State of Washington
Joint Legislative Audit and Review Committee (JLARC)

Washington Medicaid Study

Report 04-4

January 7, 2004

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JLARC staff, under the direction of the Committee and the Legislative Auditor, conduct performance audits, program evaluations, sunset reviews, and other policy and fiscal studies. These studies assess the efficiency and effectiveness of agency operations, impacts and outcomes of state programs, and levels of compliance with legislative direction and intent. The Committee makes recommendations to improve state government performance and to correct problems it identifies. The Committee also follows up on these recommendations to determine how they have been implemented. JLARC has, in recent years, received national recognition for a number of its major studies.

WASHINGTON MEDICAID STUDY

REPORT 04-4

REPORT DIGEST

JANUARY 7, 2004

STATE OF WASHINGTON

JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE

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WASHINGTON MEDICAID STUDY

Washington Medicaid will spend $12 billion in the 2003-05 biennium, capturing over 30 percent of the state's biennial appropriations, and over 75 percent of the biennial appropriations to the Department of Social and Health Services (DSHS). Medicaid provides funding for acute and long term care services to over 900,000, or 16 percent, of Washingtonians. Within DSHS, the program is managed by six separate Administrations (Medical Assistance, Aging and Disability Services, Health and Rehabilitative Services, Children's, Juvenile Rehabilitation, and Economic Services), with managerial support from three Offices (Chief Information Officer, Chief Financial Officer and Chief Administrative Officer). Policy questions are generally presented to the Legislature from the perspective of each entity, as if each administrative area constituted a separate Medicaid program.

JLARC initiated and authorized the Washington Medicaid study at its October 2002 meeting in response to the need to gain a comprehensive understanding of Washington Medicaid. JLARC opted to look at Washington Medicaid as one program, rather than "just a funding source" for a collection of services. JLARC anticipated that this conceptual shift in how Washington Medicaid is viewed would shine new light on performance, management, and accountability issues that would otherwise not be clearly apparent to the Legislature and to state managers.

Medicaid in Perspective

Medicaid is a jointly funded and administered program of medical and health-related services coverage for low-income people who meet income and resources eligibility criteria. Federal law and rules establish a policy framework; within this framework, each state customizes the program to suit the needs of its citizens, and manages the day-to-day operations. Medicaid is much more than a primary health care insurance program providing funding for doctor visits, inpatient hospital services, and prescription drugs. It also provides long term care services for the elderly and disabled, therapies and other support services for persons with developmental disabilities, persons with mental illness, children in foster care, persons receiving substance abuse services and juvenile offenders.

Federal law does not place a ceiling on the total amount of spending on eligible services for eligible individuals for either the states or federal government for the basic medical assistance program. Certain services and groups of people are **required** to be covered; other services and groups **may** be covered at state option.

Managing Medicaid

Thinking of Medicaid as one program, rather than "just a funding source" for a collection of services administered by multiple organizations within DSHS

promotes the idea that all of the pieces must fit together and work together to get the job done. That job, ultimately, is managing 30 percent of the state's operating budget. To understand how the program is managed, we categorized 27 management activities into six functional areas: Policy; Beneficiary and Plan Enrollment; Fiscal Management; Legal, Hearings and Appeals; Quality Assurance; and, Data Collection and Reporting.

Many of these activities are performed by several DSHS entities; we characterized each activity using one of **three management models: centralized, decentralized, or mixed. We do not mean to suggest that any one model is preferred.** Each model has advantages and disadvantages, and each can work when sufficient communication and collaboration is employed. However, this JLARC review led to five findings and six recommendations that highlight areas where improvements can occur.

We found that Washington, like other states, has taken advantage of the flexibility offered by the federal Medicaid program to customize a program for this state. The incremental nature of Medicaid policy development over the past decades from the federal level, and at the state level, is evident in the approaches taken to managing the program. Because Medicaid has grown and developed incrementally, states' organizational responses have also been incremental.

We found that most Washington Medicaid management functions and activities are decentralized with little agency-wide coordination. Our general observation about Medicaid management is that there is no comprehensive view of the Medicaid program or its management, and that existing data systems do not promote or support this view. DSHS is charged with the responsibility for managing a large, complex 21st century health care organization, and is trying to do it with a largely decentralized management structure and major data systems that are over 20 years old.

We found that DSHS recognizes the need to improve service coordination and integration across the agency, whether these services are Medicaid funded or not.

Conclusions and Recommendations

This report includes five recommendations intended to achieve the following:

- **Improve Medicaid data to support a comprehensive approach to legislative policy making and DSHS management of Washington Medicaid.** DSHS has the opportunity to address some of the data collection, analysis and reporting issues discussed throughout this report with a new Medicaid Management Information System (MMIS). Such an approach could address another data issue described in this report – complying with a required federal report that is 12 quarters in arrears.
- **Improve the forecasting of Medicaid caseloads and manage costs.** Medicaid is not considered comprehensively in Washington. As a result, some biennial caseload driven expenditures are not forecast through the formal Caseload Forecast Council (CFC) process. Additionally, approximately 40 percent, or $5 billion, in biennial Medicaid expenditures has not undergone rigorous review of cost containment efforts. Finally, the newly merged Aging and Disability Services Administration is working with a consultant to bring greater consistency and logic to the rate structure for similar services and clients.
- **Improve the oversight of decentralized Medicaid management.** We did not find that DSHS has a mechanism in place to comprehensively guide or review the performance of largely decentralized management functions and activities. Such a mechanism could build upon this report, and increase the possibility that the expertise and capacity that has been developed in certain Medicaid managing administrations is available to all Medicaid managing administrations.

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CHAPTER ONE – INTRODUCTION

GOALS OF THE STUDY

JLARC initiated and authorized the Washington Medicaid study at its October 2002 meeting in response to the need to gain a comprehensive understanding of Washington Medicaid.

Washington Medicaid will spend $12 billion in the 2003-05 biennium, capturing over 30 percent of the state's biennial appropriations, and over 75 percent of the biennial appropriations to the Department of Social and Health Services (DSHS). Medicaid provides funding for acute and long term care services to over 900,000, or 16 percent, of Washingtonians.

Within DSHS, the program is managed by six separate Administrations, with managerial support from three Offices (See Figure 1). Policy questions are generally presented to the Legislature from the perspective of each entity, as if each administrative area constituted a separate Medicaid program. Recognizing the piecemeal manner in which information about Washington Medicaid is presented to the Legislature, JLARC decided to examine Medicaid as a programmatic whole, rather than "just a funding source" for a collection of services administered by multiple organizations within DSHS.

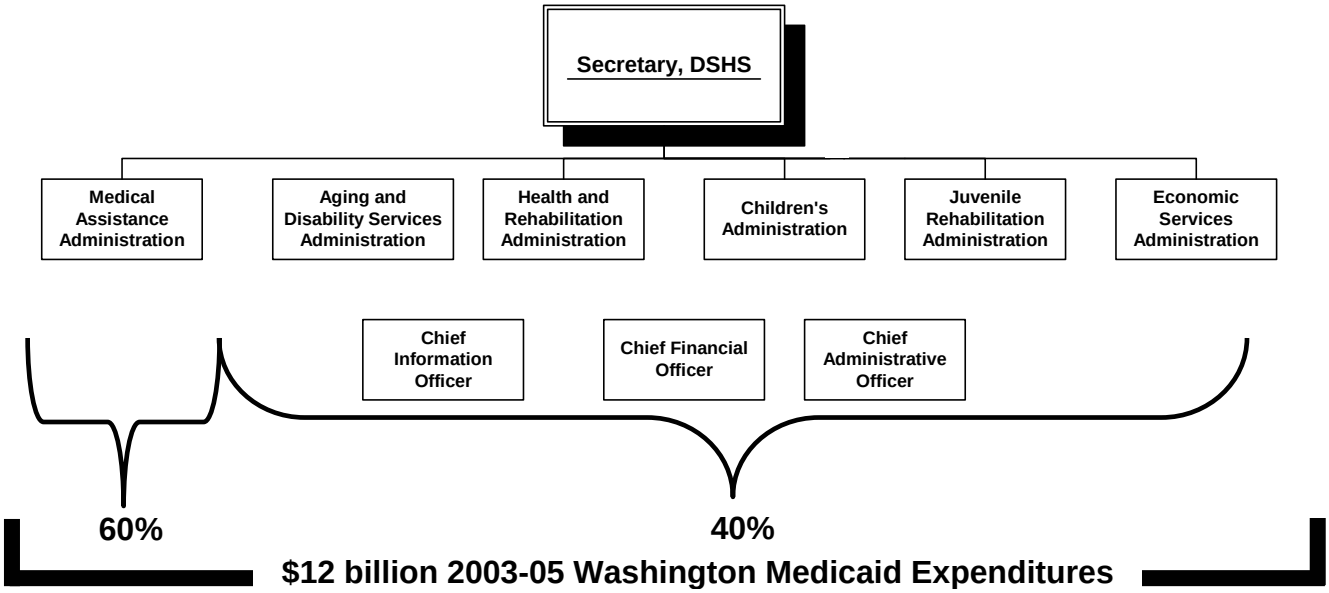
Thinking of Medicaid as one program, rather than separate and multiple sets of services provided to specific populations, promotes the idea that regardless of the model used to fulfill management responsibilities, all the pieces must fit together and work together to get the job done. That job, ultimately, is managing 30 percent of the state's operating budget.

Study Approach

JLARC's Washington Medicaid study intends to enhance the decision-making capacity of the Legislature and DSHS by providing a comprehensive view of Washington Medicaid in relation to the national picture and by providing an understanding of how the entirety of Washington Medicaid is managed.

To accomplish this goal, the study team conducted research and data analysis about the state and national Medicaid programs, and spoke with Medicaid managers in other states to create the contextual information in the overview and the discussion of service integration efforts. We conducted extensive interviews with DSHS and other state agency staff to assemble the picture of Washington Medicaid management. We also gathered information from representatives of various national research organizations that study Medicaid, and with representatives of the federal administering agency, the Centers for Medicare & Medicaid Services (CMS).

Figure 1 – Department of Social and Health Services Organizational Chart



Washington Medicaid Responsibilities

Medical Assistance Administration –	
Fee-for-Service Managed Care, Healthy Options, Waiver Hospital Selective Contracting Waiver	Disease Management Waiver Take Charge Family Planning Waiver
Aging and Disability Services Administration –	
Aging: Nursing Facilities Community Options Program Entry System (COPES) Waiver Medically Needy Residential Waiver	Developmental Disabilities: Residential Habilitation Centers (RHC) Community Alternatives Program (CAP) Waiver
Health and Rehabilitation Administration –	
Mental Health: State Hospitals Managed Care, Mental Health (RSNs) Waiver	Alcohol and Substance Abuse: Fee-for-Service
Children's Administration –	
Fee-for-Service	
Juvenile Rehabilitation Administration –	
Fee-for-Service	
Economic Services Administration –	
Eligibility Determination (Administrative Services)	
Chief Information Officer –	
Information Technology (Administrative Services)	
Chief Financial Officer –	
Fiscal Processes (Administrative Services)	
Chief Administrative Officer –	
Vendor Payment and Data Analysis (Administrative Services)	

Findings

We found that Washington, like other states, has taken advantage of the flexibility that the federal Medicaid program offers to customize a program for this state. As Medicaid professionals observe "Once you've seen one Medicaid program, you've seen one Medicaid program." Like other states, Washington has exercised its ability to cover populations and services that are not required by the federal government. We tapped into federal money as it became available for targeted initiatives, such as breast and cervical cancer, or to refinance existing 100 percent state funded programs, such as the Residential Habilitation Centers, or to expand the range of services or expand the numbers of people who are covered, such as community-based services as an alternative to nursing facility care. **The cumulative effect of the choices made to create Washington Medicaid, and the consequences of those choices, are presented in Chapter Two.** Additional detail is provided in Appendix 4.

