillet-Harris, Shoalwater Bay Tribe; **(conferenced)** Danno Ives, Lou Schmitz, Port Gamble S'Klallam Tribe; Marilyn Scott, Upper Skagit Tribe; and Jim Roberts, Northwest Portland Area Indian Health Board. **Washington State Attendees:** Roger Gantz, Jenny Hamilton, Colleen Cawston, Jan Ward Olmstead
Purpose of Meeting	• Explain federal bridge financing concept in light of Washington's budget and delay in national health reform (NHR). • Engage tribes in discussion/support for Basic Health adult parents. • Meet state's commitment to transparency.
Concept Overview	Assuming eventual passage of NHR, concept focused on short-term Bridge to sustain Basic Health (BH) and Medical Care Services (MCS) programs. With NHR implementation, MCS enrollees transfer to Medicaid; BH enrollees up to 133% FPL (or as determined) transfer to Medicaid, and remaining BH enrollees transfer to Health Insurance Exchange or NHR's state Basic Health option. • Washington faces $2.6 billion deficit for 2009-11 biennium – BH and MCS programs in jeopardy. • General concept paper submitted (1-16-10) at Governor's request to start discussion with CMS for federal financing. • Timing of legislative session/budget critical - March 11 is date anticipated for Governor Gregoire to receive Legislature's 2010 supplemental budget for signature. • Delay in NHR caused revised concept to sustain current BH with existing design: 1. Federal match for citizen parents up to 200% of FPL (~20,000 individuals). 2. WA Legislature determining enrollment cap for budget. 3. Potential CMS constraints being reviewed creatively in light of NHR. Meeting discussion intended to focus on Bridge rather than current of-the-moment subjects – potential HCA/DSHS-HRSA merger and potential changes to the MCS program.
Tribal Questions and Discussion	Comments and questions raised by tribes/participants: • Questions on issues not directly related to the Bridge proposal were discussed because they were of more immediate concern to Tribes: o Anticipated funding for chemical dependency residential and outpatient care. o GAU /ADATSA program changes being debated by WA Legislature in defining "Disability Lifeline".

AGENDA TOPIC	BRIEF SUMMARY OF KEY POINTS AND ACTION ITEMS
	• Pace of anticipated 1115 Demonstration Waiver acknowledged given expectation of need for federal approval to sustain state funding for BH/MCS programs in the 2010 supplemental budget. Concerns raised "for the record" that process did not follow DSHS protocol/CMS requirements, although need to depart from standard communication protocols understood. • Continuation of BH (including benefits and cost sharing) also acknowledged as important. Concerns raised "for the record" that use of Medicaid dollars to sustain BH should not become a precedent for waiving the standard Medicaid cost sharing requirement exemption for AI/AN. Assurance given that this unique financing effort was designed to serve only as a bridge to sustain BH until full implementation of NHR and application of Medicaid requirements. • Pilot to determine eligibility for Medicaid at Port Gamble S'Klallam reviewed.
Anticipated Next Steps	• Revise concept paper for CMS with program details and budget status – this will guide need for state Plan Amendment or 1115 Demonstration Waiver. • Enactment of NHR may offer revised opportunities. • Updates on progress and further consultation as appropriate.
CONSULTATION **Proposal for Federal Financing of State-Funded Programs** **1:30 p.m. – 2:30 p.m.**	
Overview	Overview provided of Educational Roundtable discussion (attendees were same as for morning discussion). Tribal representatives were asked if they supported the Proposal for Federal Financing of State-Funded Programs.
Specific Tribal Responses	• Marilyn Scott, Upper Skagit Tribe and Chair of the AIHC - *Interested in sustaining BH by whatever means possible until passage of NHR*. • Bill Riley, Jamestown S'Klallam Tribe (JT) - *commend plan; BH critical to JT; willing to live the unknowns at this point to ensure BH continuation; expressed "trust and faith you will do the right thing."* • Kerstin Powell, Port Gamble S'Klallam Tribe - *BH is vital and important, has kept Tribe out of priority one status and has enabled them to venture into prevention.* • Kim Zillyett-Harris, Shoalwater Bay Tribe – *second Port Gamble's comments* • June O'Brien, Squaxin Island Tribe - *Not supporting BH is like not supporting Apple Pie.* • Dorothy Hamel, Colville - *support bridge, but would need to take back to tribal council for official support.* • Rick George, Nooksak Tribe - *support.*

9. Budget Neutrality:

With federal approval, implementation of Washington's transitional bridge will begin no later than January 1, 2011, which is required to sustain both BH and MCS programs for the foreseeable future. We would actually like to implement in 2010 if possible; our Congressional delegates have pegged October 2010 as their target.

While neither Section 1115 nor Title XIX of the Social Security Act *require* that 1115 demonstration waivers be budget neutral, the Department of Health and Human Service (DHHS) has a long standing policy that approval of any waiver is conditioned upon budget neutrality over the life of the demonstration. The demonstration with the waiver cannot be expected to cost the Federal government more than without the waiver. Washington's proposal meets this requirement.

We have been apprised by CMS that the cost without the waiver can include charges that would otherwise be permitted under a Medicaid State plan amendment (SPA). The ability to consider SPA rules in the calculations is critical to Washington's demonstration. The PPACA requires states' Medicaid programs to cover adults with dependent children and childless adults up to age 65, in households with income up to ~138% of the FPL, in January 2014. Section 1902(k)(2) of the Act allows states to "phase-in" this coverage through a SPA beginning April 1, 2010. This is the foundation of our transitional bridge demonstration.

As described in section 5, *Eligibility Determination, "*countable income" for the Section 1902(k)(2) early expansion can be based on methods that are "reasonable, consistent with the objectives of the Medicaid program and are in the best interest of the [Medicaid] beneficiary." This allows states to use an existing income determination method such as Family Medicaid (TANF) or SSI-related rules. We propose to use TANF to remain consistent with the eligibility determination method already in place for the MCS program today.

Applying this to the transitional bridge demonstration, with an unrestricted state appropriation, would support additional families with dependent children and childless adults with gross earned incomes up to 200% of FPL. As shown in exhibit 21, this could *potentially* allow Washington's transitional bridge demonstration to cover up to about 387,000 "newly eligible" **citizen** adults in 2011 through a SPA. Based on various participation scenarios estimated by the Urban Institute (see Exhibit 21), more likely this number would be between 220,000 and 290,000 adults.

Washington does not have the financial capacity to expand its Medicaid program to cover these adults until the enhanced federal medical assistance percentage (FMAP) for "newly" eligible Medicaid clients goes into effect on January 1, 2014. Even a limited "phase-in" of additional lower income persons is beyond current capacity due to both the number of low-income uninsured persons at the lowest income levels.

At best, as we described early, our transitional bridge would allow the continuation of coverage for approximately 92,000 individuals in the MCS and BH programs (in 2011), 69,000 of whom would be financed through the demonstration waiver with federal support. Our budget neutrality calculations are based on this premise.

Exhibit 21:

Estimated Washington Citizens Potentially Eligible for Optional Medicaid Coverage							
Adult Groups (age 19 - 64)	2008 Population [1]	Forecast State Pop Growth [2] (2008-2011)	Estimated 2011 Individuals	Standard Scenario [3]		Enhanced Scenario [3]	
				Participation Rate	Individuals	Participation Rate	Individuals
Childless Adults (0 - 200% FPL)							
- Employer Coverage	272,532	4.2%	283,978	25%	70,995	25%	70,995
- Public Coverage	203,552	4.2%	212,101	25%	53,025	25%	53,025
- Non-Group Coverage	34,771	4.2%	36,231	54%	19,565	60%	21,739
- Uninsured	313,582	4.2%	326,752	57%	186,249	75%	245,064
- Total	824,435		859,063		329,834		390,823
Parents/Caretaker Relatives (75 - 200% FPL)							
- Employer Coverage	122,581	4.2%	127,729	25%	31,932	25%	31,932
- Public Coverage	65,905	4.2%	68,673	25%	17,168	25%	17,168
- Non-Group Coverage	6,710	4.2%	6,991	54%	3,775	60%	4,195
- Uninsured	57,860	4.2%	60,290	57%	34,365	75%	45,218
- Total	253,054		263,684		87,241		98,513
UNINSURED TOTAL	371,442		387,043		220,614		290,282

[1] Data are from the 2008 biennial Washington State Population Survey (WSPS2008 v2). Totals may differ due to rounding.

