



FEB 19 2010

Indian Policy

**STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES**

Health and Recovery Services Administration
626 8th Avenue, SE • P.O. Box 45502
Olympia, Washington 98504-5502

February 13, 2010

Dear Tribal Leader:

SUBJECT: Update on 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 (the Department) 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.

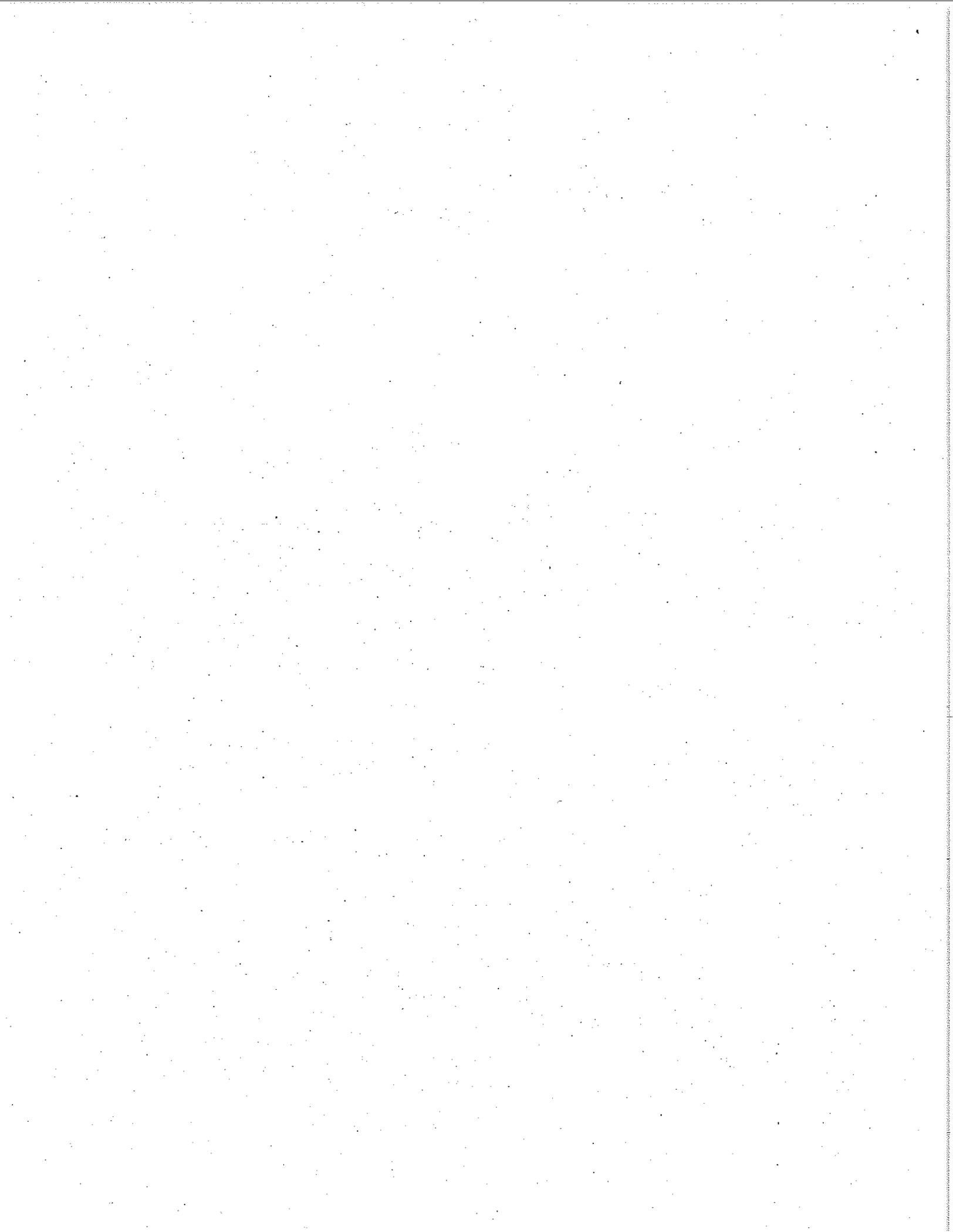
Department and Health Care Authority (HCA) representatives will meet with Washington tribes to share information on the status and anticipated impact of Governor Gregoire's request for federal financing to help sustain the Basic Health and Medical Care Services (ADATSA and GAU) programs for low-income adults. We don't believe there will be any negative effects, and anticipate a positive outcome for Tribal members who receive their health coverage through these programs.

Because time is short to develop the 2009-11 State budget, we are asking to meet earlier than standard communication protocol requires; we are scheduling the update to coincide with the next Indian Policy Advisory Committee (IPAC) Health and Recovery Services Administration (HRSA) quarterly subcommittee meeting in March.

Please mark your calendars as these sessions will be held on **Tuesday, March 9, 2010**, at the HRSA Cherry Street Plaza Building in Olympia in the Apple/Peach Conference Rooms at 626 8th Avenue, SE.

- The Educational Roundtable is scheduled **from 11:00 a.m. until noon**
- A consultation will follow **from 1:00 p.m. until 2:00 p.m.**

Based on the most recent version of National Health Reform (NHR), most of the individuals currently enrolled in the Basic Health (BH) and Medical Care Services (MCS) programs would become newly eligible for public or subsidized coverage, assuming NHR is fully implemented in 2013-2014. At that time, using the framework defined by the Patient Protection and Affordable Care Act (PPACA), individuals with family incomes up to 133 percent of the federal poverty level (FPL) would be covered through Medicaid; those with incomes between 133 and 200 percent of the FPL could receive subsidized coverage available in a Health Insurance Exchange or state Basic Health option.



Tribal Representatives
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Relative to this NHR design, we propose an effective financing bridge for "new eligibles" that potentially face a loss of health coverage in the interim as a result of Washington's fiscal crisis.

As you know, the \$2.7 billion gap in anticipated revenues creates an enormous challenge for the Governor and Legislature to balance Washington's 2009-2011 budget within existing revenues. As a result of the shortfall, the elimination of the BH and MCS programs was proposed beginning July 2010. The Governor's *revised* budget reinstates both programs with limits on enrollment and an assumption that additional state revenues will be generated to keep the ongoing programs functioning intact. However, without federal support to leverage state revenues, the viability of the BH and MCS programs remains in jeopardy.