We found that the incremental development of Medicaid policy over the past decades from the federal and state level is evident in Washington's, and other states'[1] approaches to managing the program. No single reference source identifies all the various federal requirements for administering and operating Medicaid. Requirements are in statute, in the Code of Federal Regulations (CFR), in the state Medicaid Manual, in State Medicaid Director letters, and in CMS communications with guidance regarding particular issues. Because of Medicaid's incremental growth, states' organizational responses to these changes also have been incremental.

JLARC used a set of management functions common to a service delivery organization to structure our analysis of Washington Medicaid and developed a framework. We categorized and described the management model employed to accomplish each major activity within these functions: **decentralized, centralized or mixed**. This report does not mean to suggest that any one model is preferred. Each model has advantages and disadvantages, and each can work when sufficient communication and collaboration are used. Figure 2 displays the model DSHS uses for individual Medicaid activities, and Chapters Three, Four, and Five present descriptions and discussion of the functions and activities.

JLARC found that most Washington Medicaid management functions and activities are decentralized with little agency-wide coordination, such as rate setting (detailed rates information is supplied in Appendix 3). A few functions and activities are centralized and performed on behalf of DSHS as a whole, such as assuring payment accuracy. Some management functions and activities are organized using a mixed model, where one office (such as accounting) provides specialized expertise to, and agency-wide coordination of, operational areas in each of the Administrations that manage Washington Medicaid.

Our general observation about Medicaid management is that there is no comprehensive view of the Medicaid program or its management, and that existing data systems do not promote or support this view. Consequently, there is great variability in the capacity and resources dedicated to aspects of Medicaid management in each of the program areas. Such

[1] 33 percent of states, including Washington, locate the Medicaid program in the welfare agency. 24 percent locate the program in an umbrella agency including welfare and public health; 24 percent have Medicaid as a separate agency, and 20 percent include Medicaid in the public health agency. American Public Human Services Association, "Organizing Medicaid Responsibilities: A Look at Current State Agency Structure," The Washington Memo, July-September 2000, Vol. 12 No. 4. 50 states plus the District of Columbia responded.

Figure 2 – Washington Medicaid Management Model by Function and Activity

Management Function Activity	Centralized	Decentralized	Mixed	Other State Agency*
Policy				
Eligibility & Scope		X		
State Plan			X	
Rules			X	
Beneficiary & Provider Enrollment				
Outreach		X1		Department of Health
Eligibility Determination		X		
Beneficiary Enrollment		X		
Provider Credentialing		X		
Provider Enrollment		X1		Department of Health
Plan Enrollment		X		
Fiscal Management				
Forecast	X1			Caseload Forecast Council
Budgeting			X	
Accounting			X	
Contracting			X	
Audit (Internal)	X			
Collections		X		
Ratesetting		X		
Payment		X		
Payment Review & Audit	X			
Fraud	X1			Office of Attorney General
Legal/hearings/appeals				
Advice & Litigation	X1			Office of Attorney General
Fair Hearings		X1		Office of Administrative Hearings
Quality Assurance				
Survey and Certification	X			
Abuse	X1			Office of Attorney General
Satisfaction		X		
Performance Measures			X	
Data Collection & Reporting				
Information Technology Organization		X		
Data Collection & Analysis		X		
X1 - performed in collaboration with an entity outside DSHS				

*Because this analysis focuses on operational management, entities external to the agency with comprehensive oversight responsibilities, such as the Legislature or OFM, are not cited. State agencies that have an operational role in executing the function, such as the Office of the Attorney General, are cited.

variability can result in the types of issues identified by JLARC's recent performance audit of the Division of Developmental Disabilities (DDD)[2]. DSHS is charged with the responsibility for managing a large, complex 21st century health care organization, and is trying to do it with a largely decentralized management structure and major data systems that are over 20 years old.

We found that DSHS recognizes the need to improve service coordination and integration across the agency, whether these services are Medicaid funded or not. Chapter Six presents some of these efforts, with emphasis on the planned Washington Medicaid Integration Project, authorized by the Legislature in the 2003-05 operating budget.

The analysis JLARC employed in this study, based on a conceptual shift to a comprehensive view of Washington Medicaid, has revealed a number of opportunities for improvement across DSHS. These recommendations are in Chapter Seven.

A Word about Terminology . . .

For the purpose of discussing Washington Medicaid operations, our analysis segmented the total Medicaid population into three groups: managed care, fee-for-service, and waiver. These groups can be subject to different federal requirements, state policies and operations. Where relevant, we have distinguished these differences for each group.

"**Managed care**" refers to either Healthy Options (Washington's name for Medicaid managed care) or mental health services delivered through the county-based Regional Support Networks (RSN). Managed care is characterized by a total payment to a contracted organization that provides, or assures the provision of, all covered care to the individual for that total payment. This meaning contrasts with fee-for-service.

"**Fee-for-Service**" refers to a system of payments to providers where each covered service (each doctor visit, each hospitalization, etc.) has a separate rate, and is paid separately.

"**Waivers**" refers to a mechanism available to states to set aside federal requirements and constraints, allowing states to cover populations or services for which federal matching payments normally would not be provided.

A WORD ABOUT DATA

The accuracy, reliability, and timeliness of nationally reported Medicaid data have long been cause for concern among researchers and the General Accounting Office (GAO). A common observation among Medicaid managers, in Washington and elsewhere, is that the data and format required to comply with federal reporting is simply not useful to their daily operations.[3]

Submission of the required reports is viewed by states as a compliance exercise; therefore, the submissions often are not carefully scrutinized. Like most data sets, the numbers are most accurate in the aggregate, but become less accurate the farther one "drills down" into the detail.

[2] "Performance Audit of the Division of Developmental Disabilities," JLARC 02-13, December 2002, and "Division of Developmental Disabilities Performance Audit," JLARC 03-6, June 2003.

[3] One former Medicaid official documented this view: "States keep data for their own purposes that is different from what they report to CMS, because the CMS reports are not viewed as being particularly useful." Correspondence from T. Riley, National Academy of State Health Policy, 12/19/2000, in KFF p. 148.

The GAO, and other research groups, have found that the best way to collect timely and accurate data about specific aspects of the national Medicaid program is to survey each state.[4]

It was not feasible for JLARC to conduct a nationwide survey to capture the data necessary to present both a comprehensive and detailed look at beneficiaries and expenditures for Washington Medicaid. This report emphasizes the difficulties in obtaining data about the total Washington Medicaid program. The data presented in the charts throughout this report represent the best estimates for the comprehensive program that Medicaid managers could generate.

The report also highlights that these difficulties carry through to national numbers. Despite these limitations, the data used to produce the national charts are the best that are readily available to researchers working with the Medicaid program. **In some cases, national data is for 1998, the last year for which this data is complete.**

[4] "Medicaid Enrollment: Amid Declines, State Efforts to Ensure Coverage After Welfare Reform Vary," General Accounting Office, September 10, 1999 (GAO-HEHS-99-163).

CHAPTER TWO – MEDICAID IN PERSPECTIVE

WHAT IS MEDICAID?

Medicaid is a jointly funded and administered program that pays for medical and health-related services coverage for low-income people who meet income and resources eligibility criteria. Participation in Medicaid is mandatory for the federal government and voluntary for the states. Once a state agrees to participate, the federal and state governments both provide money and administration for the program. All 50 states have chosen to participate in Medicaid to obtain federal financing for their medical and health-related services programs.

When one hears the term "Medicaid" one usually thinks of a primary health care insurance program that provides funding for eligible individuals to visit doctors and other practitioners, obtain inpatient hospital services, and obtain prescription drugs. However, Medicaid expenditures also provide:

- Long term care services for the elderly and disabled;
- Therapies and other support services for persons with developmental disabilities, persons with mental illness, children in foster care, persons receiving substance abuse services, and juvenile offenders; and
- Administration for all Medicaid services.

Brief History of Medicaid

Congress enacted Medicaid as Title XIX of the federal Social Security Act in 1965 as a social welfare program. Individuals must meet income and resources criteria to be eligible for services. Among the key aspects established by this legislation:

- The concept of the eligible individual's entitlement to services; and
- Open-ended federal matching for services.

In the ensuing decades, the legislation has been changed many times, often by expanding eligibility and services. A key change occurred in 1981, which created the concept of "**the waiver**." Waivers allow states to deviate from the constraints imposed by the basic medical assistance program by extending coverage to groups or to services that would not normally receive federal match.[5] The 1981 change allowed states to offer home and community-based care, and to enter into managed care arrangements.

What is an entitlement?

Medicaid law requires that an eligible individual have access to all medically necessary services offered under the basic medical assistance program. Individuals are described as "entitled" to

[5] Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Resource Book," July 2002, p. 97.

these services. The law also created an entitlement to the states – the federal government may not limit matching funds for eligible services to eligible individuals.[6]

Can states or the federal government limit total expenditures on Medicaid?

Because of the obligation established in federal law, there is no ceiling on the total amount of spending on eligible services for eligible individuals for either the states or federal governments for the basic medical assistance program.[7] However, waivers, which allow states flexibility from the constraints of the requirements of the basic program, do provide mechanisms that can contribute to limiting expenditures (for instance, a waiver can set a finite number of participants).[8] Washington currently operates seven waivers that address the needs of particular populations, and is pursuing what has become known as the Medicaid Reform waiver. This waiver would allow premiums to be charged for coverage of children in families whose incomes exceed the federal poverty level.[9]

What about Medicare and Medicaid?

Congress enacted Medicare and Medicaid in 1965, as Title XVIII and Title XIX of the Social Security Act, respectively. Medi**care** is a federal health insurance program that provides automatic eligibility for all people age 65 and older, people of any age with permanent kidney failure, and certain disabled people under age 65.[10]

The Centers for Medicare & Medicaid Services manage Medicare, which is the largest federally administered health care program. Medicare is 100 percent federally funded and administered. In fiscal year 2002, Medicare consumed $254 billion, or nearly 13 percent, of the federal budget.[11] Medicare covers 35 million people age 65 and over, and 6 million younger adults with a permanent disability.[12] An estimated 40 percent of Medicare beneficiaries have incomes below 200 percent of the federal poverty level.[13]

Medicare provides basic benefits,[14] does not cover prescription drugs and requires premiums and cost sharing.[15] Nationwide, approximately 13 percent of Medi**caid** enrollees are also enrolled in Medi**care**; in Washington, 12 percent are enrolled in both programs. These "dual enrollees" are part of the aged/blind/disabled enrollment group that drives the majority of Medicaid costs.