[2] Growth rate for adults age 19-64 is from the Washington State Office of Finance Management's November 2009 State Population Forecast.

[3] Participation rates are from the Urban Institute's "*Medicaid Coverage and Spending in Health Reform: National and State-by-State Results at or Below 133% FPL* " (May 2010) prepared for the Kaiser Commission on Medicaid and the Uninsured.

Per-Capita Budget Neutrality Approach:

To achieve the transitional goal of sustaining coverage through December 2013 in the BH and MCS programs, we propose a "**per capita client spending**" approach to budget neutrality, rather than the traditional aggregate federal spending approach. Our proposal ensures that Washington does not supplant federal for state funds, and that annual federal costs are not more than they would be under a Medicaid SPA. This is based on a shared-risk provision in which, for the 3 years of the transitional bridge:

- Federal financial participation (FFP) would be limited to a base-year (2011) per-capita for BH and MCS coverage adjusted by a trend factor (in 2012 and 2013) and minor revisions that reflect steps towards PPACA compliance described in section 1, *Transitional Bridge Milestones*. Base year data reflect our best actuals forecast for BH, MCS-DL and MCS-ADATSA programs.
- Per capita costs under the demonstration would be below the per-capita costs of providing coverage to the same individuals through the state's existing Medicaid program. Estimates of these "hypothetical" Medicaid costs were constructed with assistance of our actuaries. Their work is attached in Appendix 2.
- **Without the waiver:** Demonstration program base-year per-capitas would be trended forward at their current program trend rates, assuming that current aggressive utilization management and competitive purchasing strategies would continue to keep trend way below national averages in 2012 and 2013. Average annual growth in Medicaid acute care spending per enrollee was estimated by the Urban Institute to be approximately 5.8% for the period 2000-2007[29]. HHS' national health expenditure (NHE) per-capita growth is projected to be in the 5.1% range during the 2011-15 period. We doubt that we could sustain trend at this level, but because the duration of our demonstration is so narrow we believe the impact of any understated "without waiver" trend only underscores the merits of our proposal.
- **With the waiver:** Demonstration program base-year per-capitas would be trended forward by the trend factor assumed in the President's budget for Medicaid (6.5% as informed by CMS), discounted by 1% based on actuarial confirmation that our intended joint procurement strategy for Medicaid and Basic Health purchasing is likely to achieve such a result. While the MCS and BH programs would reap some benefits of aggressive joint purchasing, their risk pools are nowhere near the size of Medicaid and they would therefore not be likely to achieve the reduced trend estimated under the "hypothetical" without waiver scenario.
- CMS and Washington State would share the financial cost for caseload changes in the BH and MCS programs. If enrollment in one or both these programs exceeded state funding available, Washington would be able to limit enrollment. If additional funding were available, Washington would expand enrollment. In either case, a reciprocal adjustment would occur so that federal liability remained a calculation of actual enrollment for the period multiplied by the per-capita cost and the FMAP for the period.
- CMS and Washington State would share the financial cost for per-capita changes in the BH and MCS programs based on the trend anticipated. If actual per-capita costs were above "without waiver"estimates, the excess would be borne in total by the state. If actual per-capita costs were below budget neutrality, federal liability would be based on the actual per-capita, not the without waiver cost. In either case, our approach ensures that Washington does not supplant federal for state funds.

We have also assumed that for the final 2 years of the demonstration, 2014-2015, NHR would have been implemented and we would be PPACA compliant. Because our demonstration populations would be

predominantly eligible for Medicaid and our transitional bridge would effectively be unnecessary we have assumed that costs with the waiver and costs without the waiver would be the same in 2014-2015.

Supporting Budget Neutrality Details:

A budget neutrality EXCEL workbook accompanies this proposal - **WA 1115 Waiver Transitional Bridge Demonstration Waiver - BN&Historical Exp (070510).xlsx**. It includes:

- Historical trends and expenditures – see worksheet **Historical Trends & Costs**.
- Estimated costs to cover BH and MCS (DL and ADATSA) enrollees under the Medicaid program (i.e., costs without the waiver) and estimated costs to sustain the BH and MCS (DL and ADATSA) programs with federal financing to support the demonstration (i.e., costs with the waiver). See worksheet **Demo Projections – W&WO Waiver.**
- Calculations and methodology that underlies development of estimates – see worksheets **BH W&WO Waiver PMPM Estimates** and **MCS W&WO Waiver PMPM Estimates.**
- Enrollment projections for the demonstration, for subgroups of BH and MCS for whom the state would claim federal match or fully fund – see worksheet **Enrollment.**

10. Standard Funding Questions:

1. Section 1903(a) (1) provides that Federal matching funds are only available for expenditures made by states for services under the approved state Plan.

    a. Do providers receive and retain the total Medicaid expenditures claimed by the state (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?

    Providers retain the total Medicaid expenditures claimed by the state, including the Federal and non-Federal share. No portion of the payment is returned to the state.

    b. Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of any payment returned to the state, local governmental entity, or any other intermediary organization?

    Governmentally owned or operated entities participating in the certified public expenditure program certify the non-Federal share and receive the Federal share of the inpatient hospital payment, which is later cost settled. Other government entities that participate in intergovernmental transfer programs submit the non-Federal share of the payment and receive the entire Medicaid payment (Federal and non-Federal share). No portion of the either payment is returned to the state, local government entity, or any other intermediary organization.

    c. If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned, and the disposition and use of the funds once they are returned to the state (i.e., general fund, medical services account, etc.).

    No portion of the payment is returned to the state.

2. Section 1902(a) (2) provides that the lack of adequate funds from local sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

    a. Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other) is funded.

    The state portion of the Medicaid payment is paid with state Funds – General through the Medical Assistance Services budget.

    b. Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the state to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

    The NFS comes from appropriations from the legislature to the Medicaid agency.
    Funds derived through CPEs are not appropriated to an agency. Please see attachment WA 1115 Waiver Transitional Bridge Demonstration Waiver Response to CMS Questions - Questions 2&3.xlsx that lists all entities that certify their expenditures and their operational nature.

    c. Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment.

See attached Excel file (WA 1115 Waiver Transitional Bridge Demonstration Waiver Response to CMS Questions - Questions 2&3.xlsx).

d. If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local government entity transferring the funds.

Funds provided through CPE are not transferred to the state Medicaid agency. They are certified according to the state's CPE protocol as described in Supplement 3 to Attachment 4.19-A, Part 1.

e. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).

Payments made using CPE are paid according to the state's CPE protocol as described in Supplement 3 to Attachment 4.19-A, Part 1.

f. For any payment funded by CPEs or IGTs, please provide the following:
   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority; and
   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

See attached Excel file (WA 1115 Waiver Transitional Bridge Demonstration Waiver Response to CMS Questions - Questions 2&3.xlsx). This was also provided with responses to CMS RAI questions for SPA #09-025.

3. Section 1902(a) (30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a) (1) provides for Federal financial participation to states for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

See attached Excel file (WA 1115 Waiver Transitional Bridge Demonstration Waiver Response to CMS Questions - Questions 2&3.xlsx). This was also provided with responses to CMS RAI questions for SPA #09-025.

4. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

Both upper payment limit demonstrations reflect the anticipated effects of the increases to inpatient and outpatient rates as submitted in SPAs 10-001A and 10-001B.

For Outpatient:

- **See Excel file WA 1115 Waiver Transitional Bridge Demonstration Waiver Response to CMS Questions - Question 4 (OP UPL).xlsx**

Outpatient Upper Payment Limit Calculation

To calculate the Outpatient Upper Payment Limit (UPL), Washington State Medicaid completes the following process:

a. **Defines and classifies hospitals included in the UPL Calculation:**

Includes in-state hospitals that provide outpatient services to Washington State Medicaid clients

Excludes out-of-state hospitals and Critical Access hospitals (CAHs). CAHs are paid based on estimated costs

Groups hospitals into three CMS-designated classes:

- **State government-owned or operated facilities**
- **Government facilities that are not state-government-owned or operated**
- **Privately-owned or operated facilities.**

b. **Extracts Data:**

The data used are the most available complete year of outpatient data ("Covered billed charges" and "Payments") from the Washington State's Medicaid Management Information (MMIS) System for these hospitals. [For the SFY 2011 UPL analysis the state used SFY 2008 claims data, the most complete data available at the time of the calculation].

c. **Determines the Upper Payment Limit:**

Washington State estimates the available Medicaid outpatient upper payment limit amount based on the sum of all hospital estimated costs within each CMS designated class. Estimated cost is used as a proxy for what Medicare would payment for similar services, based on the assumption that it is Medicare's intent under the Outpatient Prospective Payment System to pay reasonable costs.