Through an infusion of additional Medicaid funds, Washington's Bridge proposal would allow us to continue our BH program at its current coverage level, 200 percent of the FPL¹. Our goal is to sustain coverage in BH for approximately 65,000 individuals until NHR is implemented. We also propose to use Medicaid funds to continue the existing MCS program, which provides medical coverage to vulnerable adults who have medical or behavioral health incapacity. Many of these individuals eventually apply or qualify for Supplemental Security Income (SSI) and Medicaid. Retaining the MCS program as a bridge to the NHR Medicaid expansion ensures that, with limited state resources, Washington would continue to provide coverage for its most medically and behaviorally vulnerable adults until their transfer to Medicaid under NHR.

The Department and HCA staffs are currently working on an expedited process with CMS to determine what can be accomplished and whether an 1115 Medicaid Demonstration waiver or State Plan Amendment will need to be submitted for approval. Federal statute requires states to confer with Tribes on efforts such as this. Attached is the initial concept paper submitted to Secretary Sebelius to initiate discussion of Washington's request.

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

Sincerely,



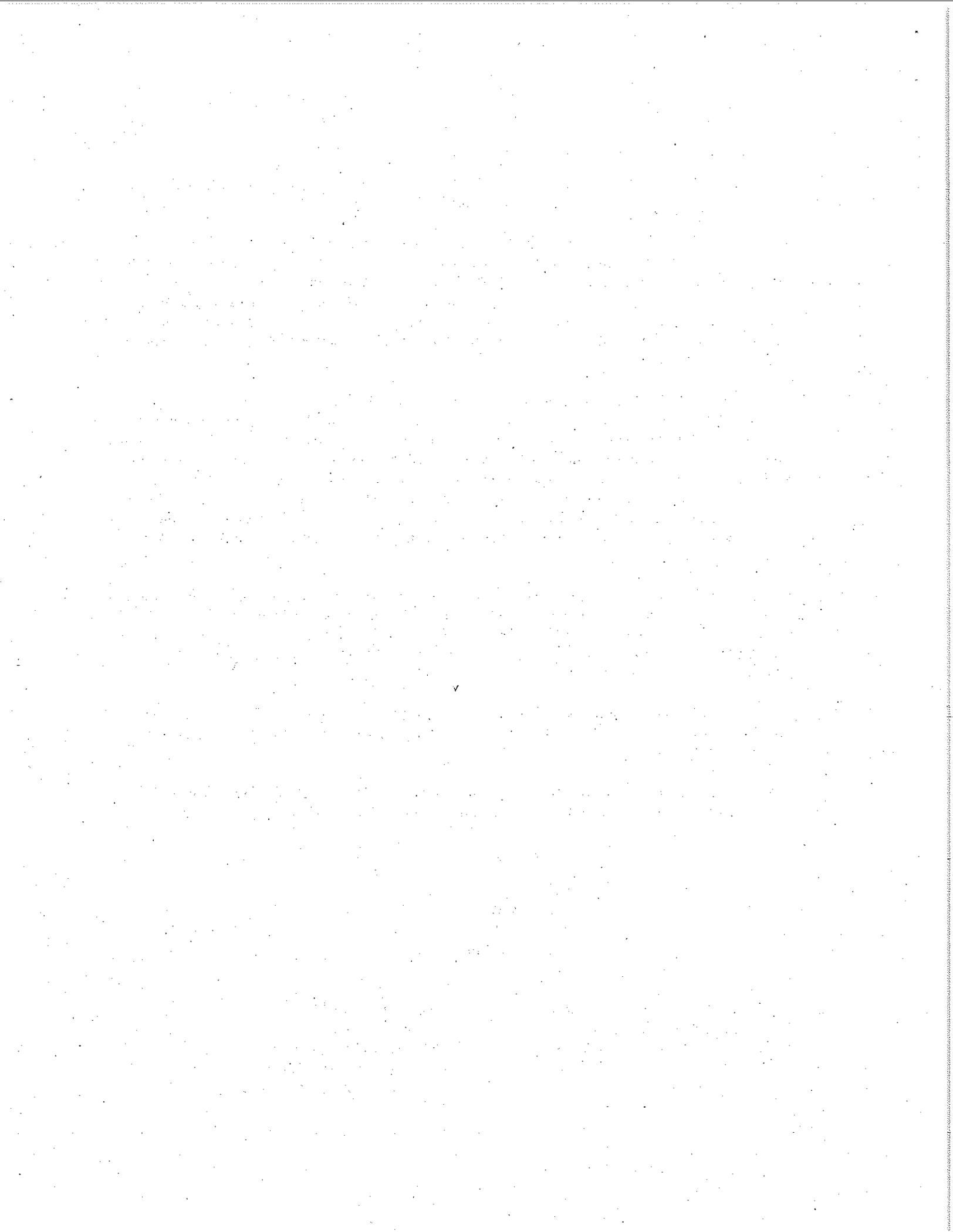
Doug Porter
Assistant Secretary

Enclosures

cc: Colleen F. Cawston, IPSS, DSHS
Roger Gantz, HRSA, DSHS
Jenny Hamilton, HRSA, DSHS
Steve Hill, HCA
IPAC Delegates

Jan Olmstead, HCA
Richard Onizuka, HCA
Heidi Robbins Brown, HRSA, DSHS
Deb Sosa, HRSA, DSHS
Tribal Program Administrators

¹ Currently, 77 percent of the individuals enrolled in BH are in families with income up to 133 percent of the FPL.



PROPOSAL TO SUPPORT A WASHINGTON STATE BRIDGE TO NATIONAL HEALTH REFORM FOR LOW-INCOME ADULTS

Summary

Washington State is proposing a federal financing partnership to preserve its Basic Health (BH) and Medical Care Services (MCS) programs for low-income adults not otherwise eligible for Medicaid today. Based on the most recent version of National Health Reform (NHR), which we assume will be enacted soon; these citizens will become newly eligible for public or subsidized coverage when NHR is fully implemented in 2013-2014. At that time, using the framework defined by the Patient Protection and Affordable Care Act, (PPACA) individuals with family incomes up to 133 percent of the federal poverty level (FPL) will be covered through Medicaid; those with incomes between 133 and 200 percent of the FPL can receive subsidized coverage available in a Health Insurance Exchange or state Basic Health option. Relative to this NHR design, our proposal is an effective bridge for "new eligibles" who potentially face a loss of coverage in the interim as a result of Washington's fiscal crisis.