[6] Social Security Act, Title XIX, Section 1903 (a).
[7] Social Security Act, Title XIX, Section 1903 (a).
[8] Kaiser, "Resource Book," p. 97.
[9] DSHS, "A Section 1115 Demonstration Waiver Application," July 21, 2003, p. 17. The coverage of these children is optional to the state.
[10] CMS, "Overview of Medicare," 1996.
[11] Congressional Budget Office, Historical Budget Data, Tables 1 and 9.
[12] Kaiser Family Foundations, "Medicare Quick Facts," accessed 9/11/03, http://www.kff.org/docs/sections/medicare/quickfacts.html.
[13] Kaiser, "Medicare Quick Facts". 200 percent of federal poverty level is $17,960 for one person.
[14] Part A covers inpatient hospital services, skilled nursing facility (SNF) benefits, and hospice care. Part B covers physician and outpatient hospital services, annual mammography and other cancer screenings, and services such as laboratory procedures and medical equipment. Both Part A and Part B cover some home health visits, subject to certain requirements.
[15] Medicaid pays Medicare premiums and cost sharing on behalf on certain eligible people.

What role does Medicaid play in the health care economy?

Medicaid provides full or partial health care coverage for 16 percent of Washington residents (900,000), and 16 percent of U.S. residents (44 million).[16] Of the $1 trillion spent in the U.S. on personal health care in calendar year 2000, Medicaid paid for 17 percent.[17] For calendar year 1998 (the most recent figures available at the state level), Washington Medicaid paid for 16 percent of the total state personal health care spending of $19 billion[18] (See Figure 3).

What role does Medicaid play in public budgets?

Nationally

Medicaid is the second largest health care program administered by the federal government, and in fiscal year 2002, consumed $147.5 billion, or 7 percent, of the federal budget. Medicaid and Medicare represent 20 percent of federal outlays.[19]

Washington

Medicaid is the second largest area of states' total spending, behind only elementary and secondary education.[20] In Washington, Medicaid is expected to consume 31 percent of operating budget appropriations in fiscal years 2003-05.[21] In the same period, Medicaid is planned to fund 76 percent of the operations of DSHS[22] (See Figure 4). Medicaid provides funding to every major program area of DSHS, except the Division of Vocational Rehabilitation and the Special Commitment Center (See Figure 5).

WHERE DOES THE MONEY COME FROM?

Medicaid is financed by federal and state funds, and collections from the assets of recipients. When state and federal authorities agree about the populations, services, and administrative activities to be covered by the Medicaid program, the expenditures of the program are split between the two partners. Any collections from third parties or estate recoveries are also split.[23]

[16] Centers for Medicare and Medicaid Services (CMS), Medicaid Statistical Information System (MSIS) report, Federal Fiscal Year (FFY) 2000; U.S. Bureau of the Census, 2000 Geographic Comparison Table – Age and Sex. Percentage includes individuals covered by Medicaid who also have other insurance, including Medicare.

[17] CMS, Office of the Actuary, "National Health Care by Type of Expenditure, Calendar Year 2000." "Personal health care" includes health services delivered to a person, and excludes expenditures on research, construction, public health activities and administration.

[18] CMS, Office of the Actuary, "1998 State Estimates – Personal Health Care."

[19] Congressional Budget Office, Historical Budget Data, Tables 1 and 9.

[20] National Association of State Budget Officers (NASBO), "2001 State Expenditure Report," p. 4. The estimate considers total state spending – operating, capital and transportation budgets.

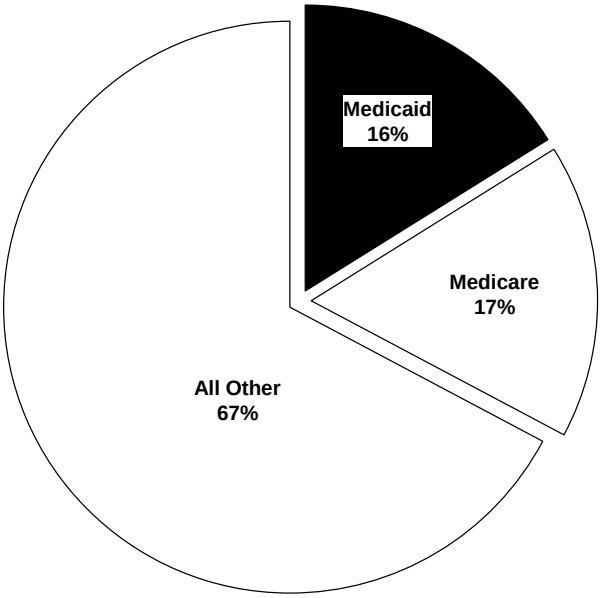
[21] Includes both state and federal shares. Derived from data provided by Washington's Legislative Evaluation and Accountability Program (LEAP).

[22] Derived from data provided by LEAP.

[23] 42 CFR 433.300 – 322.

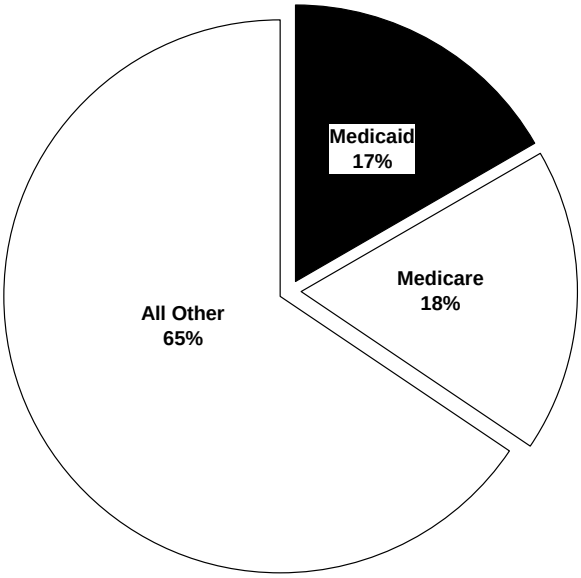
Figure 3 – Personal Health Care Expenditures by Source

Washington – 1998
n = $19.2 billion



Source: CMS, Office of the Actuary.

U.S. – 2000
n = $1.1 trillion

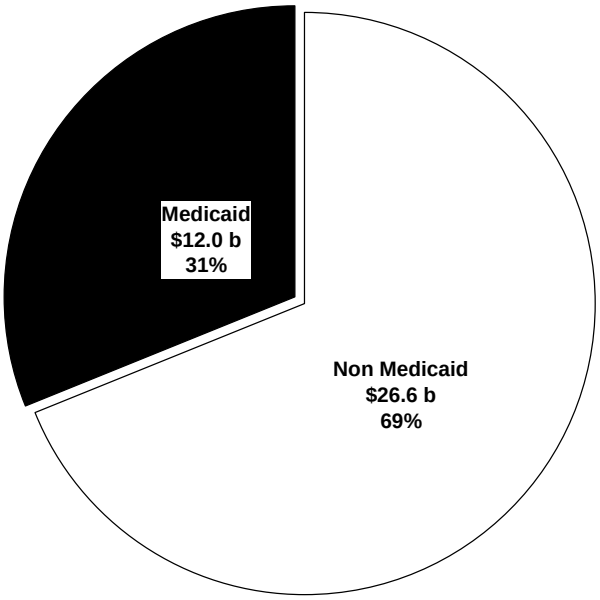


Source: CMS Office of the Actuary and U.S. Bureau of the Census.

Figure 4 – Medicaid as a Portion of 2003-05 Budgets

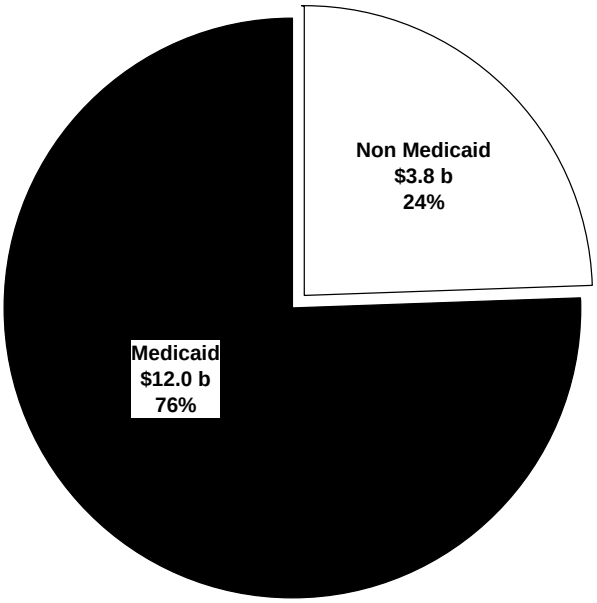
Medicaid Captures:

31% of State Budget
$38.6 Billion Biennial State Budget (all funds)



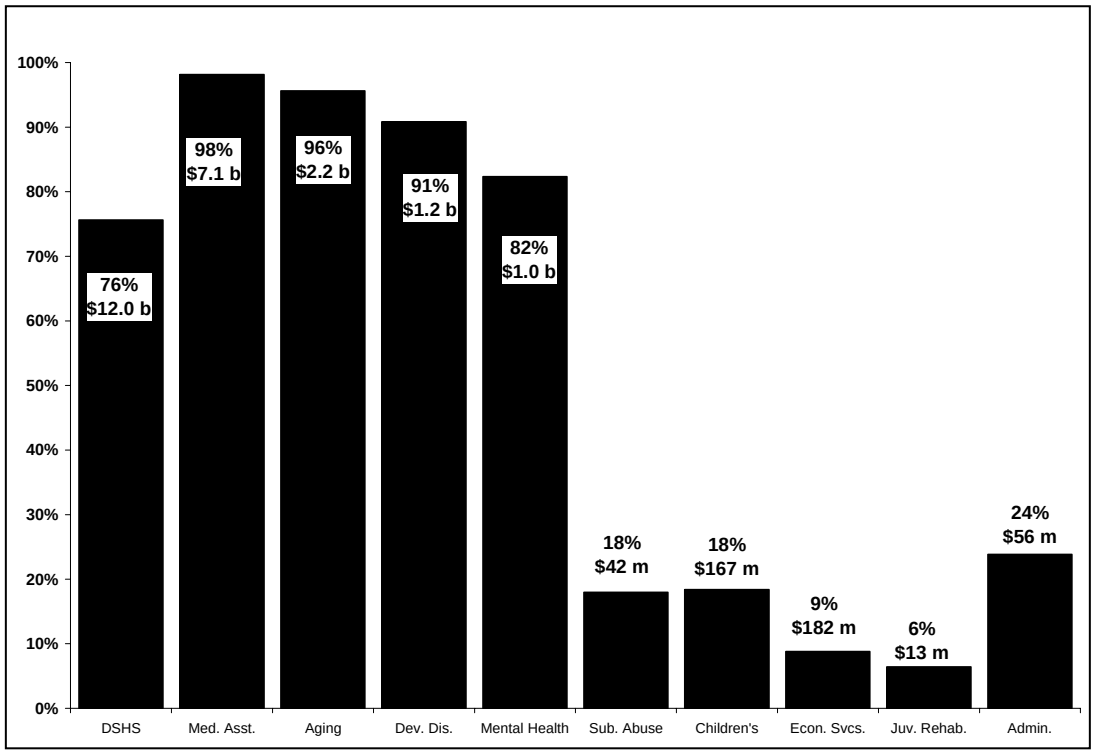
Source: LEAP, 2003-05 Enacted.