Hospital cost is calculated based on the sum of the hospital's claim covered charges multiplied by most recently available hospital-specific Medicare outpatient cost-to-charge ratios (CCRs) effective for the Medicare Outpatient Prospective Payment System. Medicare outpatient CCRs are extracted from the CMS outpatient provider-specific file.

The formula for calculating a Hospital's Total Cost (which serves as the basis for the Upper Payment Limit) is equal to:

Hospital's Total Covered Billed Charges * Hospital's Medicare outpatient CCR

The UPL "gap" for each hospital is equal to the difference between estimated costs and Washington State Medicaid payments, including third-party liability and patient payment amounts. These UPL gap amounts are summed for each hospital to determine the total amount over or under the UPL for each provider class.

The Medicare outpatient provider specific file, which contains the outpatient Medicare CCRs, can be found on the CMS website at the following URL:
https://www.cms.gov/PCPricer/OutPPS/list.asp

For the SFY 2011 UPL, the state used the provider specific file "OPSF April 2010 Update - Created 04-28-2010.txt" included in the 2nd Quarter 2010 files.

For Inpatient:

- **See Excel file WA 1115 Waiver Transitional Bridge Demonstration Waiver Response to CMS Questions - Question 4 (IP UPL).xlsx**

Inpatient Upper Payment Limit Calculation

To calculate the Inpatient Upper Payment Limit (UPL), Washington State Medicaid completes the following process:

a. **Defines and classifies hospitals included in the UPL Calculation:**

Includes in-state hospitals that provide inpatient services to Washington State Medicaid clients

Excludes out-of-state hospitals and Critical Access hospitals (CAHs). CAHs are paid based on estimated costs

Groups hospitals into three CMS-designated classes:
State government-owned or operated facilities
Government facilities that are not state-government-owned or operated
Privately-owned or operated facilities.

b. **Extracts Data:**

The data used are the most available complete year of inpatient data ("Covered billed charges" and "Payments") from the Washington State's Medicaid Management Information (MMIS) System for these hospitals. [For the SFY 2011 UPL analysis the state used SFY 2008 claims data, the most complete data available at the time of the calculation].

c. **Determines the Upper Payment Limit:**

Washington State estimates the available Medicaid inpatient upper payment limit amount by applying provider-specific Medicare payment-to-charge ratios to each provider's Medicaid charges as a proxy for what Medicare would pay for similar services. The Medicare payment-to-charge-ratio is calculated based on the Form CMS 2552 Medicare cost report data with reporting dates that best overlap the UPL analysis SFY.

Medicare payment-to-charge ratios are calculated as follows:

- **Medicare Payments: Based on Medicare cost report worksheet E Part A, Line 16 (Total Medicare Inpatient Payments) less the sum of:**
  - **Line 1.03 (Managed Care Patients Payments prior to March 1st or October 1st)**
  - **1.04 (Managed Care Patients Payments on or after October 1 and prior to January 1)**
  - **1.05 (Managed Care Patients Payments on or after January 1st but before April 1st/October 1st)**
  - **11.01 (Nursing and Allied Health Managed Care payments)**

- **Medicare Charges: Based on the Title XVIII Part A version of Medicare cost report worksheet D-4, column 2, Line 103 (Total Medicare program inpatient charges)**

- **Medicare Payment-to-Charge-Ratio: Based on total Medicare payments divided by total Medicare charges**

The formula for calculating payments under Medicare (which serves as the basis for the Upper Payment Limit) is equal to:

Hospital's Total Covered Billed Charges * Hospital's Medicare Payment-to-Charge Ratio

The UPL "gap" for each hospital is equal to the difference in estimated Medicare payments and Washington State Medicaid payments, including third-party liability and patient payment amounts. These UPL gap amounts are summed for each hospital to determine the total amount over or under the UPL for each provider class.

5. Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, other) that, in the aggregate, exceed its reasonable costs of providing services?

   a. In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

   No.

   b. If so, how do these arrangements comply with the limits on payments in §438.6(c) (5) and §438.60 of the regulations?

   N/A.

   c. If payments exceed the cost of services (as defined above), does the state recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

No public provider receives payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services. For the public providers that are reimbursed full costs, cost settlements will be performed to determine the actual costs incurred, and any excess federal payments will be returned. For Critical Access Hospitals that are reimbursed full costs, cost settlements will be performed to determine the actual cost incurred, and any excess federal payments will be returned.

Accompanying EXCEL spreadsheets include:

- **WA 1115 Waiver Transitional Bridge Demonstration Waiver Response to CMS Questions - Questions 2&3.xlsx**
- **WA 1115 Waiver Transitional Bridge Demonstration Waiver Response to CMS Questions - Question 4 (OP UPL).xlsx**
- **WA 1115 Waiver Transitional Bridge Demonstration Waiver Response to CMS Questions - Question 4 (IP UPL).xlsx**

C. Contacts:

For further information please contact:

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D. Appendices:

Appendix 1 – Overview of Current Washington State Public Programs
(Excerpted from original concept paper)

Over the years, Washington State has been progressive in establishing an array of public programs that provide coverage for low-income Washingtonians, up to 200 percent of the FPL for adults and 300 percent of the FPL for children. Recent legislative efforts have taken steps to streamline options and steer the state toward more efficient and seamless coverage for this population. This approach is entirely consistent with the coverage structure under NHR. Washington public coverage programs available for children, parents and elderly adults, and childless adults, are described below. Washington currently surpasses the NHR eligibility standard (133% of the FPL) for some adult populations - those primarily covered through BH - and we are currently considered an "expansion state" for NHR purposes.

***Programs for Children*:** *Apple Health for Kids* encompasses several programs administered by the Medicaid Purchasing Administration (MPA) to create seamless coverage for children under age 19. For children in families with incomes up to 300 percent of the FPL, coverage is financed through multiple federal and state funding sources. For example:

- Children in families with income up to 200 percent of the FPL are financed through the Title XIX Medicaid program.
- Children in families with income between 133-200 percent of the FPL receive enhanced match through our ability to claim an additional increment between our Medicaid and Title XXI Children's Health Insurance Program (CHIP) match rates.
- Children in families with income between 200-300 percent of the FPL are financed by Title XXI CHIP. These children also have modest premium requirements; $20 per child in families with income between 200-250 percent of the FPL; and $30 per child in families with income between 250-300 percent of the FPL. To ensure affordability, the premiums are capped at two per family.
- Children who are not eligible for Medicaid or CHIP coverage due to their citizenship status are still eligible for *Apple Health for Kids,* financed with state funds. Washington's commitment to coverage for children applies to all children residing in the state.
- Also covered by CHIP are unborn children whose parents do not meet citizenship requirements.

***Medicaid and CHIP Programs for Adults/Pregnant Women*:** The MPA also administers several programs for specific sub-groups of adults.

- Parents who care for children enrolled in "*Apple Health for Kids*" with family income up to approximately 75 percent of the FPL[4] are financed through the Title XIX Medicaid program.
- Women who are pregnant and whose family income is up to 185 percent of the FPL are financed by Title XIX Medicaid.
- Women who have been screened and diagnosed with breast or cervical cancer or a pre-cancerous condition, and whose family income is up to 250 percent of the FPL, are financed by Title XIX Medicaid.
- Workers who have disabilities and whose family income is up to 220 percent of the FPL, pay premiums based on a sliding income scale, otherwise financed through Title XIX Medicaid.
- Adults who are age 65 or older, blind, have disabilities and whose family income is up to approximately 75 percent of the FPL[5] are financed by Title XIX Medicaid.

[4] In determining net income certain disregards such as child care costs and child support paid by the family are deducted.
[5] Net income and resources that define income for eligibility determination are based on Social Security Administration definitions for SSI.

There are two **additional *state-funded* (currently) programs** that provide coverage for low-income individuals, primarily adults:

Basic Health - administered by the Health Care Authority (HCA) and

Medical Care Services - administered by the MPA.

These two medical coverage programs are the crux of our 1115 demonstration waiver proposal.