With a \$2.6 billion gap, the Governor's and Legislature's challenge of balancing Washington's 2009-2011 budget within existing revenues is enormous. It necessitated proposing the elimination of the BH and MCS programs beginning July 2010. The Governor's *revised* budget reinstates both programs with limits on enrollment and an assumption that additional state revenues will be generated to keep the ongoing programs functioning intact. Without federal support to accompany additional state revenues, the viability of the BH and MCS programs remains in jeopardy.

The Senate and Conference Committee's version of the PPACA currently allows states to expand their Medicaid coverage to 133 percent of the FPL beginning in April 2010. Washington State does not have state funds to support such a full Medicaid entitlement expansion at this time. Instead, our proposal is to implement a NHR Bridge based on our existing BH and MCS programs.

The ability to use Medicaid funds to cover adults with family income up to 133 percent of the FPL would allow us to continue our BH program at its current coverage level, 200 percent of the FPL¹. Retaining BH is integral to Washington's ability to consider the PPACA state Basic Health option for individuals with income between 133 and 200 percent of the FPL. Without a federal financing partnership, we anticipate that BH will have to terminate or greatly limit its enrollment and administrative capacity in July 2010. We would then face the future prospect of rebuilding the program and its administrative infrastructure to support consideration of a state Basic Health option as part of NHR implementation in 2014. Our proposal gives Washington the flexibility to more readily implement a full range of coverage options under NHR, and of equal importance it sustains coverage for approximately 65,000 individuals in the meantime.

Washington's proposed NHR Bridge would also use Medicaid funds to continue the existing MCS program, which provides medical coverage to vulnerable adults who have a medical or behavioral health incapacity. Many of these individuals eventually apply or qualify for Supplemental Security Income (SSI) and Medicaid. Retaining the MCS program as a bridge to the NHR Medicaid expansion ensures that, with limited state resources, Washington can continue to provide coverage for its most medically and behaviorally vulnerable adults until they transfer to Medicaid in 2014.

To implement Washington's proposed NHR Bridge we will need the authority to adopt enrollment limits for the BH and MCS programs until they are replaced by the Medicaid expansion in 2013-2014. At that

¹ Currently, 77 percent of the individuals enrolled in BH are in families with income up to 133 percent of the FPL.

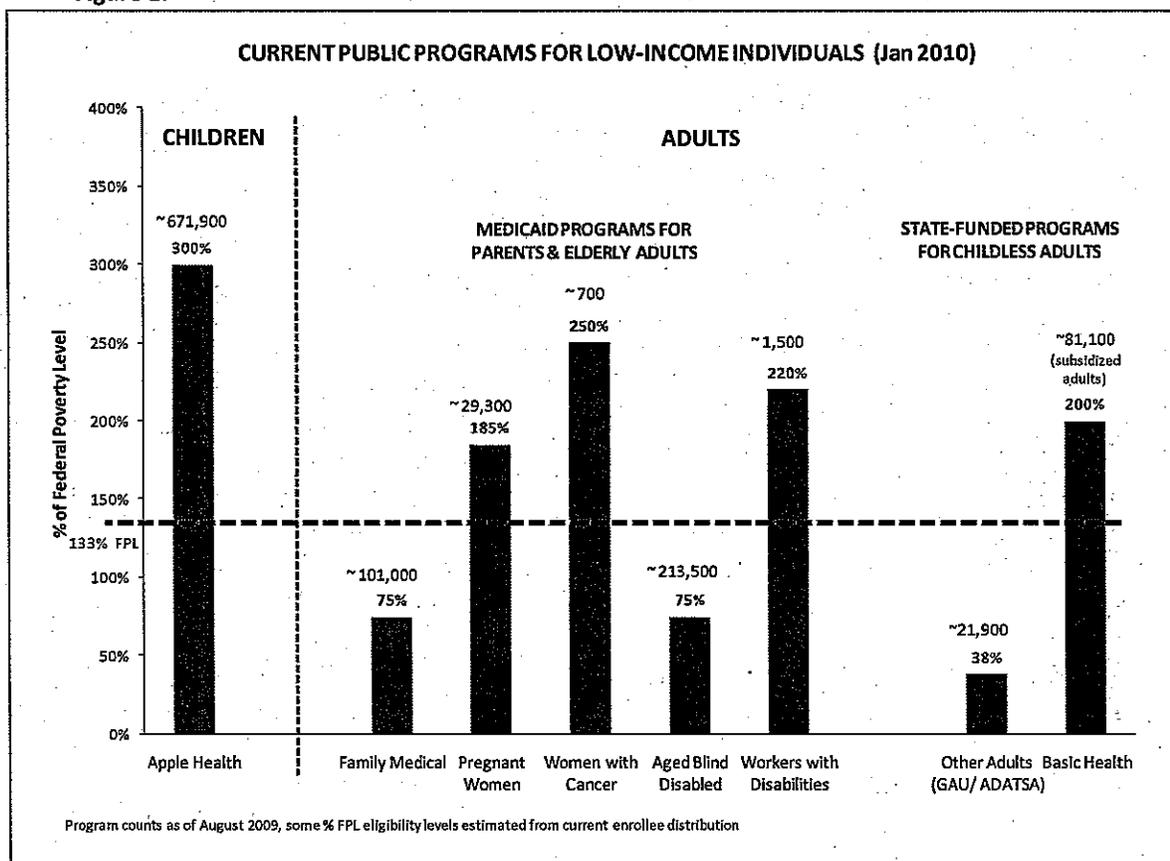
time, limits on enrollment would be replaced by an entitlement to coverage for all citizens up to 133 percent of the federal poverty level.

Remaining sections of this proposal provide information on the BH and MCS program designs, covering background details, scope of benefits, cost sharing, and an estimate of the fiscal implications. To set the context, we first summarize current coverage options for low-income Washingtonians.

Current Washington State Public Coverage Context:

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 anticipated coverage structure under NHR. Washington public coverage programs available for children, parents and elderly adults, and childless adults, are shown in Figure 1 with an overlay of the potential NHR Medicaid eligibility level set to 133 percent of the FPL. As is clear, Washington currently surpasses that eligibility standard for some adult populations - those primarily covered through BH - and we are currently considered an “expansion state” for NHR purposes. The potential suspension of state-funded BH and MCS programs could alter that status.