76% of DSHS Budget
$15.8 Billion Biennial Budget (all funds)



Source: LEAP, 2003-05 Enacted.

Figure 5 – Washington Medicaid - DSHS Program Dependence
$15.8 Billion Biennial Budget (all funds)



Source: LEAP, 2003-05 Enacted.

Federal and State Participation

In federal fiscal year (FFY) 2001, nationwide, the federal government financed 56 percent of the Medicaid program, with the states on average providing 42 percent of expenditures. In Washington, for the comparable period, the U.S. provided 50 percent of the funding, while the state financed 48 percent of expenditures[24] (See Figure 6).

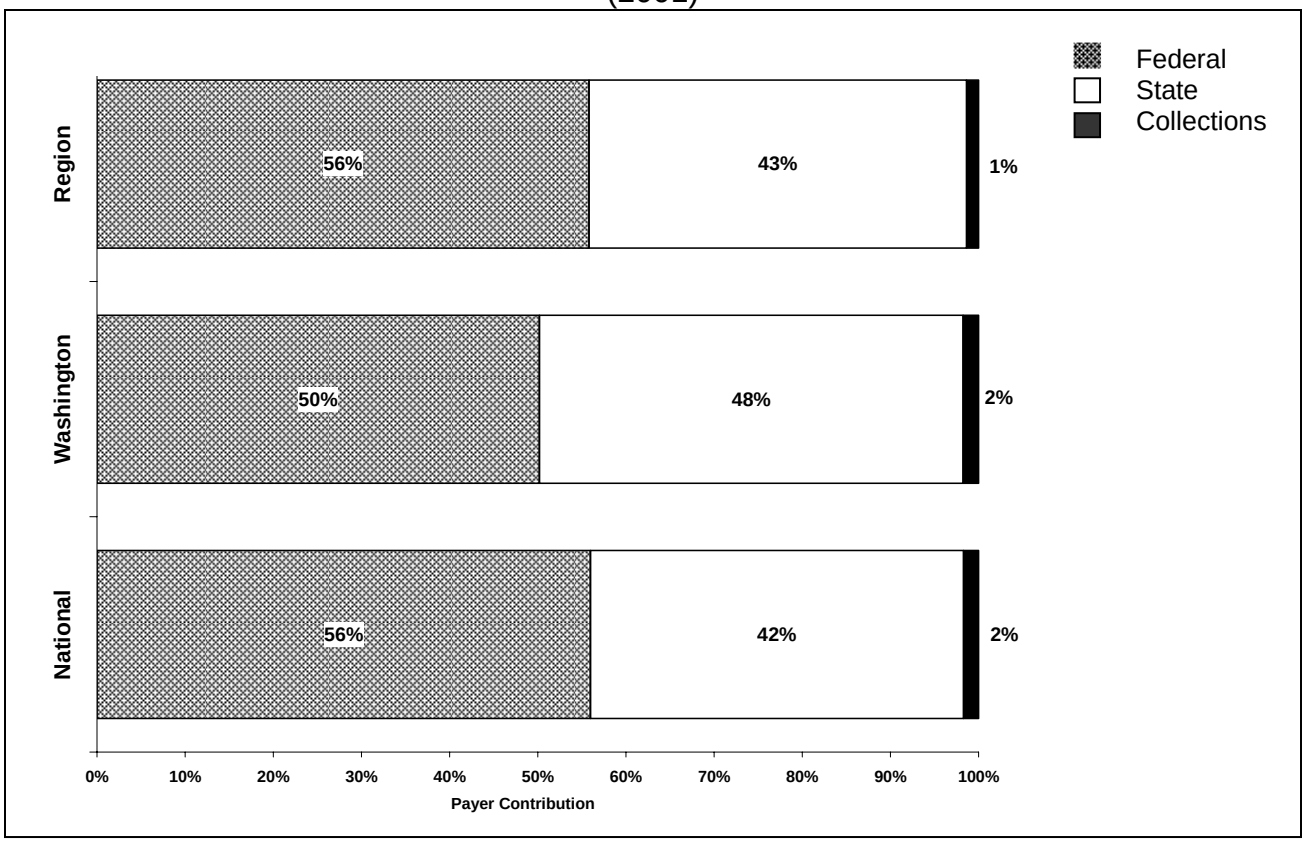
Collections

Collections result from recoveries of funds from Medicaid beneficiaries' estates and from third party payers who are obligated to pay before Medicaid pays. In 2001, Washington generated over $85 million, or two percent of total expenditures, in collections. This collection rate is consistent with the national picture, and higher than the average for this CMS region.[25] Collections activities are described in more detail in Chapter Four.

[24] CMS, CMS 64 reports for FFY 2001.

[25] CMS, CMS 64 reports for FFY 2001. Washington is part of CMS Region X, which also includes Alaska, Idaho, and Oregon.

Figure 6 – Who Pays for Medicaid?
(2001)



Source: Centers for Medicare and Medicaid Services (CMS).

How is each partner's share of Medicaid expenditures determined?

The share each partner pays for *services* is determined by a federal statutory formula, called the Federal Medical Assistance Percentage (FMAP), or "F-map." By statute, the federal share or "match" for each state cannot be lower than 50 percent, or higher than 83 percent.[26] There is no ceiling on federal expenditures for non-waiver Medicaid services – state spending will be matched.

The result of the federal match formula varies by state, and is driven by the relationship between the state's per capita income and the national per capita income. The underlying concept of the formula is that the poorer the state is in comparison to the nation, the higher the federal match rate needs to be to fund the expected higher demand for Medicaid services.[27] Washington has a lower match rate than other states because its per capita income is higher than the national average.

[26] Social Security Act, Title XIX, Section 1905 (b).

[27] The U.S. General Accounting Office (GAO) has issued at least three reports that recommend changing the formula to use elements (poverty level and total taxable resources) that more accurately predict demand and the ability of the state to pay for it. See General Accounting Office, "Changing Medicaid Formula Can Improve Distribution of Funds to States," (GAO/GGD-83-27, 1983); "Medicaid Formula: Fairness Could Be Improved" (GAO/T-HRD-91-5, 1990); "Medicaid: Alternatives for Improving the Distribution of Funds" (GAO/HRD-91-66FS).

The share each partner pays for *administration* is, generally, 50 percent, and the same match rate applies in every state. The federal partners pay higher, or "enhanced" match rates for certain specific activities (again, these rates apply in every state), such as 90 percent for the design of the Medicaid Management Information System (MMIS), 75 percent for the operation of the MMIS, and 75 percent for survey and certification of nursing facilities. There is no ceiling on the total amount of federal funds that can be claimed for allowable administrative costs – state spending will be matched by federal funds.[28]

WHERE DOES THE MONEY GO?

Nationally, 5 percent of Medicaid spending goes to administer the program, and 95 percent of Medicaid funding goes to providers of services. In Washington, 10 percent of Medicaid is spent on administration, with 90 percent of spending flowing to providers.[29]

Administration

States have some flexibility in categorizing expenditures as either "administration" or "services," which presents difficulties in making state-to-state or state-to-nation comparisons. A comparison of Washington's reporting with that of the other states in the region revealed that the other states treat transportation services as services, while Washington categorizes these expenditures as administration. Similarly, the other states either do not provide interpreter, outreach and linkage services, or they only provide a very small amount, categorized as services.

If transportation, interpreters and outreach and linkage are counted as "services" rather than "administration" Washington's percentage of administration for Medicaid is reduced to 8 percent. While data limitations prevent a complete explanation, Medicaid professionals in DSHS attribute this still greater than average percentage to aggressively billing the federal government for all allowable activities.

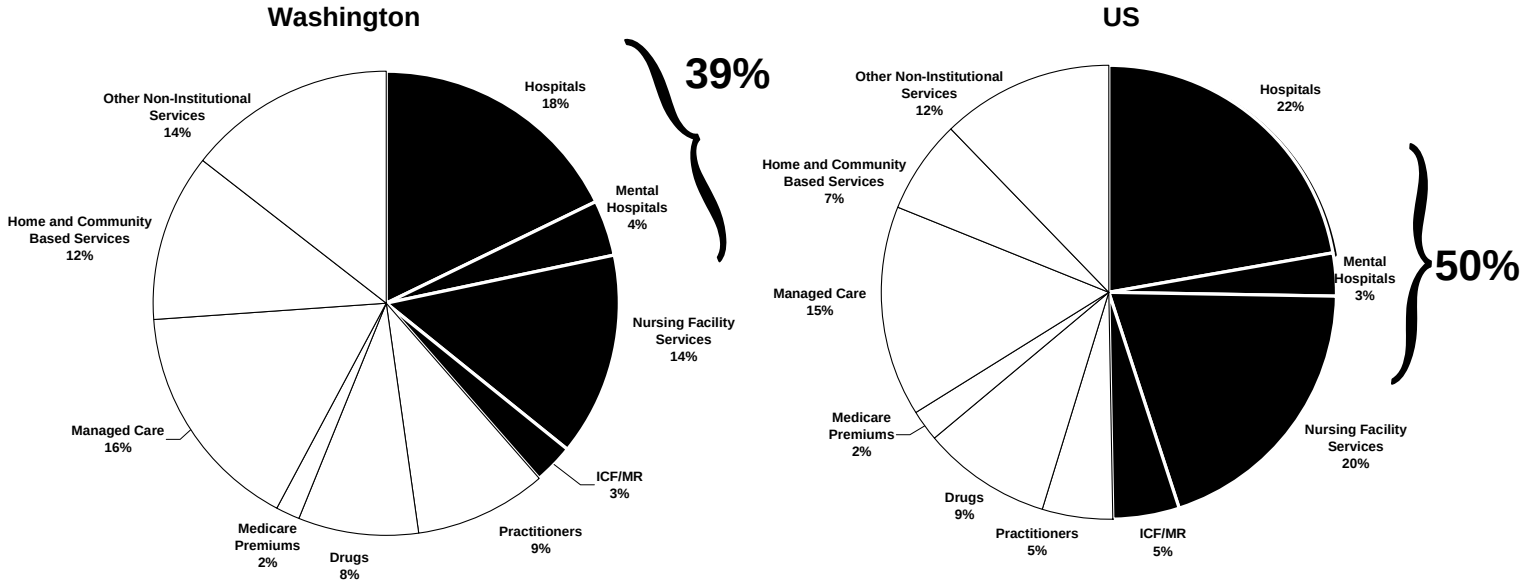
Providers

Institutions (hospitals, psychiatric hospitals, nursing homes, and intermediate care facilities for the mentally retarded (ICF/MR)) are the major recipients of Medicaid funding, receiving 50 percent of expenditures nationwide, and 39 percent in Washington.[30]

Why is Washington's institutional spending so much less than that of the nation? The primary driver of this difference seems to be attributable to the proportion of expenditures going to home and community-based services, and, other non-institutional services. Nationally, these programs, which serve people in their own homes or outside of institutions, are 19 percent of total spending, while in Washington this percentage is 26 percent (See Figure 7).