Appendix 2 – Milliman's actuarial estimates for budget neutrality calculations of coverage costs "without a waiver".

This document will be provided as soon as we have it in hand.

E. Endnote References:

[1] In January's concept paper we noted that the Governor's *initial* budget required an elimination of the BH and MCS programs beginning July 2010 in order to balance to existing revenues. The Governor's *revised* budget later reinstated both programs with limits on enrollment and an assumption that additional revenues could be generated to keep the ongoing programs functioning intact.

[2] Amendments adopted on the final day of Budget debate removed the requirement that if federal funding was not approved, the Basic Health program would be discontinued as of April 1, 2011.

[3] NHR provides an opportunity, based on an amendment by Senator Cantwell that reflects the historic success of Washington's BH program, to implement a federally subsidized state Basic health option for individuals with income between 133 and 200 percent of the FPL. This could incorporate about 23% of Washington's current Basic Health program.

[4] The actuarial firm Milliman has advised us that a pool size lower than 60,000 enrollees would likely leave the BH program no longer viable.

[5] To see the full revenue forecast report go to www.erfc.wa.gov.

[6] The average used is a 2011 per member per month cost forecast by our actuarial consultant Milliman for Disability Lifeline enrollees.

[7] With appropriation from the Legislature, the enabling BH statute allows for eligibility up to 250 percent of the FPL. Funding to that level has never been appropriated.

[8] E2HB 2782 as enacted is available at:
http://apps.leg.wa.gov/documents/billdocs/2009-10/Pdf/Bills/Session%20Law%202010/2782-S2.SL.pdf

[9] 52 percent of previous GA-U clients eventually applied for SSI through the GA-X program or became SSI-eligible within a 24-month period.

[10] 30 percent of previous GA-U enrollees were on GA-X or SSI within 12-months of their GA enrollment.

[11] Groups given statutory priority include members of the Washington National Guard and Reserves who served in Operation Enduring Freedom, Operation Iraqi Freedom, or Operation Noble Eagle, and their spouses and dependents; and former BH members who disenrolled from BH to enroll in Medicaid but subsequently became ineligible for Medicaid.

[12] Administrative policy and procedures for managing the wait list are available at
http://apps.leg.wa.gov/WAC/default.aspx?cite+182-25-030.

[13] Estimates at a finer breakdown would not be meaningful given survey sampling – details of the survey methodology and results are available at: http://www.ofm.wa.gov/sps/default.asp

[14] Washington State Institute for Public Policy, "General Assistance Programs for Unemployable Adults", December 2009.

[15] Examples of "good cause" include an emotional or physical disability that prevents participation, or the unavailability of treatment.

[16] An alternate option for those who do not meet Medicaid citizenship requirements will need to be considered in planning for NHR implementation.

[17] Gross family income at 133 percent of the FPL was used as a proxy for Washington's current Medicaid income eligibility level. Without completing a full screen of current BH enrollees this is the best we could do.
[18] Page 20 of the 2010 Basic Health Member Handbook explains the current preexisting waiting period: http://www.basichealth.hca.wa.gov/documents/22-405.pdf

[19] In comparison, Milliman noted that guaranteed access with no underwriting, the effect of eliminating pre-existing condition exclusions, would be likely to increase premiums in the individual market by around 80%.

[20] Requirements for mental health parity are locally considered to be more stringent in state than federal law.

[21] Total Basic Health General Fund State expenditures for benefits for July-December 2009 were $107,400,000.

[22] Premiums are required for up to 3 children in a family.

[23] Lowest deductible/preferred provider examples Regence *Breakthru 70* and LifeWise *WiseEssentials Rx* are taken from commercial web sites January 2010. Table shows *Breakthru 70* product details first. Dental services are covered through supplemental policies.

[24] 2008 estimates based on data from the Office of the Insurance Commissioner's annual report.

[25] Based on the February 2010 subsidized BH enrollment by managed care plan.

[26] Details are available through the Office of the Insurance Commissioner, an elected position, at: www.insurance.wa.gov.

[27] http://apps.leg.wa.gov/documents/billdocs/1999-00/Pdf/Bills/Session%20Law%202000/6199-s2.sl.pdf

[28] Race/ethnicity are not required data elements for application to the BH program. It may be that the majority of Tribal members in the program are sponsored but there is no way to know for sure – over 70% of enrollees do not report their race/ethnicity.

[29] Holahan, J. Yemane, A. Enrollment is Driving Medicaid Costs – But Two Targets Can Yield Savings. Health Affairs 2009;28(5):1453-1465.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Medicaid Purchasing Administration
626 8th Avenue, S.E. • P.O. Box 45502
Olympia, Washington 98504-5502

July 9, 2010

Dear Tribal Leader:

SUBJECT: Review Washington's Proposal for Federal Financing Support to Sustain State-Financed Health Coverage Programs

In accordance with the Washington State Department of Social and Health Services American Indian Policy 7.01, the Department of Social and Health Services Communication and Consultation Protocols, and the Centers for Medicare and Medicaid Services (CMS) public process on Tribal Consultation, I am formally requesting an opportunity to meet with representatives from Washington State Tribes, recognized American Indian organizations, and urban Indian clinics.

Medicaid Purchasing Administration (MPA) and Health Care Authority (HCA) representatives will meet with Washington tribes to update information provided in our March 9, 2010, consultation on Washington State's request for federal financing support to sustain our Basic Health and Medical Care Services (GAU and ADATSA) programs. We are scheduling the update to avoid conflict with local, regional and national Tribal summer activities and to make efficient use of the time available. We have coordinated with CMS so there will be an hour reserved for them to discuss the proposed demonstration with you and to hear any concerns you may have. The formal CMS request to meet with you is enclosed. In addition to the discussions on the proposed 1115 demonstration waiver, we hope there will be enough time for a brief overview of MPA and HCA planning activities regarding National Health Reform (NHR) implementation.

Please mark your calendars as these sessions will be held on **Monday, August 2, 2010,** at the MPA Cherry Street Plaza Building in Olympia in the Apple/Peach Conference Rooms at 626 8th Avenue, SE.

- An Educational Roundtable is scheduled from **9:30 a.m. until 11:00 a.m.**
- The CMS discussion is scheduled from **11:00 a.m. until noon.**
- A consultation on the proposed demonstration waiver will follow from **1:00 p.m. until 2:00 p.m.**

Since our previous consultation, the enactment of the Patient Protection and Affordable Care Act (PPACA) and subsequent discussions with CMS on our revised concept, have culminated in an 1115 demonstration waiver proposal, which was submitted to CMS today (copy enclosed).

Washington State now proposes to draw upon the early Medicaid expansion option afforded under the PPACA to sustain the Basic Health and Medical Care Services programs until 2014 when National Health Reform (NHR) is fully implemented. Approval of the proposed waiver would increase fiscal flexibility to extend a critical coverage bridge to some 90,000 individuals, with about 69,000 financed through the waiver. In 2014, these individuals will transfer to the Medicaid program, or have subsidized access through an Exchange or the PPACA Basic Health option.

During our March consultation, all tribal representatives expressed support for the original proposal on behalf of their Tribes. Concerns expressed were documented and are included in the current demonstration waiver proposal in section 8, beginning on page 41. Through this waiver, Tribal members who receive their health coverage through the Basic Health and Medical Care Services programs can expect an even more positive outcome than was anticipated at our March meeting.

If you have any questions about this effort, please contact Deb Sosa, Tribal Manager, via telephone at (360) 725-1649 or via email at deborah.sosa@dshs.wa.gov. You may also contact Jenny Hamilton, Project Administrator at (360) 725-1101 or via email at jenny.hamilton@dshs.wa.gov.

Thank you for your continued work with us to retain health coverage for American Indian/Alaskan Native families and other residents of the State of Washington. We look forward to meeting with you again.