Figure 1:



In 2009 via 2SSB 5945, the legislature authorized Washington’s Department of Social and Health Services (DSHS) to seek a federal Medicaid demonstration waiver to expand health coverage for low-income Washingtonians. The primary goal of that waiver is to support purchasing and health care

delivery redesign steps toward a high-performing² and seamless program for individuals with household income up to 200 percent of the FPL. In light of the ongoing NHR conversation and the future coverage framework it defines for every state, we have adopted a two-phased approach to respond to our 2009 directive. We include reference to this effort here to avoid confusion – these are two *separate* initiatives we are discussing with CMS. While they are linked, the flexible financing partnership to keep the BH and MCS programs in operation is a much more immediate initiative needing a fast track to resolution; the purchasing and delivery system redesigns are a longer term ongoing effort supported by an 1115 Demonstration Waiver request that is currently in development with the assistance of CMS staff.

To put our NHR Bridge proposal for the preservation of BH and MCS coverage in perspective, Washington's public programs for children and adults shown in Figure 1 are briefly described as follows.

Programs for Children: In 2007 2SSB 5093 authorized *Apple Health for Kids*, to expand subsidized coverage to all children in families with income up to 300 percent of the FPL and to ensure coverage continuity through programs that fall under *Apple Health for Kids*. It also directed DSHS to design and implement a "Buy-In" option for children in families with income above 300 percent of the FPL. These expansions were viewed as the final steps toward the goal of ensuring access to health care coverage by 2010, for all Washington's children.

Apple Health for Kids encompasses several programs administered by DSHS 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. Through a new "Buy-In" option, children in families with incomes above 300 percent of the FPL will be required to pay the full amount of health care coverage and an additional administrative cost.

Medicaid and CHIP Programs for Adults/Pregnant Women: DSHS 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 FPL³ are financed through the Title XIX Medicaid program.

² Specified program features include: A single eligibility standard that maximizes federal financing; A single application process; Common core benefits with the option of supplemental coverage for children and individuals who are aged, blind and disabled; Purchasing innovations and quality improvement investments that may include incentives for preventive care, provider payment reforms, options for cost-sharing, coordination of medical and behavioral health care, targeted care management, and mandated enrollment in managed care; Premium assistance that maximizes enrollment in employer-sponsored health insurance; and Options for shared state and federal savings from care management for individuals eligible for coverage by both Medicare and Medicaid.

³ In determining net income certain disregards such as child care costs and child support paid by the family are deducted.

- 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 FPL⁴ are financed by Title XIX Medicaid.

There are two **additional state-funded 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 DSHS.

Keeping these two medical coverage programs operational is central to our NHR Bridge proposal.

Basic Health

(<http://www.basicealth.hca.wa.gov/>):

Background: The Basic Health program (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 FPL⁵. 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 plans⁶. In its procurement processes the State tries to contract with the same managed care plans for both BH and Medicaid. Historically, BH has also served as an enrollment door for Medicaid children via *Basic Health Plus*, which provides comprehensive Medicaid coverage delivered by the same managed care plans that serve other BH enrollees. This unique link between Medicaid and BH offers an effective vehicle for serving entire families in the same managed care plan.

BH has become a nationally recognized "ready laboratory" for assessing the impacts of health policy options on low-income families. NHR currently includes a state Basic Health option as an alternative to obtaining subsidized coverage via a health insurance exchange.

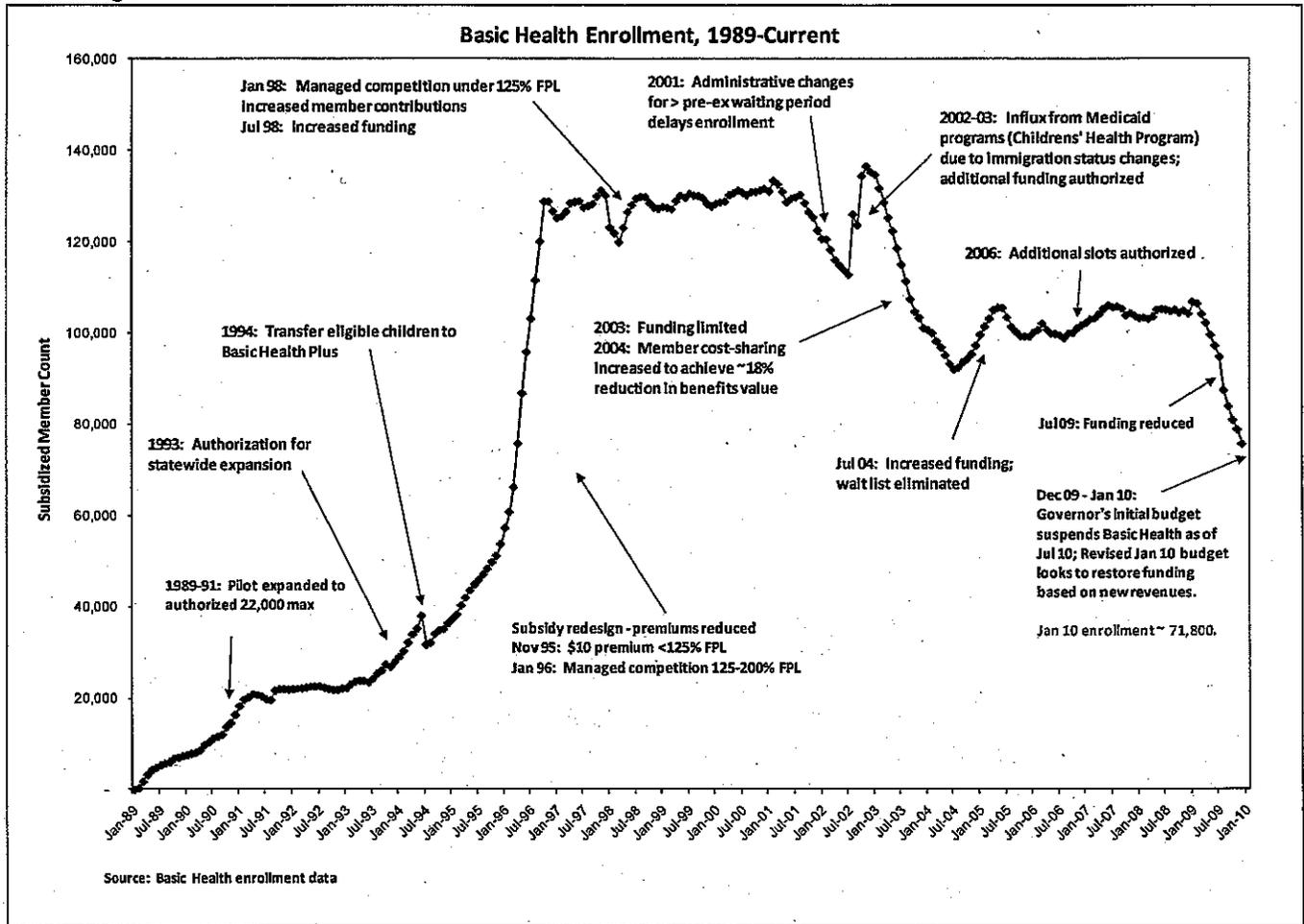
Enrollment: Figure 2 graphically represents the history of BH, showing its success with steady enrollment over the past two decades and fluctuations clearly tied to available legislative appropriation. Based on enrollment that from the mid 1990s rarely waived below 100,000, reached a cap of 130,000 in 2003, and then declined during the 2003-05 and current recessions, it is clear that low income Washingtonians find BH coverage critical. While the current caseload is limited to 65,000, there are nearly 90,000 people on the waiting list. Our proposed federal financing partnership would help preserve the program beginning July 2010, with a capped enrollment of approximately 65,000 individuals who would continue to receive coverage through the NHR bridge period using the same efficient administrative processes in operation today.

