Washington State Health Care Authority

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

November 9, 2023
Virtual meeting held electronically (Zoom)
2–4 p.m.

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

Members present

Christine Eibner
David DiGiuseppe
Eddy Rauser
Kai Yeung
Pam MacEwan
Robert Murray
Roger Gantz

Members absent

Esther Lucero
Ian Doyle

Call to order

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

Agenda items

Welcoming remarks

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

Meeting summary review from the previous meeting

One FTAC member offered an amendment on page 4. Members present voted by consensus to adopt the September 2023 meeting summary as amended.

Public comment

Cris Currie, volunteer, Health Care for All – Washington, suggested Medicaid Managed Care Organizations (MCOs) be evaluated for their value and that FTAC view background presentations as recordings ahead of meetings.

Lori Bernstein shared personal experience with an MCO requiring prior authorization for a COVID-19 booster, asked if 2024 FTAC meetings would be extended, and for action items from the last meeting to be highlighted.

Roger Collier remarked that while approval of a Section 1115 waiver to transfer Medicaid enrollees to an untested system is unlikely, the federal government may be amenable to such after the future system demonstrates ability to combine programs.

Raleigh Watts mentioned health carriers' reported profits and encouraged FTAC to examine the benefits of a state-administered program (Model A as proposed by the Universal Health Care Work Group) such as the Washington Health Trust.

Kathryn Lewandowsky, Vice Chair, Whole Washington, noted the financial benefit for large employers to be self-insured versus smaller companies struggling to afford employees' benefits from the marketplace.

Commission updates & goals for today

Liz Arjun, Health Management Associates (HMA)

With additional resources allocated to this work, the Commission voted to extend 2024 meetings to three hours. FTAC agreed to add calls on off months for discussion if needed. Today's meeting will provide an overview of Medicaid and will surface opportunities to include Medicaid in Washington's future system. The January 2024 meeting will build off this one and explore topics and themes identified by FTAC for further discussion.

Presentation: Washington's Medicaid enrollment processes

Joan Altman, Director of Gov't Affairs & Strategic Partnerships, Washington Health Benefit Exchange (HBE)
Melissa River, Lead Policy Manager, Office of Medicaid Eligibility & Policy, Health Care Authority (HCA)

The Health Care Authority (HCA) is the Washington state agency for policy and purchasing of Apple Health (Medicaid) programs. The Health Benefit Exchange (HBE) operates Washington's marketplace and Healthplanfinder, a streamlined application for both Medicaid and individual market coverage. Both agencies work together to facilitate Medicaid eligibility and enrollment.

Apple Health is divided into Classic Medicaid (individuals aged 65 and older, or individuals that have blindness or a disability) and modified adjusted gross income (MAGI) -based Medicaid (individuals aged 64 and younger). For MAGI, Healthplanfinder determines eligibility, facilitates plan selection and automatic enrollment, and processes renewals. Healthplanfinder interfaces with state and federal databases to provide enrollees' real-time eligibility. HCA contracts with the Department of Social and Health Services (DSHS) to administer Classic Medicaid and to facilitate eligibility. Apple Health applications are accepted year-round and eligible individuals are approved for a one-year period. Beginning July 1, 2024, Apple Health coverage will extend to residents who meet income requirements regardless of immigration status (limited enrollment based on current funding levels).

Presentation: Understanding Washington's Medicaid program & opportunities for universal health care

Roger Gantz, FTAC Member

Medicaid is the nation's publicly funded health insurance program for people with low income. For low-income Medicare enrollees, Medicaid also provides wrap-around coverage for services not covered by Medicare. Jointly financed by the federal government and states, Medicaid is administered by states within federal guidelines. States are reimbursed by the federal government for a percentage of Medicaid allowable costs - the federal medical assistance percentage (FMAP). Washington's current FMAP is 50 percent, though certain eligibility groups have higher FMAPs. States must cover certain "mandatory" populations and can receive federal funding to cover "optional" populations.

Asset/resource eligibility requirements apply only to certain groups under Classic Medicaid. The proportion of Medicaid enrollment to expenditures by eligibility group was illustrated. Washington covers the 15 mandatory benefits under federal law and 28 other optional services.

Washington's Medicaid program does not have any premium or point of service cost-sharing. Generally, Medicaid payment rates are lower than Medicare and commercial payment rates for the same services. However, for certain provider types, e.g., rural health clinics (RHCs), Medicaid payment rates may be higher due to federal payment requirements.

Apple Health is largely administered by MCOs with 1.8 million Apple Health beneficiaries currently enrolled in managed care. Evidence on the impact of MCOs on quality, access to care, and costs is limited.

While Medicaid eligibility is categorical (e.g., income, age, disability status), there may be waiver strategies, e.g., Section 1115 demonstration waivers, to incorporate Medicaid into Washington's universal health care system. Medicaid's breadth of benefit coverage, e.g., dental, hearing, and long-term care and support services, could be treated as supplemental coverage to the universal plan and provided through separate delivery systems.

Discussion

The logistics of retaining the federal match under a 1115 waiver is important, e.g., people could fail to provide necessary eligibility information. ProviderOne, the current program through which the state claims federal match rates, will likely need to stay in place but could be simplified. Healthplanfinder could also be continued, though more information is needed to determine whether asset tests for Classic Medicaid can be worked around. ProviderOne also divides payments based on eligibility groups and assigns the correct match rate and dollar amount the state will draw back.

The assumption is that FMAPs would continue in a universal system, though federal dollars could not be claimed for anyone other than those currently eligible for Medicaid under existing eligibility criteria.

Generally, Medicaid's provider reimbursement rates are lower compared to commercial coverage and Medicare. However, for hospital providers, supplemental payments are added to Medicaid rates bringing them close to, if not at, what Medicare pays. Though, this is not the case for non-hospital physicians, so Medicaid provider rates could be examined more selectively on the assumption that the state could retain access to supplemental dollars. Even selectively increasing Medicaid provider rates would be a state expense and the implications of doing so need to be examined. In a future system, provider rates will need to be standardized. Commercial payment benchmarks are too high and increasing Medicaid rates to match them would subsidize inefficiency.

Members saw value in evaluating whether MCOs are beneficial for quality, access to care, and costs. Commission Member Jane Beyer attended the meeting and suggested looking into Connecticut's experience shifting their Medicaid program away from managed care and back to a fee-for-service model in 2011.

Members agreed that a comparison of benefits between Medicaid, Medicare, the marketplace, and public employees' benefits does not exist. An actuarial analysis comparing these benefits and the respective provider rates would be helpful to anchor the Commission's discussion of a uniform benefit design.

FTAC's next meeting will further examine what surfaced at today's meeting with regards to Medicaid.

Adjournment

Meeting adjourned at 3:57 p.m.

Next meeting

January 12, 2024
Meeting to be held on Zoom
2–4:30 p.m.