Sincerely,

Doug Porter
Assistant Secretary

Enclosures

cc: Colleen F. Cawston, Director, IPSS, DSHS
Preston Cody, HCA
Roger Gantz, Director, MPA
Jenny Hamilton, Project Administrator, MPA
IPAC Delegates
Sheryl Lowe, AIHC
Jan Olmstead, Program Manager, HCA
Richard Onizuka, Director, HCA
Heidi Robbins Brown, Deputy Assistant Secretary, MPA
Jim Roberts, NWPAIHB
Deb Sosa, Manager, MPA
Tribal Program Administrators

HISTORICAL TRENDS AND EXPENDITURES

Eligibility Group: BASIC HEALTH ADULTS

Calendar Year	2005	2006	2007	2008	2009	5 Year Average
Annual Net Premium Increase	9.00%	7.20%	4.50%	6.20%	2.20%	5.82%
Composite Benchmark Rate Change[1]	9.30%	7.20%	5.90%	5.10%	2.40%	5.98%
Benchmark Plan Rate (40-54 yr old)	$ 203.52	$ 218.10	$ 231.80	$ 243.48	$ 250.23	$ 229.43
Actual Average Plan Rate PMPM	$ 189.61	$ 205.62	$ 218.66	$ 235.76	$ 247.82	$ 219.49
Actual Average Member Premium PMPM	$ 35.66	$ 36.92	$ 35.20	$ 36.13	$ 34.47	$ 35.68
Actual Average State Subsidy PMPM	$ 153.95	$ 168.70	$ 183.46	$ 199.63	$ 213.35	$ 183.82
Total State Subsidy Paid	$ 188,665,667	$ 203,087,547	$ 230,680,170	$ 251,549,720	$ 236,855,696	$ 222,167,760
Average Total Monthly Enrollment	101,869	100,355	104,395	104,366	93,154	100,828
Total Annual Member Months	1,222,427	1,204,254	1,252,742	1,252,386	1,117,850	1,209,932

[1] **Modifications in Basic Health benefits (2007-2009) were evaluated to allow adjustment of the benchmark rate to standardize the trend.**

Actuarial Adjustment	0.70%	-0.40%	0.20%
Realization of prior year Rx changes made		-0.70%	

2007 Benefit Changes

- Five therapeutic classes of drugs now charged at the generic copay ($10) instead of the name-brand copay (50%)
- Addition of oxygen therapy
- Addition of DME with a $25 copay and annual max benefit of $500
- Addition of occupational therapy subject to PT restrictions
- Extension of the PT/OT benefit to 12 post surgical visits
- Limitation of sleep studies to one per year

2008 Benefit Changes

- Removal of DME benefit enhancement made for the 2007 benefit year

2009 Benefit Changes

- Removal of the diabetes pre-existing condition waiting period

Eligibility Group: MEDICAL CARE SERVICES - Disability Lifeline

Calendar Year	2005	2006	2007	2008	2009	5 Year Average
Percap Annual Growth Rate[2]	1.22%	1.21%	1.20%	1.18%	1.17%	1.20%
Percap	$ 529.68	$ 541.17	$ 550.93	$ 563.95	$ 570.25	$ 551.20
Total expenditures	$ 69,274,744	$ 80,363,198	$ 86,082,125	$ 95,864,765	$ 111,179,252	$ 88,552,817
Average Total Monthly Enrollment	10,904	12,369	13,020	14,176	16,243	13,342
Total Annual Member Months	130,849	148,423	156,234	170,114	194,914	160,107

[2] The state Medicaid program has engaged in aggressive purchasing and utilization management. MCS inpatient hospital rates are significantly discounted. Trends have been lower than the Medicaid national average (5.8% for 2004-07) and overall per-capita national health expenditures (4.9% for 2004-09).

Eligibility Group: MEDICAL CARE SERVICES - ADATSA

Calendar Year	2005	2006	2007	2008	2009	5 Year Average
Percap Annual Growth Rate[3]	3.06%	2.97%	2.88%	2.80%	2.73%	2.89%
Percap	$ 191.43	$ 195.74	$ 195.82	$ 203.94	$ 220.02	$ 201.39
Total expenditures	$ 9,361,531	$ 10,348,275	$ 10,424,177	$ 11,499,377	$ 11,263,349	$ 10,579,342
Average Total Monthly Enrollment	4,077	4,406	4,436	4,697	4,264	4,376
Total Annual Member Months	48,927	52,872	53,237	56,361	51,167	52,513

[3] The state Medicaid program has engaged in aggressive purchasing and utilization management. MCS inpatient hospital rates are significantly discounted. Trends have been lower than the Medicaid national average (5.8% for 2004-07) and overall per-capita national health expenditures (4.9% for 2004-09).

Washington State Transitional Bridge Proposal - July 2010
Federal Financing Support With and Without Waiver

DEMONSTRATION TOTAL FEDERAL EXPENDITURES

	DEMONSTRATION YEARS					
	Transitional Bridge			National Health Reform		TOTAL
	CY11	CY12	CY13	CY14	CY15	2011-2015
Without Waiver	$189,242,899	$214,811,316	$235,206,746	$255,959,004	$278,207,141	$1,173,427,106
With Waiver	$131,670,254	$153,329,904	$167,803,393	$255,959,004	$278,207,141	$986,969,697
Difference (With-Without Waiver)	($57,572,645)	($61,481,411)	($67,403,353)	$0	$0	($186,457,409)

Eligibility Group: BASIC HEALTH ADULTS

WITHOUT WAIVER

		DEMONSTRATION YEARS					
		Transitional Bridge			National Health Reform		TOTAL
		CY11	CY12	CY13	CY14	CY15	
Trend Rate [1]	5.98%						
Eligible member months		579,600	579,600	579,600	579,600	579,600	
Total cost (FFP) per member		$159.14	$168.66	$178.74	$189.43	$200.76	
Total expenditure		$92,238,139	$97,753,980	$103,599,668	$109,794,928	$116,360,664	$519,747,378

[1] "Without waiver" is based on the average 5-year (Cy 2005-09) adjusted trend in the actual program as a proxy.

WITH WAIVER

		DEMONSTRATION YEARS					
		Transitional Bridge			National Health Reform		TOTAL
		CY11	CY12	CY13	CY14	CY15	
Trend Rate [2]	5.50%						
Eligible member months		579,600	579,600	579,600	579,600	579,600	
Total cost (FFP) per member [3]		$106.20	$117.64	$124.11	$189.43	$200.76	
Total expenditure		$61,553,520	$68,185,912	$71,936,137	$109,794,928	$116,360,664	$427,831,161

[2] The "with waiver" is based on a trend factor that is ~1% below the President's Budget (as informed by CMS). Lower-than-average trend for BH is achievable as a result of the joint procurement strategy being developed. Our actuaries have confirmed that this is a reasonable expectation.

[3] A 5% premium increase is assumed in CY12 for elimination of pre-ex exclusion for adults; CY11 incorporates adjustment for mental health parity and reduction of cost sharing for the lowest income (band A) enrollees.

Eligibility Group: MEDICAL CARE SERVICES - DISABILITY LIFELINE ADULTS

WITHOUT WAIVER

		DEMONSTRATION YEARS					
		Transitional Bridge			National Health Reform		TOTAL
		CY11	CY12	CY13	CY14	CY15	
Trend Rate [4]	5.14%						
Eligible member months		172,563	198,264	214,048	227,757	241,427	
Total cost (FFP) per member		$489.06	$514.20	$540.63	$568.41	$597.63	
Total expenditure		$84,393,357	$101,946,970	$115,720,039	$129,460,444	$144,284,277	$575,805,087

[4] The historical trend for the current MCS-DL population would not be sustainable in reality as a result of heavy discounting of hospital services. The *closest* historical medical trend is that of the CN disabled adult population, which we use as a proxy for the MCS-DL population under Medicaid. Calculations are based on standard regression analysis of the historical experience of the CN non-dual adults.

WITH WAIVER

		DEMONSTRATION YEARS					
		Transitional Bridge			National Health Reform		TOTAL
		CY11	CY12	CY13	CY14	CY15	
Trend Rate [5]	5.5%						
Eligible member months		172,563	198,264	214,048	227,757	241,427	
Total cost (FFP) per member		$343.84	$362.75	$382.70	$568.41	$597.63	
Total expenditure		$59,333,432	$71,920,056	$81,916,003	$129,460,444	$144,284,277	$486,914,213

[5] The "with waiver" trend factor is based on a trend that is ~1% below the President's Budget (as informed by CMS).