⁴ Net income and resources that define income for eligibility determination are based on Social Security Administration definitions for SSI.

⁵ 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.

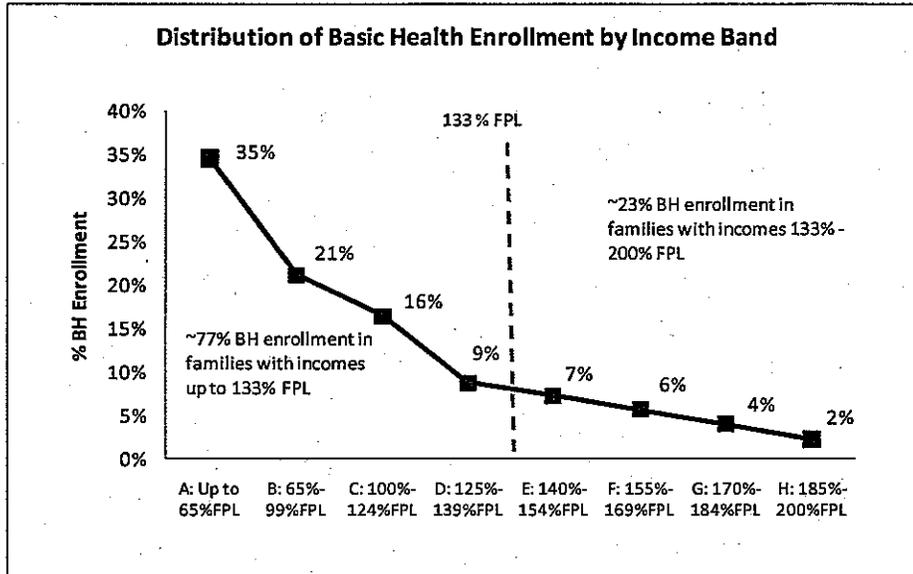
⁶ Of Washington's 39 counties, Community Health Plan of Washington (CHPW) serves 37, Molina Health Care 26, Group Health Cooperative 5, Kaiser Permanente 2, and Columbia United Providers 1.

Figure 2:



BH enrollees are bucketed into 8 groups, or bands, defined by income. Based on the December 2009 distribution of BH enrollment shown in Figure 3, enrollment is skewed toward families with the lowest incomes. More than a third falls into the lowest income band A, with incomes up to 65 percent of the FPL. Furthermore, approximately 77 percent of current BH enrollment is from families with incomes up to 133 percent of the FPL, the group that would be newly eligible for Medicaid coverage under NHR. We anticipate that beginning in July 2010, a BH bridge program of 65,000 individuals would include approximately 50,000 people with incomes up to 133 percent of the FPL and a further 15,000 people with incomes between 133 and 200 percent of the FPL. As evidenced by the growing waiting list (currently nearly 90,000), low-income individuals who are enrolled and those who wish to enroll in BH consider the coverage affordable, accessible, and adequate.

Figure 3:



Covered Benefits: In Section 1302 of the Patient Protection and Affordable Care Act, NHR currently requires the benefits design for the state Basic Health option to meet a definition of “essential health benefits” that include 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 scope of benefits encompasses most of these “essential health benefits” categories and covers specific services comparable to Medicaid. We believe that the scope of benefits generally comports favorably with the definition of a “Benchmark Benefits Package” established in Section 1937 of the Social Security Act. A comparison of the current BH benefits package and Medicaid is shown in Appendix 1. A more detailed description of the BH schedule of benefits is included as Appendix 2, “Appendix A: Schedule of Benefits” pages 24-37, excerpted from the “2010 Basic Health Member Handbook” available in full at <http://www.basichealth.hca.wa.gov/documents/22-405.pdf>. We propose to continue this operational scope of benefits through the duration of the NHR Bridge and offer it as a potential model for the NHR state Basic Health option.

Cost Sharing: Consistent with coverage in the broad commercial market, cost sharing in BH comes in the form of subsidized premiums, copayments, coinsurance, and deductibles up to an out-of-pocket maximum.

Premiums vary by family size, age, income and health plan choice. 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). Enrollee premium contributions for a “benchmark” plan are shown in Table 1. Enrollees with higher incomes pay a higher percentage of the total premium cost. Contributions for a young adult (age 19-39) range from ~13 percent of premium in the 0-65 percent of the FPL income band (A) to ~62 percent of the FPL in the 185-

200 percent of the FPL income band (H). The average monthly State contribution per enrollee for the period July – December 2009 was approximately \$214⁷.