[28] Kaiser, "Resource Book", p. 133.
[29] CMS, CMS 64 reports for FFY 2001.
[30] CMS, National and Washington CMS 64 reports for FFY 2001. Includes Disproportionate Share Hospital (DSH) funding, which is provided in lump sums to hospitals and mental hospitals to offset uncompensated care costs.

Figure 7 – Where Do Medicaid Service Dollars Go?



Source: Centers for Medicare and Medicaid Services (CMS).

WHO AND WHAT ARE WE PAYING FOR? WHY?

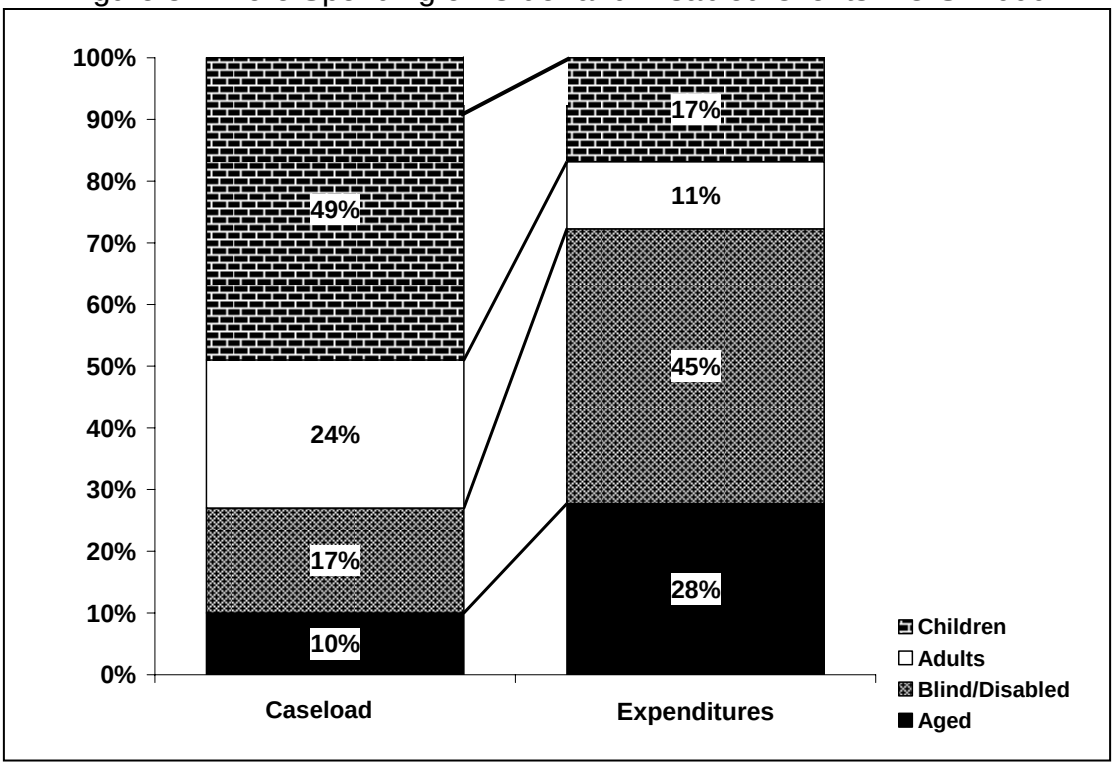
Approximately 16 percent of the population, from all age groups, is enrolled in Medicaid, both nationally and in Washington. Children represent the largest proportion of enrollees, at 49 percent nationwide, and 58 percent in Washington (one third of all Washington children, and 40 percent of all births, are covered by Medicaid).[31] This higher than average enrollment of children is attributable to the legislative decision in 1994 to cover children up to age 19 in families with household income up to 200 percent of the federal poverty level,[32] and through effective outreach through schools. Washington extended coverage to these children well in advance of other states. However, as the chart on the following page depicts, while children make up half or more of Medicaid enrollees, they represent one quarter or less of expenditures. Children are a relatively healthy population, requiring fewer health care services.

Conversely, while the aged, blind or disabled groups represent roughly one-quarter or less of enrollees (27 percent nationally and 21 percent in Washington), these groups consume the majority of funds because of their use of acute and long term care services. Nationally, 73 percent of Medicaid expenditures fund services to this population, while Washington spends 58 percent.[33]

Why is Washington's proportion of spending for these groups so much less than that of the nation? The primary driver of this difference seems to be attributable to the proportion of expenditures going to home and community-based services, and, other non-institutional services (See Figures 8 and 9).

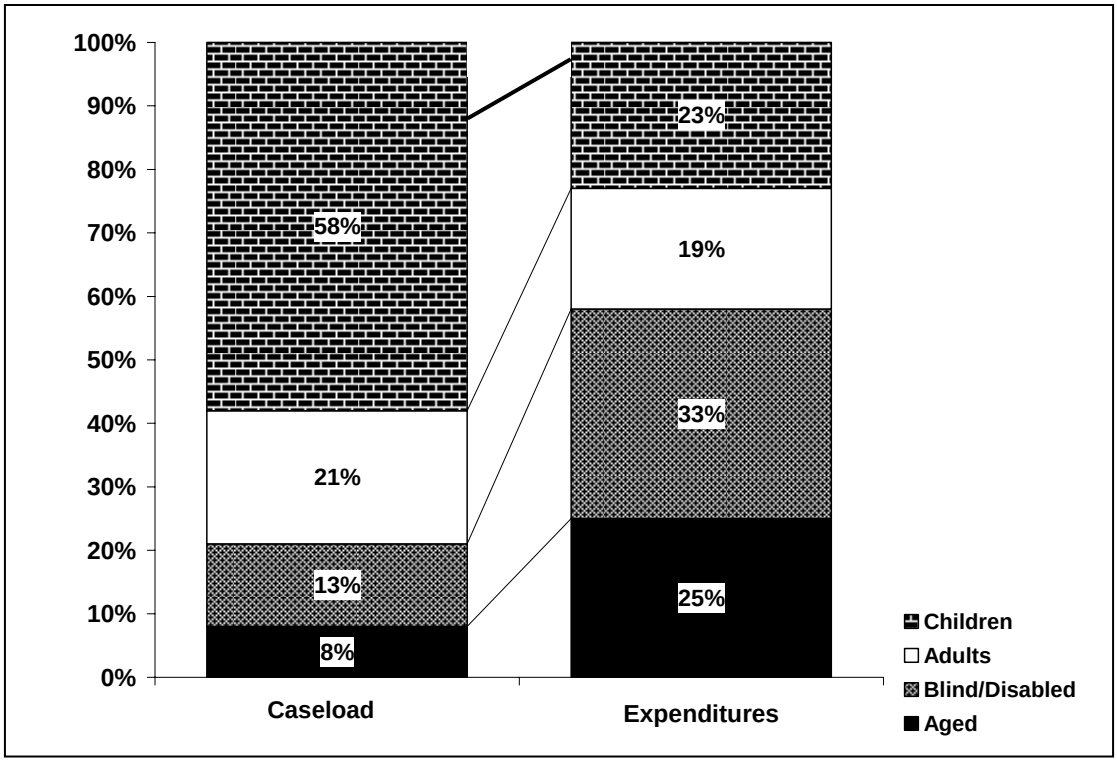
[31] DSHS, "A Section 1115 Demonstration Waiver Application", July 21, 2003, p. 17.
[32] 200% of the federal poverty level is $36,800 for a family of four in 2003.
[33] CMS, National and Washington MSIS reports for FFY 2000.

Figure 8 – More Spending on Older and Disabled Clients – U.S. 2000



Source: Centers for Medicare and Medicaid Services (CMS).

Figure 9 – Less Spending on Aged & Disabled, More on Kids – WA 2000



Source: Centers for Medicare and Medicaid Services (CMS).

Does the federal government require us to do this?

Federal law and code set forth guidance for a state's Medicaid program, but Medicaid is not a uniform program nationwide. Federal guidance establishes a broad framework, but each state has latitude to shape its program through the choices it makes. The standard remark related to flexibility and variability in Medicaid programs is: "Once you've seen one Medicaid program, you've seen one Medicaid program."

Participation in Medicaid obligates states to cover certain populations and certain services. These are known as "**mandatory populations**" and "**mandatory services**." States must meet three federal requirements about service provision, including: covered services must be available statewide (statewideness); covered services must be extended to every member of a covered group (comparability); and, service limitations, such as a number of mental health office visits, must be "sufficient in amount, duration and scope to reasonably achieve its purpose."[34]

What drives mandatory spending?

Both nationally and in this state, over 75 percent of **mandatory** spending is attributable to hospital care, physicians and related services. Nursing home care represents 20 percent of **mandatory** expenditures in Washington; nationally, this figure is 12 percent[35] (See Appendix 4 for additional graphs of mandatory and optional spending).

Are we paying for services we aren't required to pay for?

Beyond the minimum requirements for a state's participation in Medicaid, federal law establishes "**optional populations**" and "**optional services**" for which federal match will be paid if the state chooses to cover them. The constraint on the federal payment is that services provided must be "medically necessary." Medical necessity is not defined in federal law or administrative code,[36] though it is defined in Washington Administrative Code.[37]

[34] Kaiser, "Resource Book", p. 60 and 42 CFR 440.230(b).

[35] Washington data: DSHS Medical Assistance Administration, using CMS 64 2001 reported expenditures. U.S. data: Urban Institute based on 1998 CMS 2082 and CMS 64, in Kaiser Commission Policy Brief "Medicaid 'Mandatory' and 'Optional' Eligibility and Benefits," July 2001.

[36] Medical necessity is defined only for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children, in a State Medicaid Director letter, 1/10/2000.

[37] DSHS WAC 388-500-0005 defines the term:

> **"Medically necessary"** is a term for describing [a] requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

The federal provisions described above – statewideness, comparability, and scope – apply if a state chooses to cover optional populations or optional services. Also, generally, covered optional populations are eligible for mandatory services (See Figure 10).

Figure 10 – Summarized Federal Medicaid Parameters Mandatory and Optional Groups and Services

Mandatory Groups	Mandatory Services

• Temporary Assistance for Needy Families (TANF) Recipients
• Pregnant Women
• Income Eligible Children
  ▪ ages 0 - 5 to 133% of Federal Poverty Level (FPL)[38]
  ▪ ages 6 – 19 to 100% FPL
• Foster Care/Adoption
• SSI Recipients (Aged, Blind, Disabled)
• Qualified Medicare Beneficiaries
	• Inpatient Hospital
	• Outpatient Hospital
	• Physician Services
	• Nursing Home Care
	• Lab and x-ray
	• Home Health
	• Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Screens
	• Rural Health Clinics
	• Medicare Premiums
	• Family Planning
	• Transportation

Optional Groups	**Optional Services**
• Children up to 200% FPL • Medically Needy • Breast & Cervical Cancer Treatment • Take Charge Family Planning • Non SSI Aged, Blind Disabled	• Prescription drugs • Home & community services • Intermediate Care Facilities for the Mentally Retarded (ICF/MR) • Dental • Vision • Durable medical equipment • Mental health facility services • Other practitioners/services • Interpreters • Personal care • Targeted case management • Hospice

Source: Kaiser Commission.

Why do we cover optional populations and services?