Eligibility Group: MEDICAL CARE SERVICES - ADATSA ADULTS

WITHOUT WAIVER

		DEMONSTRATION YEARS					
		Transitional Bridge			National Health Reform		TOTAL
		CY11	CY12	CY13	CY14	CY15	
Trend Rate [6]	5.14%						
Eligible member months		47,031	47,031	47,031	47,031	47,031	
Total cost (FFP) per member		$268.15	$321.29	$337.80	$355.16	$373.42	
Total expenditure		$12,611,403	$15,110,366	$15,887,039	$16,703,633	$17,562,200	$77,874,641

[6] The historical trend for the current MCS-ADATSA population would not be sustainable in reality as a result of heavy discounting of hospital services. The *closest* historical medical trend is that of the CN disabled adult population, which we use as a proxy for the MCS-ADATSA population under Medicaid. Calculations are based on standard regression analysis of the historical experience of the CN non-dual adults.

Washington State Transitional Bridge Proposal - July 2010
Total Expenditures With and Without Waiver

DEMONSTRATION TOTAL STATE, FEDERAL and ENROLLEE EXPENDITURES

	DEMONSTRATION YEARS					
	Transitional Bridge			National Health Reform		TOTAL
	CY11	CY12	CY13	CY14	CY15	2011-2015
Without Waiver	$378,485,798	$429,622,631	$470,413,491	$511,918,009	$556,414,283	$2,346,854,211
With Waiver	$299,600,283	$346,826,575	$377,982,725	$511,918,009	$556,414,283	$2,092,741,875
Difference (With-Without Waiver)	($78,885,514)	($82,796,056)	($92,430,766)	$0	$0	($254,112,336)

Eligibility Group: BASIC HEALTH ADULTS

WITHOUT WAIVER

		DEMONSTRATION YEARS					
		Transitional Bridge			National Health Reform		TOTAL
		CY11	CY12	CY13	CY14	CY15	
Trend Rate [1]	5.98%						
Eligible member months		579,600	579,600	579,600	579,600	579,600	
Total cost per member		$318.28	$337.32	$357.49	$378.86	$401.52	
Total expenditure		$184,476,278	$195,507,959	$207,199,335	$219,589,855	$232,721,329	$1,039,494,756

[1] "Without waiver" is based on the average 5-year (Cy 2005-09) adjusted trend in the actual program as a proxy.

WITH WAIVER

		DEMONSTRATION YEARS					
		Transitional Bridge			National Health Reform		TOTAL
		CY11	CY12	CY13	CY14	CY15	
Trend Rate [2]	5.50%						
Eligible member months		579,600	579,600	579,600	579,600	579,600	
Total cost per member		$274.96	$304.59	$321.34	$378.86	$401.52	
Total expenditure		$159,366,816	$176,538,590	$186,248,213	$219,589,855	$232,721,329	$974,464,803

[2] The "with waiver" is based on a trend factor that is ~1% below the President's Budget (as informed by CMS). Lower-than-average trend for BH is achievable as a result of the joint procurement strategy being developed. Our actuaries have confirmed that this is a reasonable expectation.

[3] A 5% premium increase is assumed in 2012 for elimination of pre-ex exclusion for adults

Eligibility Group: MEDICAL CARE SERVICES - DISABILITY LIFELINE ADULTS

WITHOUT WAIVER

		DEMONSTRATION YEARS					
		Transitional Bridge			National Health Reform		TOTAL
		CY11	CY12	CY13	CY14	CY15	
Trend Rate [4]	5.14%						
Eligible member months		172,563	198,264	214,048	227,757	241,427	
Total cost per member		$978.12	$1,028.39	$1,081.25	$1,136.83	$1,195.26	
Total expenditure		$168,786,714	$203,893,940	$231,440,078	$258,920,888	$288,568,555	$1,151,610,174

[4] The historical trend for the current MCS-DL population would not be sustainable in reality as a result of heavy discounting of hospital services. The *closest* historical medical trend is that of the CN disabled adult population, which we use as a proxy for the MCS-DL population under Medicaid. Calculations are based on standard regression analysis of the historical experience of the CN non-dual adults.

WITH WAIVER

		DEMONSTRATION YEARS					
		Transitional Bridge			National Health Reform		TOTAL
		CY11	CY12	CY13	CY14	CY15	
Trend Rate [5]	5.5%						
Eligible member months		172,563	198,264	214,048	227,757	241,427	
Total cost per member		$687.67	$725.50	$765.40	$1,136.83	$1,195.26	
Total expenditure		$118,666,865	$143,840,113	$163,832,007	$258,920,888	$288,568,555	$973,828,427

[5] The "with waiver" trend factor is based on a trend that is ~1% below the President's Budget (as informed by CMS).

Eligibility Group: MEDICAL CARE SERVICES - ADATSA ADULTS

WITHOUT WAIVER

		DEMONSTRATION YEARS					
		Transitional Bridge			National Health Reform		TOTAL
		CY11	CY12	CY13	CY14	CY15	
Trend Rate [6]	5.14%						
Eligible member months		47,031	47,031	47,031	47,031	47,031	
Total cost per member		$536.31	$642.57	$675.60	$710.33	$746.84	
Total expenditure		$25,222,806	$30,220,732	$31,774,078	$33,407,266	$35,124,399	$155,749,281

[6] The historical trend for the current MCS-ADATSA population would not be sustainable in reality as a result of heavy discounting of hospital services. The *closest* historical medical trend is that of the CN disabled adult population, which we use as a proxy for the MCS-ADATSA population under Medicaid. Calculations are based on standard regression analysis of the historical experience of the CN non-dual adults.

WITH WAIVER		DEMONSTRATION YEARS					
		Transitional Bridge			National Health Reform		TOTAL
Trend Rate [7]	5.5%	CY11	CY12	CY13	CY14	CY15	
Eligible member months		47,031	47,031	47,031	47,031	47,031	
Total cost (FFP) per member [8]		$229.28	$281.18	$296.64	$355.16	$373.42	
Total expenditure		$10,783,301	$13,223,936	$13,951,253	$16,703,633	$17,562,200	$72,224,322

[7] The with waiver trend factor is based on a trend that is ~1% below the President's Budget (as informed by CMS).

[8] Premium increase assumed in 2012 as a result of benefit expansion to include full mental health parity under managed care.

WITH WAIVER		DEMONSTRATION YEARS					
		Transitional Bridge			National Health Reform		TOTAL
Trend Rate [7]	5.5%	CY11	CY12	CY13	CY14	CY15	
Eligible member months		47,031	47,031	47,031	47,031	47,031	
Total cost (FFP) per member [8]		$458.56	$562.35	$593.28	$710.33	$746.84	
Total expenditure		$21,566,603	$26,447,872	$27,902,505	$33,407,266	$35,124,399	$144,448,645

[7] The with waiver trend factor is based on a trend that is ~1% below the President's Budget (as informed by CMS).

[8] Premium increase assumed in 2012 as a result of benefit expansion to include full mental health parity under managed care.

CY 2011 Adult Basic Health Base Year Per-Capitas											
	Without Waiver			With Waiver (pre-ex included)				With Waiver (no pre-ex)			
	Total	State	Federal	Total	Enrollee	State	Federal	Total	Enrollee	State	Federal
Trended Adjusted Medical Base [1] Total	$283.00	$141.50	$141.50								
Trended Mental Health Base [2] Total	$18.60	$9.30	$9.30								
Trended Chemical Dependency [3]	$16.68	$8.34	$8.34								
Total PMPM [4]	$318.28	$159.14	$159.14	$274.96	$62.56	$106.20	$106.20	$288.71	$65.69	$111.51	$111.51

ASSUMPTIONS & NOTES

[1] All cost sharing was removed from the BH benefit package; hearing aids, glasses, durable medical equipment and comprehensive PT/OT services were added. Adjustment was made for an annual trend rate of 2% for utilization and 0.5% for costs.

[2,3] Standard payment rate for non-disabled adults.

[4] Includes Plan Administration based on a 13.5% administrative factor and a 2% increase for premium taxes. Total includes an adjustment for achieving mental health parity effective January 1, 2011 but does not account for dental (which would only increase the "without waiver" estimated PMPM.)