Table 1. Enrollee premium contributions by age range and income band

| | A | B | C | D | E | F | G | H |
|-------------------|---------------|----------------|------------------|------------------|------------------|------------------|------------------|------------------|
| Age Range | 0-64 % FPL | 65-99 % FPL | 100-124 % FPL | 125-139 % FPL | 140-154 % FPL | 155-169 % FPL | 170-184 % FPL | 185-200 % FPL |
| 0-18 ⁸ | \$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 |

Additional cost sharing is designed to encourage efficient utilization of cost-effective services. For example:

- 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 not subject to the deductible.
- 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.

Existing cost sharing responsibilities are described in more detail in Appendix 2 - "Appendix A: Schedule of Benefits" pages 24-37, excerpted from the "2010 Basic Health Member Handbook" available in full at: <http://www.basichealth.hca.wa.gov/documents/22-405.pdf>.

Medical Care Services:

Background: Washington is one of 12 states that have elected to provide both cash grants and medical coverage to low-income adults (without dependents) who are unable to work ("incapacitated") due to mental or physical impairments, for at least 90 days. This is commonly known as general assistance and is a bridge for the most vulnerable of our state's adults (aged 18 to 64) who are otherwise not eligible for Supplementary Security Income (SSI) and Medicaid.

Many recipients have temporary conditions and are able to leave general assistance and return to work after a short time; others have chronic conditions and may receive services for an extended period, often transitioning to SSI. While our proposal targets a federal financing partnership for the medical coverage only, delivered through the Medical Care Services (MCS) program, both cash grant and medical coverage components of general assistance are described here to set the context. Four DSHS programs currently provide general assistance. They include:

⁷ Total Basic Health General Fund State expenditures for benefits for July-December 2009 were \$107,400,000.

⁸ Premiums are required for up to 3 children in a family.

- **General Assistance – Unemployable (GA-U):** Incapacitated adults who are not aged 65 or older, or who have not been determined to meet SSI criteria as disabled or blind, receive MCS coverage and a cash grant financed by DSHS⁹. Delivery of health care is through a statewide contract for managed care.
- **General Assistance – Expedited (GA-X):** GA-U adults with the most serious impairments are likely to meet the disability criteria for SSI based on an assessment by a contracted physician. In order to actually receive general assistance, these individuals are required to apply for SSI¹⁰.

SSI-eligible: When DSHS has sufficient medical evidence to indicate that a general assistance recipient is likely eligible for SSI, that eligibility is presumed and federally matched Medicaid benefits are authorized to cover medical costs. While SSI eligibility is being approved, Medicaid coverage and the cash grant assistance are *both* financed by DSHS. Typically, once SSI eligibility is approved DSHS is reimbursed for most, if not all, general assistance distributed while waiting for the SSI application review (i.e., retroactive to the date of the presumptive eligibility determination).

NOT SSI-eligible: When a GA-X adult is determined to *not* be eligible for SSI, DSHS is also reimbursed for general assistance distributed while waiting for the SSI application review. Ongoing cash grant and MCS medical coverage are then received through the GA-U program, financed by DSHS, with delivery of health care through a statewide contract for managed care.

- **Aged, Blind and Disabled (ABD):** Adults who are legal residents, age 65 or older, and would meet SSI criteria as either blind or disabled but for their citizenship status, receive MCS medical coverage and a cash grant financed by DSHS. As a result of systems, not policy, issues, delivery of health care for ABD individuals is via fee-for-service rather than a statewide contract for managed care.
- **Alcohol and Drug Treatment:** Under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA), individuals who are incapacitated from gainful employment due to drug or alcohol abuse are provided shelter and/or medical benefits, treatment, and support through limited MCS medical coverage and a cash grant financed by DSHS. Delivery of health care for ADATSA individuals is also currently via fee-for-service. Eventually, these persons will receive care through the statewide contract for managed care.

General Assistance Redesign: Grounded in Governor Gregoire’s five-point health care strategy¹¹, and consistent with efforts to improve health care delivery and purchasing directed by the 2009 legislature in 2SSB 5945, general assistance has been redesigned since the 2009 Legislature ordered an overhaul of the GA-U program to reduce costs and provide better coordinated service. With executive, legislative and consumer support, statutory changes are now being sought during the 2010 legislative session to implement the redesign in tandem with the Governor’s revised budget direction to restore funding for MCS coverage.

⁹ 52 percent of GA-U clients eventually apply for SSI through the GA-X program or become SSI-eligible within a 24-month period.

¹⁰ 30 percent of GA-U enrollees are on GA-X or SSI within 12-months of their GA enrollment.

¹¹ In 2005 Governor Gregoire launched a five-point health care strategy that (a) emphasizes evidence-based health care, (b) promotes prevention, healthy lifestyles and healthy choices, (c) better manages chronic care, (d) creates more transparency in the health care system and (e) makes better use of information technology. Known as the Governor’s “Big 5” and formalized via Executive Order in January 2007, this has been a catalyst for Washington’s increased commitment to quality improvement.

Key changes under review include:

- Transfer of individuals currently supported through the ADATSA program to GA-U with the addition of a mental health benefit and concurrent elimination of the ADATSA program.
- Delivery of all ongoing MCS coverage for GA-U and general assistance ABD populations through a statewide managed care contract that provides integrated medical and behavioral health services, encourages better utilization of evidence-based and best-practice services (e.g., generic drugs), increases the predictability of expenditures, and supports identification of likely SSI recipients for transfer to GA-X.
- Improvements in the determination of “incapacity” using social and vocational factors that are more consistent with the SSI disability process.
- The Governor’s proposed adoption of enrollment limitations to allow the GA-U program to meet current fiscal pressures and sustain essential core MCS coverage. Example approaches being discussed include enrollment caps (as for BH based on funding available) and limitations on the duration of benefits. Specific details are yet to be determined during the 2010 Legislative session.

Figure 4 shows the anticipated “revised” general assistance program structure and highlights (shaded in green) the MCS coverage component that would be supported by our proposed federal financing partnership.