No state's Medicaid program covers only mandatory services for mandatory groups.[39] One reason is the coverage of prescription drugs, which is an optional service. Another driver of optional spending is to obtain federal match for a state's institutions for the developmentally disabled – an optional service. Similarly, states have chosen to cover home and community-based waiver services for elderly, physically disabled, and developmentally disabled people who are eligible for institutional care – also an optional service.

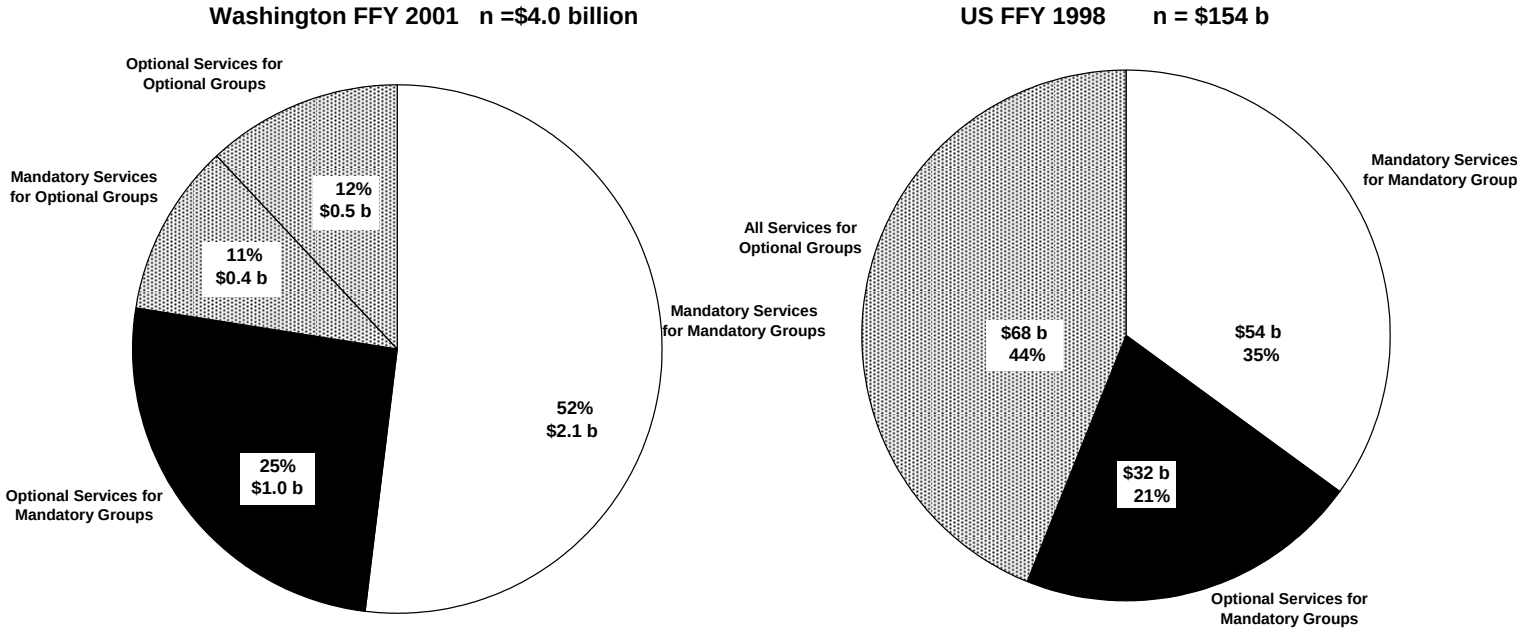
[38] Currently, 100 percent of the FPL for a family of three is $15,260.
[39] Kaiser, "Resource Book," p. 57.

What choices have been made about optional spending?

In Washington, 48 percent of Medicaid spending is attributable to optional services and populations; nationally, optional spending is 65 percent.[40] In both cases, over one-half of these expenditures are driven by three service categories – home and community-based services for the elderly and disabled and the developmentally disabled, prescription drugs, and nursing facility care for optional populations.[41]

More of Washington Medicaid's expenditures fund mandatory services for mandatory populations than the national experience. Policymakers have limited ability to trim program expenditures by modifying the extent of optional coverage. Data limitations prevent a complete explanation of the apparent disparity with the national data. One factor that may contribute to this picture is that this comparison does not reflect the same time period. For national data, 1998 is the most recent complete data set available. States have significantly modified their Medicaid programs since that time; a look at 2001 national data may reveal less difference between Washington and the United States (See Figure 11).

Figure 11 – How Much Medicaid Spending is Required?



Source: DSHS, Urban Institute.

[40] Washington data: DSHS Medical Assistance Administration, using CMS 64 2001 reported expenditures. US data: Urban Institute based on 1998 CMS 2082 and CMS 64, in Kaiser Commission Policy Brief "Medicaid 'Mandatory' and 'Optional' Eligibility and Benefits," July 2001.

[41] Calculations derived from analysis of Washington CMS 64 reports for FFY 2001.

CHAPTER THREE – MANAGING MEDICAID: POLICY, ELIGIBILITY, AND PROVIDERS

Developing and implementing policy regarding who, what, and how much is to be covered are the fundamental actions for administering Washington Medicaid. Once policy is established, beneficiaries and providers must be enrolled in the program. JLARC has found that the activities encompassed by these management functions are largely **decentralized** across the Medicaid managing entities in DSHS. The figure below summarizes the management model employed for each activity.

Figure 12 – Washington Medicaid - Management Model by Function and Activity

Management Function Activity	Centralized	Decentralized	Mixed	Other State Agency*
Policy				
Eligibility & Scope		**X**		
State Plan			**X**	
Rules			**X**	
Beneficiary & Provider Enrollment				
Outreach		**X1**		Department of Health
Eligibility Determination		**X**		
Beneficiary Enrollment		**X**		
Provider Credentialing		**X**		
Provider Enrollment		**X1**		Department of Health
Plan Enrollment		**X**		
X1 - performed in collaboration with an entity outside DSHS				

*Because this analysis focuses on operational management, players external to the agency with comprehensive oversight responsibilities, such as the Legislature or OFM, are not cited. State agencies that have an operational role in executing the function, such as the Office of the Attorney General, are cited.

BASIC FEDERAL REQUIREMENTS

While Medicaid is a highly structured federal program, no single reference source identifies all the various federal requirements for administering and operating Title XIX programs. However, three specific requirements set out the parameters for comprehensive management of Medicaid—

1. Designation of a **Single State Agency**;
2. Creation and maintenance of the **State Plan**; and
3. Operation of a **Medical Care Advisory Committee**.

1. Single State Agency

A state must designate a "single state agency" to administer its Medicaid program. In Washington, DSHS is this single state agency. With federal agreement, such an agency may delegate any of its administrative responsibilities, except the issuance of policies, rules, or regulations.[42]

2. State Plan

By participating in the Medicaid program, Washington agrees to contractual terms with the U.S. Department of Health and Human Services in order to receive federal matching funds. This contract is open-ended, has some specific responsibilities as well as broad parameters, and is continuously re-negotiated. Washington's **state plan** is this contract, which sets the direction for how Medicaid is administered.[43] Washington's plan is several hundred pages long, and continues to grow. The plan documents, through checklists and other forms, the negotiated agreement between the two parties. The federal Centers for Medicare and Medicaid Services (CMS) must approve all changes to Washington's plan prior to their implementation.

3. Medical Care Advisory Committee

CMS requires the single state agency director to appoint a "Medical Care Advisory Committee."[44] Washington addresses this requirement by taking a decentralized pathway. A Title XIX advisory committee participates in the development of policy, and program administration, primarily for the Medical Assistance Administration. Within DSHS, the aging/disabilities services and mental health programs have set up and operate separate advisory committees.

MEDICAID POLICY DEVELOPMENT

Medicaid is <u>not</u> a uniform program nationwide. Federal guidance establishes a broad framework, but each state has latitude to shape its own program. The national political and fiscal environments also affect Medicaid administration, where a change in who controls the executive branch or Congress, as well as changes in federal revenues, can affect the direction or speed of federal Medicaid decisions.

In administering Medicaid, each state must decide—

1. Who to cover (eligibility),
2. What services, and what extent, to cover (scope), and
3. How to maintain the plan and develop rules.

[42] 1902(a)(5); USC 1396a(a)(5); 42 CFR 431.10(e)

[43] CMS' regulation states: "A state plan must provide for methods of administration that are found by the Secretary to be necessary for the proper and efficient operation of the plan." This regulation is a reiteration of the federal statute; no definitions have been given for "methods of administration" or "proper and efficient operation," 1902(a)(4)(A); USC 1396a(a)(4)(A); 42 CFR 431.15.

[44] 42 CFR 431.12.

States make these policy decisions explicit in their federally approved plans. In Washington, DSHS must articulate these decisions in administrative code (rules) and communicate them to clients, staff, and contractors.

Eligibility and Scope Policy

Broad policy directives come from the Legislature, but also from within DSHS. There, policy development and implementation is **decentralized** across those administrations managing Medicaid funds, and includes the following elements—

- Developing policy options;
- Analyzing the effects of proposed changes;
- Creating state plan amendments, RCW, and WAC;
- Coordinating information systems so policy changes can be carried out;
- Revising training and reference manuals;
- Training field staff and providers;
- Improving the training processes; and
- Providing technical assistance.

State Plan Maintenance and Rules Development

In Washington, DSHS uses a **mixed** model of management for state plan maintenance and rules development. In both cases, one office oversees the formal, technical aspects of developing state plan amendments and rules. These staff are responsible for assuring that federal and state requirements are met.

The detailed program elements of state plan amendments, and negotiations with the federal CMS, are managed within the DSHS administration initiating the change. This means that several different administrations within DSHS can be dealing with CMS at the same time over various Medicaid policy and program directions. Negotiations with CMS can take a long time. For example, the state plan amendment for the proposed Medicaid "reform waiver" was first submitted for approval in the fall of 2001, and the third proposal was submitted in August 2003.

Similarly, staff in each of the separate DSHS administrations develop the detailed rules associated with Medicaid in their programs, while the DSHS central rules unit keeps track of approximately 4,100 rules.

ENROLLING BENEFICIARIES AND PROVIDERS

Both beneficiary and provider/plan enrollment are **decentralized** functions in Washington Medicaid.

Beneficiaries

Beneficiary enrollment is decentralized among four entities in Washington. Depending upon their service requirements, clients may apply at:

- Community Services Office for Healthy Options/TANF (public assistance) benefits,

- Home and Community Services Office for long term care services,
- Developmental Disabilities Services Office, or
- Medical Assistance's Medical Eligibility Determination Services.

The first three entities have service offices located across the state that determine eligibility for services and enroll clients to receive them; additionally, clients eligible for CSO services may apply for benefits through the Internet. The final means of enrolling beneficiaries is through Medical Assistance's Medical Eligibility Determination Services, which electronically receives applications and enrolls clients for foster care medical services, and other specific services.

Figure 13 displays key federal enrollment requirements, and how Washington fulfills them.