CY 2011 Medical Care Services Program Base Year Per-Capitas

	Disability Lifeline (DL/GAU)						ADATSA (under managed care)						ADATSA (under current fee-for-service)					
	Without Waiver			With Waiver			Without Waiver			With Waiver			Without Waiver			With Waiver		
	Total	State	Federal	Total	State	Federal	Total	State	Federal	Total	State	Federal	Total	State	Federal	Total	State	Federal
Base Medical [1]																		
- Inpatient Hospital	$100.35	$50.18	$50.18				$48.56	$24.28	$24.28				$48.56	$24.28	$24.28			
- All other	$414.56	$207.28	$207.28				$160.21	$80.11	$80.11				$160.21	$80.11	$80.11			
Total	$514.91	$257.46	$257.46				$208.77	$104.39	$104.39				$208.77	$104.39	$104.39			
Adjusted Medical Base [2]																		
- Inpatient Hospital	$351.08	$175.54	$175.54				$123.26	$61.63	$61.63				$123.26	$61.63	$61.63			
- All other	$400.73	$200.37	$200.37				$159.90	$79.95	$79.95				$159.90	$79.95	$79.95			
Total	$751.81	$375.90	$375.90				$283.16	$141.58	$141.58				$283.16	$141.58	$141.58			
Trended Adjusted Medical Base [3]																		
- Inpatient Hospital [4]	$375.22	$187.61	$187.61	$152.82	$76.41	$76.41	$131.74	$65.87	$65.87	$56.81	$28.41	$28.41	$131.74	$65.87	$65.87	$56.81	$28.41	$28.41
- All other	$428.29	$214.14	$214.14	$426.34	$213.17	$213.17	$170.90	$85.45	$85.45	$168.08	$84.04	$84.04	$170.90	$85.45	$85.45	$168.08	$84.04	$84.04
Total	$803.51	$401.75	$401.75	$579.16	$289.58	$289.58	$302.63	$151.32	$151.32	$224.89	$112.45	$112.45	$302.63	$151.32	$151.32	$224.89	$112.45	$112.45
Mental Health Base [5]																		
- Inpatient	$13.98	$6.99	$6.99	$13.98	$6.99	$6.99	$11.08	$5.54	$5.54	$11.08	$5.54	$5.54	$11.08	$5.54	$5.54	$11.08	$5.54	$5.54
- Outpatient	$55.56	$27.78	$27.78				$44.70	$22.35	$22.35	$44.70	$22.35	$22.35						
Total	$69.54	$34.77	$34.77	$13.98	$6.99	$6.99	$55.78	$27.89	$27.89	$55.78	$27.89	$27.89	$11.08	$5.54	$5.54	$11.08	$5.54	$5.54
Trended Mental Health Base [5]																		
- Inpatient	$14.19	$7.09	$7.09	$14.19	$7.09	$7.09	$11.24	$5.62	$5.62	$11.24	$5.62	$5.62	$11.24	$5.62	$5.62	$11.24	$5.62	$5.62
- Outpatient	$56.39	$28.19	$28.19				$45.37	$22.68	$22.68	$45.37	$22.68	$22.68						
Total	$70.58	$35.29	$35.29	$70.58	$35.29	$35.29	$56.61	$28.31	$28.31	$56.61	$28.31	$28.31	$11.24	$5.62	$5.62	$11.24	$5.62	$5.62
Plan Administration [7]	$66.09	$33.05	$33.05				$29.49	$14.75	$14.75	$29.11	$14.55	$14.55						
Chemical Dependency [6]	$35.24	$17.62	$17.62	$35.24	$17.62	$17.62	$206.58	$103.29	$103.29	$206.58	$103.29	$103.29	$206.58	$103.29	$103.29	$206.58	$103.29	$103.29
Trended Chemical Dependency [3]	$37.94	$18.97	$18.97	$37.94	$18.97	$18.97	$222.43	$111.21	$111.21	$222.43	$111.21	$111.21	$222.43	$111.21	$111.21	$222.43	$111.21	$111.21
Total PMPM [8]	$978.12	$489.06	$489.06	$687.67	$343.84	$343.84	$611.16	$305.58	$305.58	$533.04	$266.52	$266.52	$536.31	$268.15	$268.15	$458.56	$229.28	$229.28

ASSUMPTIONS & NOTES

[1] Medical cost estimates are based on fee-for-services (FFS) claims data for October 1, 2008 through September 30, 2009, with a claims run out through May 2010. DL/GAU includes all counties except King and Pierce which were in a managed care pilot. The DL/GAU data were adjusted by a .9694 factor for utilization differences between King/Pierce and the remainder of the state. ADATSA calculations used statewide claims data.

[2] The adjusted medical data were re-priced using the DL/GAU and ADATSA FFS utilization and Medicaid payment rates for hospital services, including an adjustment for modest reductions to covered durable medical equipment (DME) and reduced Medicaid office visit fee schedules that were effective on July 1, 2009.

[3] The FFY 2009 data were trended foreward to CY 2011 using a 3.0% per-year trend factor for price changes.

[4] Inpatient hospital services are heavily discounted for currently state-funded programs.

[5] **METHODOLOGY for calculating mental health percaps.**

Part 1: Estimate of full Medicaid mental health benefit for MCS-DL (GA-U) and MCS (ADATSA) enrollees

We calibrated a mental health service cost risk model for adult CN Disabled Medicaid enrollees' use of RSN-paid inpatient and outpatient mental health services in SFY 2007.

We used a concurrent risk model (that is, a model relating risk factors identified in SFY 2007 to imputed costs in SFY 2007).

The risk model included the following risk factors identified from MMIS-paid claims and client demographic data:

- A set of diagnosis-based risk factors grouped by level of severity (schizophrenia, bipolar, depression, etc.)
- A set of pharmacy-based risk factors grouped by drug therapy class (antipsychotics, antidepressants, etc.)
- Age and gender interaction terms

Costs were measured through claims-based reimbursement amounts for inpatient claims processed through MMIS, and through the Client Services Database mental health service cost imputation model for Evaluation and Treatment inpatient admissions and outpatient community services paid directly by the RSNs. The risk model was calibrated to the SFY 2007 adult CN Disabled population. The R-square for the calibration was 21.4 percent.

Applying the risk weights derived from the SFY 2007 calibration to the relevant SFY 2009 populations produced the following population average risk scores:

SFY 2009 CN Disabled member-month weighted mean risk score = 1.047

SFY 2009 GA-U member-month weighted mean risk score = 0.577

SFY 2009 ADATSA member-month weighted mean risk score = 0.463

The risk scores are "linear" and can be used to calculate relative risk ratios to produce "discount factors" off the Disabled Adult RSN rates for DL/GA-U and ADATSA clients:

SFY 2009 GA-U "discount factor" = 0.551

SFY 2009 ADATSA "discount factor" = 0.442

Applying these discount factors to the SFY 11 composite rates for July 2010 through June 2011 of $126.21 for Disabled Adults produces:

SFY 2011 GA-U estimated RSN per cap = $69.54

SFY 2011 ADATSA estimated RSN per cap = $55.78

These per caps reflect expected mental health service utilization for the MCS-DL (GA-U) and MCS-ADATSA populations were they enrolled as categorically needy Medicaid beneficiaries in SFY 2011.

Part 2: Direct calculation of per member per month community psychiatric inpatient costs for GA-U and ADATSA clients in SFY 2008.

Costs were measured through claims-based reimbursement amounts for inpatient claims processed through MMIS, and through the Client Services Database mental health service cost imputation model for Evaluation and Treatment inpatient admissions by the RSNs. No adjustments were made to MMIS claims-based reimbursement amounts. GA-U and ADATSA coverage months were measured through the OFM "Span" eligibility file.

[6] **METHODOLOGY for calculating chemical dependency treatment per caps.**

SFY 2009 treatment, case management, assessment and detoxification costs were calculated by pricing service encounters (recorded in the TARGET information system) at Medicaid rates for clients enrolled in MCS-DL (GA-U) or MCS-ADATSA coverage. Treatment modalities include residential, outpatient and opiate substitution treatment services. No adjustments were made to reflect county administrative costs associated with non-residential services. MCS-DL (GA-U) or MCS-ADATSA coverage months were measured through the OFM "Span" eligibility file.

[7] Plan Administration data are based on a 10% administrative factor and a 2% increase for premium taxes.