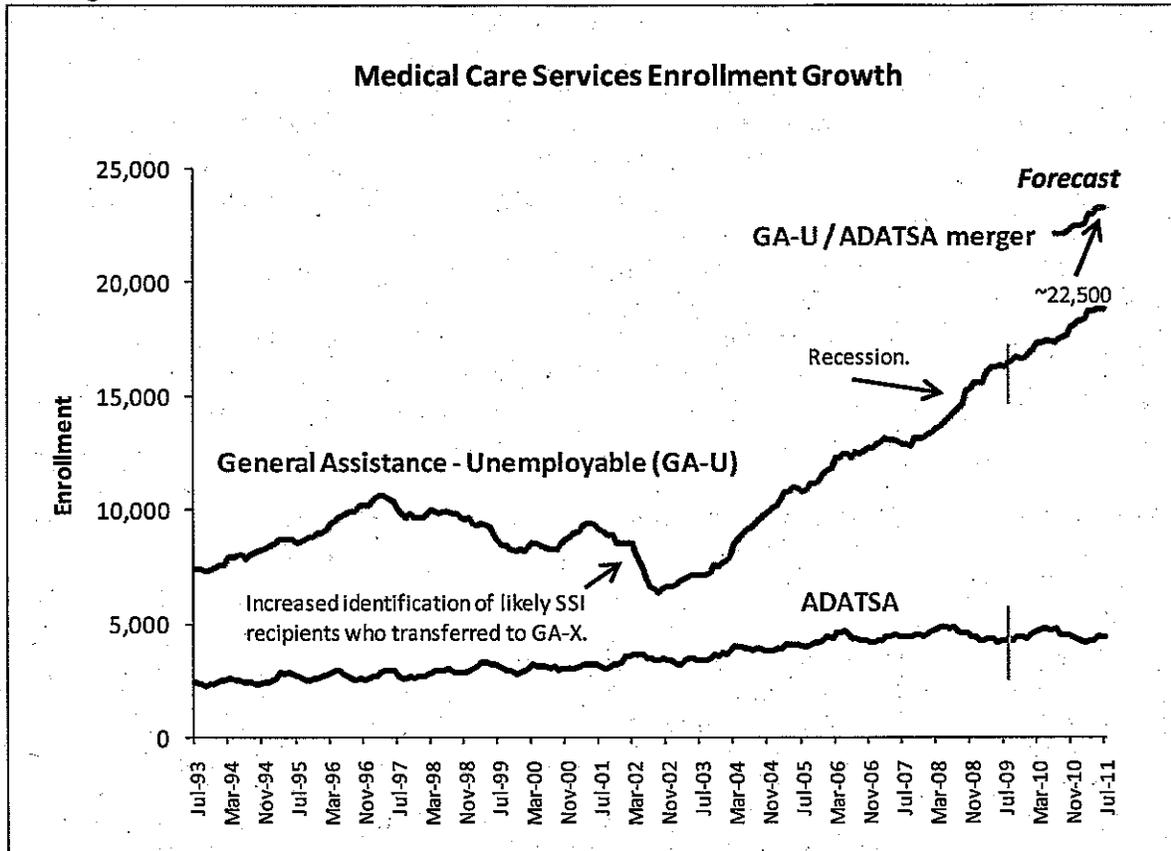
Figure 4: Revised General Assistance Programs Financing Sources

| General Assistance: | GA-U (including merged ADATSA program) | GA-X | SSI |
|---------------------|--|--|--|
| Cash assistance | DSHS financed | DSHS financed until SSI approval completed | Provided by Social Security Administration |
| Medical Coverage | DSHS-financed Medical Care Services program (managed care) | Presumptive Medicaid (standard FMAP rate) upon application for SSI | Medicaid |
| | ABD | | |
| Cash assistance | DSHS financed | | |
| Medical Coverage | DSHS-financed Medical Care Services program (managed care) | | |

Enrollment: Figure 5 graphically represents the history of the MCS caseload since July 1993. Most notable trends are (a) a steep decline in 2002, the result of efforts to identify GA-U recipients likely to be eligible for SSI and thus transferred to GA-X where they received Medicaid coverage¹² and (b) the general (ongoing) surge in enrollment during the recession to almost 17,000 GA-U enrollees receiving MCS coverage by the end of 2009. ADATSA has remained fairly constant throughout, reaching just over 4,000 in the same time period. Changes in numbers of individuals receiving MCS coverage typically correlate with (a) changes in the unemployment rate that either increase or decrease GA-U enrollees as individuals lose or gain employment, and (b) transitions off GA-U to GA-X where Medicaid coverage is provided. The projected aggregate caseload in GA-U as a result of the proposed merger of ADATSA, is approximately 22,500 enrollees in the latter half of 2010. These individuals would continue to receive medical coverage through MCS managed care and along with BH enrollees are the target for our proposed federal financing partnership.

¹² Washington State Institute for Public Policy, “General Assistance Programs for Unemployable Adults”, December 2009.

Figure 5:



Covered Benefits: The scope of benefits provided through MCS includes medical, mental health and chemical dependency coverage. Although not as comprehensive as Medicaid, MCS compares quite favorably with the definition of a “Benchmark Benefits Package” established in Section 1937 of the Social Security Act. As a result of the GA-U redesign, an expanded outpatient mental health benefit has been added with the requirement that chemical dependency (CD) treatment be a condition of eligibility if an assessment by a CD professional indicates the need for treatment. A comparison of the current MCS benefits package, Medicaid and Basic Health is presented in Appendix 1. We propose to continue this scope of benefits through the duration of the NHR Bridge.

Financial Participation:

To bridge the period until NHR is fully implemented we propose that our flexible financial partnership be based on definitions for comparable populations in the Patient Protection and Affordable Care Act.

- For citizens in families with income up to 133 percent of the FPL who receive medical coverage through the Basic Health or Medical Care Services programs, Washington would receive the Medicaid federal match in effect at the time. The state’s average 2009 monthly per capita costs and the projected costs for 2010 are presented in Table 2:

Table 2:

| Current Program | Average 2009 Per Capita | Average 2010 Per Capita for the Partnership Proposal |
|-----------------|-------------------------|--|
| Basic Health | \$250.00 | \$240.00 |
| GA-U/ABD | \$574.47 | \$504.34 |
| ADATSA | \$211.39 | N/A (transferred to GA-U) |

- For BH citizen enrollees who are members of families with income between 133 and 200 percent of the FPL, Washington would receive federal financing support consistent with subsidies that will be available in the NHR state Basic Health option *once details are known*.