Figure 13 — Medicaid Enrollment Criteria

Federal Requirements	Washington Enrollment Criteria
Ensure that all clients who want to apply for Medicaid have that opportunity; however, states are not required to perform outreach efforts, assist clients in applying for benefits, or allow clients to apply through the mail.[45]	Clients have several options to enroll for services. DSHS has outreach efforts to provide insurance to eligible clients; specifically, MAA's Healthy Kids Now initiative aided in the enrollment of 70,000 children in SCHIP and Medicaid.
Ensure that pregnant women and children have enrollment options beyond the local welfare office.[46]	Pregnant women and children can enroll by telephone, mail, or Internet through Medical Eligibility Determination Services (MEDS).
State spending on individuals enrolled erroneously may not exceed 3 percent.[47]	Medical Assistance ensures compliance with this requirement. Audits have reported eligibility error rates less than 3 percent.
The state must make final eligibility determinations for Medicaid clients.[48]	DSHS employees make the eligibility determination for clients for all services.
Determine eligibility consistently, efficiently, and in a manner consistent with clients' best interests.[49]	CMS has not provided operational guidance for states on this requirement. To ensure consistency in eligibility, DSHS uses the Automated Client Eligibility System (ACES) that supports state staff in making their eligibility decisions across the state.

[45] 1902(a)(8) and 42 USC 1396a(a)(8).
[46] 1902(a)(55) and 42USC 1396a(a)(55).
[47] 1903(u) and 42 USC 1396b(u).
[48] 1902(a)(5) and 42 USC 1396a(a)(5).
[49] 1902(a)(19) and 42 USC 1396a(a)(19).

Plan and Provider Enrollment

Generally, federal statutes do not tell the states how to enroll the plans and providers that serve Medicaid clients—nursing homes excepted.[50] States must allow clients to receive services from any provider that is qualified to provide services, and willing to serve Medicaid clients.[51] Within DSHS, plan and provider enrollment is **decentralized** across the Medicaid-funded administrations. Each administration is responsible for determining which plans/providers are qualified to provide services to clients. Once an administration makes such enrollment decisions, plans/providers must agree to the terms of the state contract, disclose ownership information, and allow state and federal auditors access to client and proprietary information.

Unlike other Medicaid providers, nursing homes are subject to more intense scrutiny for licensing and maintaining certification, primarily the result of the large federal expenditures associated with supporting residents of these facilities.[52] The Residential Care Services Division (RCSD) coordinates state compliance with federal regulations.[53] The state must license, and the federal government must certify, nursing homes for them to operate and admit Medicaid clients. For other community-based residential settings, such as adult family homes and boarding homes (assisted living facilities), federal statutes are not specific. However, in Washington, the same state entity (RCSD) licenses these providers.

Conclusion and Findings

DSHS accomplishes Medicaid policy development and implementation, and beneficiary and provider enrollment, through each of six Medicaid managing administrations. With the exception of state plan maintenance and rule development, there is no centralized oversight and coordination of these activities across DSHS.

Because so many functions and activities are decentralized across the organization, a comprehensive perspective is crucial to ensure their efficiency and effectiveness. Currently, DSHS does not have a mechanism in place with the responsibility to provide this oversight.

[50] 42 CFR 431.107.
[51] 1915(a)23 and 42 USC 1396a(a)(23).
[52] Medicare provides federal funds for clients that require post-hospital convalescence. Medicaid provides federal matching funds for long term care clients that cannot afford care using their own resources (spend-down clients); Kaiser, p.137.
[53] 1919(g)(2)(c), 42 USC 1396r(g)(2)(C).

CHAPTER FOUR – MANAGING MEDICAID: FISCAL PROCESSES

Washington Medicaid will spend approximately 30 percent, or $12 billion, of 2003-05 state appropriations. Fiscal management activities are crucial to the effective management of all Medicaid funded programs. JLARC has found that several of these activities are **centralized** in one office. Other activities are **decentralized** or employ a **mixed** approach, where one office provides department wide coordination of activities within each administration. The figure below summarizes the model used for each activity.

Figure 14 – Washington Medicaid - Management Model by Function and Activity

Management Function Activity	Centralized	Decentralized	Mixed	Other State Agency*
Fiscal Management				
Forecast	**X1**			Caseload Forecast Council
Budgeting			**X**	
Accounting			**X**	
Contracting			**X**	
Audit (Internal)	**X**			
Collections		**X**		
Ratesetting		**X**		
Payment		**X**		
Payment Review & Audit	**X**			
Fraud	**X1**			Office of Attorney General
X1 - performed in collaboration with an entity outside DSHS				

*Because this analysis focuses on operational management, players external to the agency with comprehensive oversight responsibilities, such as the Legislature or OFM, are not cited. State agencies that have an operational role in executing the function, such as the Office of the Attorney General, are cited.

Effective and efficient fiscal management of $12 billion in Medicaid expenditures in Washington each biennium is a key management function. Activities entail accurately estimating caseloads, setting the prices (rates) to be paid for services to the various groups of Medicaid clients, contracting with and paying providers, assuring that payments are made correctly, monitoring to protect against fraud, and collecting money due from other payers.

Budgeting and accounting resources and functions support all of these activities. The caseload forecasting, internal financial auditing, reviewing the integrity of payments, and investigating suspected fraud are all centralized activities, with some shared in collaboration with other state

agencies. The remaining fiscal processes are decentralized to the individual parts of DSHS that administer services through Medicaid.

FORECASTING

Washington's biennial operating budget is the most formal expression of predicted caseloads and costs, and reflects the outcome of the state's forecasting activities. Prior to the adoption of caseload assumptions in the operating budget, the Caseload Forecast Council, with input from DSHS, the Office of Financial Management (OFM) and legislative staff, formally adopts caseload forecasts for individual Medicaid programs.

The Office of Financial Management has general statutory authority to develop expenditure forecasts for the Governor's budget request.[54] For DSHS programs, OFM has delegated responsibility to the agency. Medicaid expenditure forecasting is **centralized** in the Office of Forecasting and Policy Analysis, in the DSHS Budget Office. Analysts review historical expenditures, apply forecasting methodologies to this data, and generate the estimated per capita costs to provide a range of services to those eligible for Medicaid coverage (children, aged, pregnant women, etc.).[55] This expenditure forecast includes a primary trend (assumes no program changes) and steps (program changes reflecting actual or anticipated actions).

The Caseload Forecast Council was created in 1997 and seems to be unique among the states.[56] This Council addresses only caseload forecasts - not expenditure forecasts. Staff create, and the Council adopts, caseload forecasts three times a year. Council forecasts are statutorily required to be the basis for the Governor's budget request and must be "utilized by the legislature in the development of the omnibus biennial appropriations act."[57] Council analysts carry out Medicaid caseload forecasting by reviewing eligibility data, applying forecasting methodologies, and generating estimated caseloads. These caseload forecasts include primary trends (assumes no program changes) and steps (program changes reflecting actual or anticipated policy actions).

A working group of Council, legislative, DSHS, and OFM staff reviews and agrees on forecast feasibility and accuracy within the limits of data, time, and technology. These numbers are then used to build the agency budget request and the Governor's budget request, and the Caseload Forecast Council adopts the caseload forecast in November before the next legislative session.

However, all Medicaid caseloads are not forecast or adopted by the Council.

BUDGET, ACCOUNTING, CONTRACTING AND AUDITS

DSHS financial management oversees nearly $20 million in transactions daily for all DSHS programs.[58] Budget, accounting, and contracting activities use the **mixed** model of management—a centralized office provides overall leadership, coordination and department-wide oversight to assure compliance with state and federal requirements. The six individual administrations provide day-to-day guidance over these fiscal and accounting task areas.

[54] RCW 43.88.030.
[55] Prior to the current 2003-05 forecast cycle, OFPA did NOT forecast any DD services. The incorporation of DD and Aging services into one entity, the Aging and Disability Services Administration brought this change.
[56] Forecast Council staff surveyed 50 states in 2000 to determine if other states had similar organizations.
[57] RCW 43.88C.
[58] "Managing the Business Responsibly: A Forward Approach," p. 4, DSHS, January 10, 2003.

DSHS central budget and accounting offices coordinate with OFM, the State Treasurer, and federal and local government daily. The activities of external auditors, such as the State Auditor, CMS, and other federal funding agencies providing funds, are coordinated as needed.

The central contracts office provides technical expertise but does not "hold" or execute contracts with individual medical care plans or contractors. These tasks are carried out separately in each of the DSHS administrations. Federal statutes require CMS to review any proposed contract based on a capitation rate over $1 million.[59] This extra layer of external federal review applies to both the managed care contracts for Healthy Options and to the managed care contracts with the Regional Support Networks (RSNs) for community-based mental health services.

Internal audit activities are **centralized** within the DSHS Management Services Administration. The DSHS internal audit office conducts management reviews of internal controls, and provides consultation and technical assistance, either on its own initiative or upon request.

COLLECTIONS

Washington Medicaid's collections from the resources of recipients provided approximately two percent, or $85 million, of the resources available in 2001. These "collections" mean recoveries from third parties (often other insurers) or recoveries from a beneficiary's estate. The rate mirrors the national pattern and slightly exceeds the performance of other states in our federal region.[60] The federal government and the state share these collections in the same proportion as the match rates.[61]

Federal statutes and regulatory codes require the following:

- Recipients must assign their rights of payment to the state as a condition of eligibility for Medicaid,[62]
- States must identify and obtain payment from third parties that are liable for the costs of treating a Medicaid beneficiary (Medicaid is the "payor of last resort),[63] and
- States must collect from the estate of a deceased Medicaid beneficiary.[64]

In Washington, this collections activity is **decentralized**, with two entities sharing these responsibilities. DSHS Medical Assistance Administration handles the "**third party liability**" responsibility for individuals enrolled in fee-for-service Medicaid.[65] Third party liability might include Medicare, military health insurance, private health insurers, worker's compensation programs, casualty settlements or other sources. About 7 percent of the fee-for-service caseload has some kind of third party resources available (excluding Medicare).[66] In FY 2003, $414

[59] 1903(m)(2)(A)(iii); 42 USC 1396b(m)(2)(A)(iii).
[60] CMS, CMS 64 reports for FFY 2001. Washington is part of CMS Region X, which also includes Alaska, Idaho, and Oregon.
[61] 42 CFR 433.300 – 322.
[62] Social Security Act, Title XIX, 1912(a)(1)(A), (C); 42 CFR 433.145 -148.
[63] Social Security Act, Title XIX, 1902(a)(25); 42 CFR 433.135 -154.
[64] Social Security Act, Title XIX, 1902(a)(18); 42 CFR 433.36 (H).
[65] Medical Assistance collects only for services rendered to its Medicaid fee-for-service clients. Their contracted managed care organizations are responsible for collections on behalf of their clients.
[66] DSHS estimate.

million was collected—93 percent in cost avoidances and 7 percent in recoveries. Each dollar spent for this activity generates about 35 dollars in collections.[67]

The central Office of Financial Recovery (OFR) does collections for **all** DSHS program areas. Specifically related to the key federal requirements noted above, OFR carries out the administrative requirement related to **estate recovery**. In FY 2003, $1.3 million was spent to collect $12 million, resulting in about $9 dollars generated for every dollar spent.[68] At least eight states fully or partially contract with private firms for the full range of collections activities.[69]

RATES

Setting rates for those providing services to Medicaid beneficiaries is **decentralized** within DSHS. Individual DSHS administrations develop rates and negotiate with plans and providers delivering services to their clients. A wide range of sophistication, experience, skill, and resources among these administrations is devoted to setting rates, ranging from Medical Assistance's use of an actuarial firm to set the rates for its contracted managed care providers, to other administrations' reliance on their historical rates for vendors of their services (a detailed inventory of Medicaid-funded services and rates is in Appendix 3).