[8] Total PMPM does not account for dental. It is the sum of:

- Total trended adjusted medical base
- Total trended mental health base
- Trended chemical dependency
- Plan administration

CY 2011-15 DL, ADATSA & BHP Caseload
(Caseload Adjusted for ESHB 2782 DL Policy Steps & Medicaid Citizenship)

	Medical Care Services - DL			Medical Care Services - ADATSA			Basic Health		
DATE	Total	Waiver Enrollment	Non-Waiver Enrollment	Total	Waiver Enrollment	Non-Waiver Enrollment	Total	Waiver Enrollment	Non-Waiver Enrollment
Jul-09	16,320		16,320	4,299		4,299			
Aug-09	16,266		16,266	4,248		4,248			
Sep-09	16,366		16,366	4,259		4,259			
Oct-09	16,685		16,685	4,246		4,246			
Nov-09	16,809		16,809	4,135		4,135			
Dec-09	17,140		17,140	4,046		4,046			
Jan-10	17,147		17,147	3,939		3,939			
Feb-10	17,250		17,250	3,974		3,974			
Mar-10	17,304		17,304	4,126		4,126			
Apr-10	17,301		17,301	4,095		4,095			
May-10	17,410		17,410	4,069		4,069			
Jun-10	17,453		17,453	4,011		4,011			
Jul-10	17,369		17,369	3,975		3,975	65,000		
Aug-10	17,523		17,523	3,955		3,955	65,000		
Sep-10	15,396		15,396	3,937		3,937	65,000		
Oct-10	15,300		15,300	4,000		4,000	65,000		
Nov-10	15,513		15,513	3,933		3,933	65,000		
Dec-10	15,512		15,512	3,928		3,928	65,000		
Jan-11	15,532	13,816	1,716	3,952	3,876	76	69,000	48,300	20,700
Feb-11	15,595	13,871	1,723	3,974	3,898	77	69,000	48,300	20,700
Mar-11	15,792	14,047	1,745	4,126	4,046	80	69,000	48,300	20,700
Apr-11	15,733	13,994	1,739	4,095	4,016	79	69,000	48,300	20,700
May-11	15,787	14,042	1,744	4,069	3,991	79	69,000	48,300	20,700
Jun-11	15,784	14,040	1,744	4,011	3,934	77	69,000	48,300	20,700
Jul-11	16,026	14,255	1,771	3,975	3,898	77	69,000	48,300	20,700
Aug-11	16,267	14,470	1,798	3,955	3,879	76	69,000	48,300	20,700
Sep-11	16,509	14,685	1,824	3,937	3,861	76	69,000	48,300	20,700
Oct-11	16,751	14,900	1,851	4,000	3,923	77	69,000	48,300	20,700
Nov-11	16,992	15,115	1,878	3,933	3,857	76	69,000	48,300	20,700
Dec-11	17,234	15,329	1,904	3,928	3,853	76	69,000	48,300	20,700
Jan-12	17,476	15,544	1,931	3,952	3,876	76	69,000	48,300	20,700
Feb-12	17,717	15,759	1,958	3,974	3,898	77	69,000	48,300	20,700
Mar-12	17,959	15,974	1,985	4,126	4,046	80	69,000	48,300	20,700
Apr-12	18,201	16,189	2,011	4,095	4,016	79	69,000	48,300	20,700
May-12	18,442	16,404	2,038	4,069	3,991	79	69,000	48,300	20,700
Jun-12	18,684	16,619	2,065	4,011	3,934	77	69,000	48,300	20,700
Jul-12	18,795	16,718	2,077	3,975	3,898	77	69,000	48,300	20,700
Aug-12	18,905	16,816	2,089	3,955	3,879	76	69,000	48,300	20,700
Sep-12	19,015	16,914	2,101	3,937	3,861	76	69,000	48,300	20,700
Oct-12	19,124	17,011	2,113	4,000	3,923	77	69,000	48,300	20,700
Nov-12	19,233	17,108	2,125	3,933	3,857	76	69,000	48,300	20,700
Dec-12	19,344	17,207	2,138	3,928	3,853	76	69,000	48,300	20,700
Jan-13	19,454	17,304	2,150	3,952	3,876	76	69,000	48,300	20,700
Feb-13	19,564	17,402	2,162	3,974	3,898	77	69,000	48,300	20,700
Mar-13	19,675	17,500	2,174	4,126	4,046	80	69,000	48,300	20,700
Apr-13	19,785	17,599	2,186	4,095	4,016	79	69,000	48,300	20,700
May-13	19,895	17,696	2,198	4,069	3,991	79	69,000	48,300	20,700
Jun-13	20,005	17,794	2,211	4,011	3,934	77	69,000	48,300	20,700
Jul-13	20,110	17,888	2,222	3,975	3,898	77	69,000	48,300	20,700
Aug-13	20,217	17,983	2,234	3,955	3,879	76	69,000	48,300	20,700
Sep-13	20,324	18,078	2,246	3,937	3,861	76	69,000	48,300	20,700
Oct-13	20,430	18,173	2,258	4,000	3,923	77	69,000	48,300	20,700

CY 2011-15 DL, ADATSA & BHP Caseload
(Caseload Adjusted for ESHB 2782 DL Policy Steps & Medicaid Citizenship)

	Medical Care Services - DL			Medical Care Services - ADATSA			Basic Health		
DATE	Total	Waiver Enrollment	Non-Waiver Enrollment	Total	Waiver Enrollment	Non-Waiver Enrollment	Total	Waiver Enrollment	Non-Waiver Enrollment
Nov-13	20,537	18,268	2,269	3,933	3,857	76	69,000	48,300	20,700
Dec-13	20,644	18,363	2,281	3,928	3,853	76	69,000	48,300	20,700
Jan-14	20,751	18,458	2,293	3,952	3,876	76	69,000	48,300	20,700
Feb-14	20,857	18,553	2,305	3,974	3,898	77	69,000	48,300	20,700
Mar-14	20,964	18,647	2,317	4,126	4,046	80	69,000	48,300	20,700
Apr-14	21,071	18,742	2,328	4,095	4,016	79	69,000	48,300	20,700
May-14	21,178	18,837	2,340	4,069	3,991	79	69,000	48,300	20,700
Jun-14	21,284	18,932	2,352	4,011	3,934	77	69,000	48,300	20,700
Jul-14	21,391	19,027	2,364	3,975	3,898	77	69,000	48,300	20,700
Aug-14	21,498	19,122	2,376	3,955	3,879	76	69,000	48,300	20,700
Sep-14	21,604	19,217	2,387	3,937	3,861	76	69,000	48,300	20,700
Oct-14	21,711	19,312	2,399	4,000	3,923	77	69,000	48,300	20,700
Nov-14	21,818	19,407	2,411	3,933	3,857	76	69,000	48,300	20,700
Dec-14	21,925	19,502	2,423	3,928	3,853	76	69,000	48,300	20,700
Jan-15	22,031	19,597	2,435	3,952	3,876	76	69,000	48,300	20,700
Feb-15	22,138	19,692	2,446	3,974	3,898	77	69,000	48,300	20,700
Mar-15	22,245	19,787	2,458	4,126	4,046	80	69,000	48,300	20,700
Apr-15	22,351	19,882	2,470	4,095	4,016	79	69,000	48,300	20,700
May-15	22,458	19,977	2,482	4,069	3,991	79	69,000	48,300	20,700
Jun-15	22,565	20,071	2,493	4,011	3,934	77	69,000	48,300	20,700
Jul-15	22,672	20,166	2,505	3,975	3,898	77	69,000	48,300	20,700
Aug-15	22,778	20,261	2,517	3,955	3,879	76	69,000	48,300	20,700
Sep-15	22,885	20,356	2,529	3,937	3,861	76	69,000	48,300	20,700
Oct-15	22,992	20,451	2,541	4,000	3,923	77	69,000	48,300	20,700
Nov-15	23,099	20,546	2,552	3,933	3,857	76	69,000	48,300	20,700
Dec-15	23,205	20,641	2,564	3,928	3,853	76	69,000	48,300	20,700
CY 2011	16,167	14,380	1,786	3,996	3,919	77	69,000	48,300	20,700
CY 2012	18,575	16,522	2,053	3,996	3,919	77	69,000	48,300	20,700
CY 2013	20,053	17,837	2,216	3,996	3,919	77	69,000	48,300	20,700
CY 2014	21,338	18,980	2,358	3,996	3,919	77	69,000	48,300	20,700
CY 2015	22,618	20,119	2,499	3,996	3,919	77	69,000	48,300	20,700

Citizenship/Income Adjustment Factor	
MCS-DL	89%
MCS-ADATSA	98%
Basic Health	70%

172,563	47,031	579,600
198,264	47,031	579,600
214,048	47,031	579,600
227,757	47,031	579,600
241,427	47,031	579,600