External Consultation:

Discussions on the fiscal implications for the current BH and MCS programs have been ongoing for many months. 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. No obvious stone has been left unturned. Consequences of the Governor's initial and subsequent revised budgets have been broadcast widely throughout the state. The flexible federal financing concept proposed here has been widely discussed in policy circles and acknowledged as an important bridge to NHR to retain the BH program as an integral part of NHR and to target limited state dollars to our most vulnerable citizens covered through MCS. There is broad and ongoing support for the state's BH program as evidenced by Senator Cantwell's active participation in including the state Basic Health option as a feature of NHR. General assistance programs have long been regarded as an essential "safety-net" coverage option for the state's most vulnerable low-income adults. Throughout the current 2010 Legislative session we anticipate active support and vigorous lobbying to find additional revenues that will sustain BH and MCS coverage until the implementation of NHR. This proposal for a federal financing partnership is critical to that effort.

Contacts:

For further information contact:

Jonathan Seib
Executive Policy Advisor
Office of Financial Management
jonathan.seib@gov.wa.gov,
Phone: (360) 902-0557

Roger Gantz
Director of Legislative & Policy Analysis
Department of Social and Health Services, Health and Recovery Services Administration
roger.gantz@dshs.wa.gov
Phone: (360) 725-1880

Richard Onizuka
Director of Policy
Health Care Authority
richard.onizuka@hca.wa.gov
Phone: (360) 923-2820

Appendix 1: Comparative Summary of 2010 Benefits

| MEDICAID, MEDICAL CARE SERVICES, & BASIC HEALTH (BH) COVERAGE | | | | | |
|---|---|--------------------|------------------------------|---------------------|---|
| Legend: Y = Covered Service; L = Limited Coverage; EPSDT = Early and Periodic, Screening Diagnosis and Treatment | | | | | |
| Services | Medicaid CN/SCHIP | Medicaid MN | Medical Care Services | 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 | EPSDT | Y | N | |
| Blood/Blood Administration | Y | Y | Y | Y | |
| Case Management | L - Maternity and pre-approved clients in pre- perinatal surgery | | Y | N | MCS includes extensive care coordination |
| Chiropractic Care | EPSDT | EPSDT | N | L | BH – covers maximum of 6 visits annually; must be tied to reconstructive joint surgery. |
| Dental Services | Y | Y | L | L | Limited to emergency dental services |
| Dentures Only | Y | Y | N | N | |
| Detox Alcohol (3 days) Detox Drugs (5 days) | Y | Y | L | Y | MCS – restricted coverage limitations |
| Diabetes Education | Y | Y | Y | Y | BH – up to 10 hours per year |
| Drugs and supplies, prescription | Y | Y | Y | Y | |
| Emergency Room Services | Y | Y | Y | Y | |
| Emergency Surgery | Y | Y | Y | Y | |
| Eyeglasses and Exams | Y | Y | Y | N | |
| Family Planning Services | Y | Y | Y | Y | |
| Healthy Kids (EPSDT) | Y | Y | N/A | N/A | BH – eligible kids covered through Medicaid |
| Hearing Aids | Y | EPSDT | Y | N | |
| Home Health Services | Y | Y | Y | Y | |
| Hospice | Y | Y | N | Y | |
| Inpatient Hospital Care | Y | Y | Y | Y | |
| Interpreter Services | Y | Y | Y | Y | |
| Maternity Support Services | Y | Y | N | N | BH – Pregnant women usually covered through Medicaid or CHIP |
| Medical Equipment | Y | Y | Y | L | BH - covered only during inpatient hospital stay. |
| Neurodevelopmental Centers | Y | Y | N | N | |

MEDICAID, MEDICAL CARE SERVICES, & BASIC HEALTH (BH) COVERAGE

Legend: Y = Covered Service; L = Limited Coverage; EPSDT = Early and Periodic, Screening Diagnosis and Treatment

| Services | Medicaid CN/SCHIP | Medicaid MN | Medical Care Services | Basic Health | Comments |
|--------------------------------------|-------------------|-------------|-----------------------|--------------|---|
| Nursing Facility Services | Y | Y | Y | L | Medicaid CN and MN provide both short and long-term nursing facility services. BH - alternative to hospitalization in an acute care facility at health plan's discretion. |
| Nutrition Therapy | EPSDT | EPSDT | N | N | |
| 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 | L | Y | 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 - this is considered a professional service rather than a specific "pain management" service |
| Personal Care Services | L | EPSDT | N | N | CN - Long-term care services. |
| Physical/Occupational/Speech Therapy | Y | EPSDT/L | Y | L | MN - Covered under Healthy Kids; and when client is receiving home health services. BH - covers physical or occupational therapy for maximum of 6 visits annually- must be tied to reconstructive joint surgery. |
| Physician-related Services | Y | Y | Y | Y | |
| Private Duty Nursing | L | L | N | L | BH - covered at the discretion of Health Plans |
| Prosthetic Devices & Mobility Aids | Y | Y | L | N | MCS - Limited DME benefit. |
| Psychological Evaluations | Y | Y | L | N | MCS - services covered by local community health centers |
| Inpatient Mental Health | Y | Y | Y | L | BH - covers up to 10 inpatient days; Medicaid has no inpatient limits. |

MEDICAID, MEDICAL CARE SERVICES, & BASIC HEALTH (BH) COVERAGE

Legend: Y = Covered Service; L = Limited Coverage; EPSDT = Early and Periodic, Screening Diagnosis and Treatment

| Services | Medicaid CN/SCHIP | Medicaid MN | Medical Care Services | Basic Health | Comments |
|--|----------------------|----------------|--------------------------|-----------------|--|
| Outpatient Mental Health | Y | Y | Y | Y | BH - 12 visits per calendar year. Medicaid – adults up to 12 visits per calendar year; children up to 20 visits per year with an expanded mental health provider network. Medicaid clients have access to mental health services provided by RSNs. |
| School Medical Services | Y | Y | N/A | N/A | BH – eligible children covered through Medicaid |
| 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. |
| Total Enteral/Parenteral Nutrition | Y | Y | Y | L | BH - covered at the discretion of Health Plans |
| Transportation Other Than Ambulance | Y | Y | Y | N | |
| X-ray and Lab Services | Y | Y | Y | Y | |

Appendix 2:

“Appendix A: Schedule of Benefits” pages 24-37

Excerpted from the “2010 Basic Health Member Handbook” which is available in full at:
<http://www.basicealth.hca.wa.gov/documents/22-405.pdf>.