Managed Care and the Balanced Budget Act

Federal guidelines for rate setting are most prescriptive for managed care programs, administered through Medical Assistance and the Mental Health Division in Washington. The federal 1997 Balanced Budget Act required states to set "actuarially sound" rates for the first time in calendar year 2003, and requires expanded use of those methods to set base state rates by 2006.[70] These two DSHS entities have engaged an actuarial firm (*Milliman USA*) to assist in establishing these prescribed rates for this calendar year, and expect to meet federal requirements for 2006.

Fee-for-Service

The 1997 federal Act does not affect fee-for-service providers. DSHS administrations using this payment methodology for services vary considerably in negotiations and rate development with providers.

- In both Medical Assistance fee-for-service and the Aging Administration, central offices in each administration set rates for services provided to clients based upon cost reports—submitted by providers for Aging, and a combination of cost reports and CMS guidance, when available, for Medical Assistance. Providers do not negotiate with either administration; instead, providers receive a set rate for specific services.
- Rate setting for nursing homes exemplifies the resources applied for Aging services. Aging annually receives cost reports from facilities, which include the revenues and expenses

[67] DSHS estimate. Two approaches are used: first, and preferred, is to identify the responsible third party before a Medicaid claim is paid, and get that party to pay the provider (**cost avoidance**). The second strategy is to "pay and chase"— DSHS pays the provider and collects refunds from the third party (**recoveries**).

[68] This Office collects for other aspects of Medicaid: pursuing referrals from the payment review program, recovering premium payments, and collecting pharmaceutical rebates. Collections amounted to $294 million in FY2003. About $24 is collected for each dollar spent. Sources: OFR director.

[69] Alaska, Arizona, District of Columbia, Iowa, Kentucky, Missouri, Virginia, and West Virginia. American Public Human Services Association, "Organizing Medicaid Responsibilities: A Look at Current State Agency Structure," Washington Memo, July-Sept 2000.

[70] 42 CFR 438.6(a).

claimed for the previous year. Staff analysts review reports for reasonableness and unallowable costs. The rates paid are facility-specific, and are comprised of seven components, which include data on each facility resident and a client classification based on her/his care need.

- Three entities—Children's Administration, Juvenile Rehabilitation, and Alcohol and Substance Abuse—rely on rate studies from past years to set rates. With the exception of Children's services, where field offices are allowed to conduct limited negotiations with providers, these administrations pay a set state rate for services.

Waiver Services

Rate setting and negotiations for services provided under the two Home and Community Based Services waivers are handled in the recently merged Aging and Disabilities Services Administration (ADSA). Both the Community Alternatives Program (CAP), which serves DD clients, and Community Options Program Entry System (COPES), which serves elderly and disabled clients, allows clients to live in either a home or community setting rather than an institution. The services paid for by each waiver are summarized in Appendix 3, along with the accompanying rates for each service. The large array of payment options available in the CAP waiver for similar services is worth noting. Although COPES services are also tailored to the needs of individual clients, case managers have less discretion, assuring greater congruity in rates paid for services to these clients. ADSA plans to apply techniques and rate structures developed for services to the elderly and disabled to DD services. Currently, the Administration is working with a consultant to analyze DD services that can use evaluation tools and rate setting techniques used by Aging. This may result in greater consistency and logic in the rates for similar services.

Rates for COPES services are based on a computerized tool that is intended to provide consistent client assessments. Case managers are guided by standardized rates based on the client assessment, ensuring consistency in the rates paid for similar services to similar clients.[71] DD rates are based on considerably greater discretion, including non-standard client assessments, and a "non-staff" component to the rates. Past JLARC reports have documented concerns with the lack of an automated assessment tool and the variance between client assessments across regions.[72] These non-standard assessments lead to case managers making business decisions without the guidance of standardized costs for services. ADSA's use of a consultant to assess which services can use existing rate models from the Aging division is promising; however, it appears that the reorganized ADSA Office of Rates Management is not yet fully integrated, and should be monitored to ensure reasonable congruity among rates paid for similar services.

Another Approach to Rates

During the course of the study, JLARC staff learned of the Massachusetts Division of Health Care Financing and Policy, within the Executive Office of Health and Human Services. The Division has set rates for the Medicaid Program, student health insurance, and workers compensation since the inception of Massachusetts Medicaid in 1967. A Pricing Policy Group

[71] Aging clients had been assessed by the Comprehensive Assessment, which categorized clients into three or four levels of care. As of April 2003, aging clients are assessed by the CARE tool, which provides 12 possible categorizations for clients.

[72] See JLARC: Performance Audit of Developmental Disabilities Division: Interim Report 02-13, December 2002.

within the Division develops pricing policies, rates, and methods of procurement, ensuring consistency in the purchase of state Medicaid services.[73] While we did not compare the methods of the Division with those of Medicaid-funded entities in Washington (use of encounter data, cost-reporting, etc.), such an approach ensures that the same scrutiny and resources are dedicated to this important management function.

PAYMENT

Paying the providers of contracted services promptly is key to maintaining an effective network of service providers. The federal government imposes provider payment requirements on the states, requiring payment of 90 percent of undisputed claims from non-institutional providers within 30 days.[74] DSHS payments to service providers are **decentralized** through one of three automated systems. RSNs, counties and school districts are paid via an accounting system **funds transfer**. All other contractors are paid through either the Medicaid Management Information System (**MMIS**) or the Social Services Payment System (**SSPS**). Medicaid contractors are paid through all three systems. MMIS is discussed in detail in Chapter Five.

PAYMENT INTEGRITY – OVERPAYMENTS AND FRAUD

The federal government also imposes requirements on states related to payment integrity. Critical requirements include—

- Prepayment and postpayment review of claims,[75] and
- Operation of a fraud unit separate from the single state agency if a state cannot demonstrate "minimal fraud."[76]

Overpayments - Payment Review and Audit

DSHS uses a **centralized** approach to review and audit **all** claims for DSHS payments, not only for Washington Medicaid. A unit[77] in the Medical Assistance Administration applies automated tools to a payment database, resulting in—

- Use of database edits to prevent payment of inaccurate claims,
- Attention to procedure and training issues to prevent inadvertent errors, and
- Identification of overpayments, with accompanying enforcement actions, including collections, audits, and/or criminal prosecution.

Fraud

DSHS payment review and audit staff work regularly with the Attorney General's Medicaid Fraud Control Unit (MFCU)[78] to determine when cases warrant referral for prosecution. DSHS audit staff develop these cases prior to turning them over to the Attorney General which then

[73] Massachusetts Division of Health Care Finance and Policy, http://www.state.ma.us/dhcfp/; conversation with Ellen Sandler, 10/23/03.
[74] 1902(a)(37)(A); 42 USC 1396a(a)(37)(A).
[75] 42 USC 1396a (a)(37)(B).
[76] 42 USC 1396a(a)(61).
[77] See The Lewin Group, "Medicaid Cost Containment Report No. 2," December 2002 for a discussion of this work.
[78] MFCU also has responsibility for prosecuting vulnerable adult abuse. This responsibility is discussed in the quality assurance section of the report.

investigates, prosecutes, or refers for prosecution all appropriate cases. These are federally funded at an enhanced match rate of 75 percent. The payment review program appears to be generating more referrals than MFCU can timely address, in part because the investment in resources for that activity has outpaced the investment in the MFCU.[79]

What Is The Magnitude of Improper Payments and Fraud?

States bear the primary responsibility for minimizing improper payments to their Medicaid providers. Improper payments result both from mistakes and intentional fraud. **The magnitude of improper payments of any type throughout the national Medicaid program, or in each state,[80] is unknown.** Ernst and Young noted the lack of a methodology for estimating the range of improper Medicaid payments as a reportable condition in its audit of CMS's FY 2000 financial statements.[81] CMS has undertaken a "Payment Accuracy Measurement (PAM)" project to assess the error rates in the states. Washington is one of eight states participating in the 3-year project.[82] In 2005, CMS plans to impose standardized methodologies for tracking, measuring, and reporting payment accuracy. This consistent framework could enable measurement of national and state performance in minimizing improper payments and fraud in the near term.

Conclusions and Findings

DSHS accomplishes fiscal processes throughout the organization. However, this functional area has the **most centralized activities** of any of the functional areas we examined.

Because so many functions and activities are decentralized across the organization, a comprehensive perspective is crucial to ensure their efficiency and effectiveness. Currently, DSHS does not have a mechanism in place with the responsibility to provide this oversight.

[79] MFCU "2002 Annual Report," p. 22.

[80] GAO, "State Efforts to Control Improper Payments Vary," p. 8. GAO-01-662. Three states have conducted accuracy studies using various methodologies and with disparate margins of error.

[81] "Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 2000," OIG, February 2001 (A-17-00-02001), p. 132.

[82] Washington has received attention and praise for its efforts in using technology to assist with payment reviews. See GAO, "State Efforts to Control Improper Payments Vary," p. 20, GAO-01-662.

CHAPTER FIVE – MANAGING MEDICAID: LEGAL, QUALITY ASSURANCE, AND DATA SUPPORT

Managing Washington Medicaid effectively requires legal support, processes for clients to appeal decisions, quality assurance of providers, performance measurement, and data systems support. JLARC has found that these activities are largely **decentralized** across DSHS, with the exceptions of legal support and the survey and certification of nursing homes and supported living arrangements. The table below summarizes the fiscal management model employed for each activity.

Figure 15 – Washington Medicaid - Management Model by Function and Activity

Management Function Activity	Centralized	Decentralized	Mixed	Other State Agency*
Legal/hearings/appeals				
Advice & Litigation	**X1**			Office of Attorney General
Fair Hearings		**X1**		Office of Administrative Hearings
Quality Assurance				
Survey and Certification	**X**			
Abuse	**X1**			Office of Attorney General
Satisfaction		**X**		
Performance Measures			**X**	
Data Collection & Reporting				
Information Technology Organization		**X**		
Data Collection & Analysis		**X**		
X1 - performed in collaboration with an entity outside DSHS				

*Because this analysis focuses on operational management, players external to the agency with comprehensive oversight responsibilities, such as the Legislature or OFM, are not cited. State agencies that have an operational role in executing the function, such as the Office of the Attorney General, are cited.

Since Medicaid drives **76 percent** of this agency's biennial appropriations (from all sources), having effective processes to manage the legal and data support of this $12 billion biennial operation are key elements in ensuring a reasonable standard of efficiency and effectiveness. This chapter summarizes the legal, fair hearings, quality assurance, and data support activities in the DSHS administrations funded by Medicaid resources.

LEGAL

Advice and Litigation

The Office of the Attorney General is DSHS' law firm. Over half of these legal resources are dedicated to providing assistance in family dependency issues before the DSHS Children's Administration. Other DSHS administrations rely on one or two assistant attorney generals for legal advice and support in litigation, if necessary. The Attorney General also staffs the Medicaid Fraud Control Unit, discussed in greater detail in Chapter Four, which provides legal support in cases of fraud and abuse.

Fair Hearings

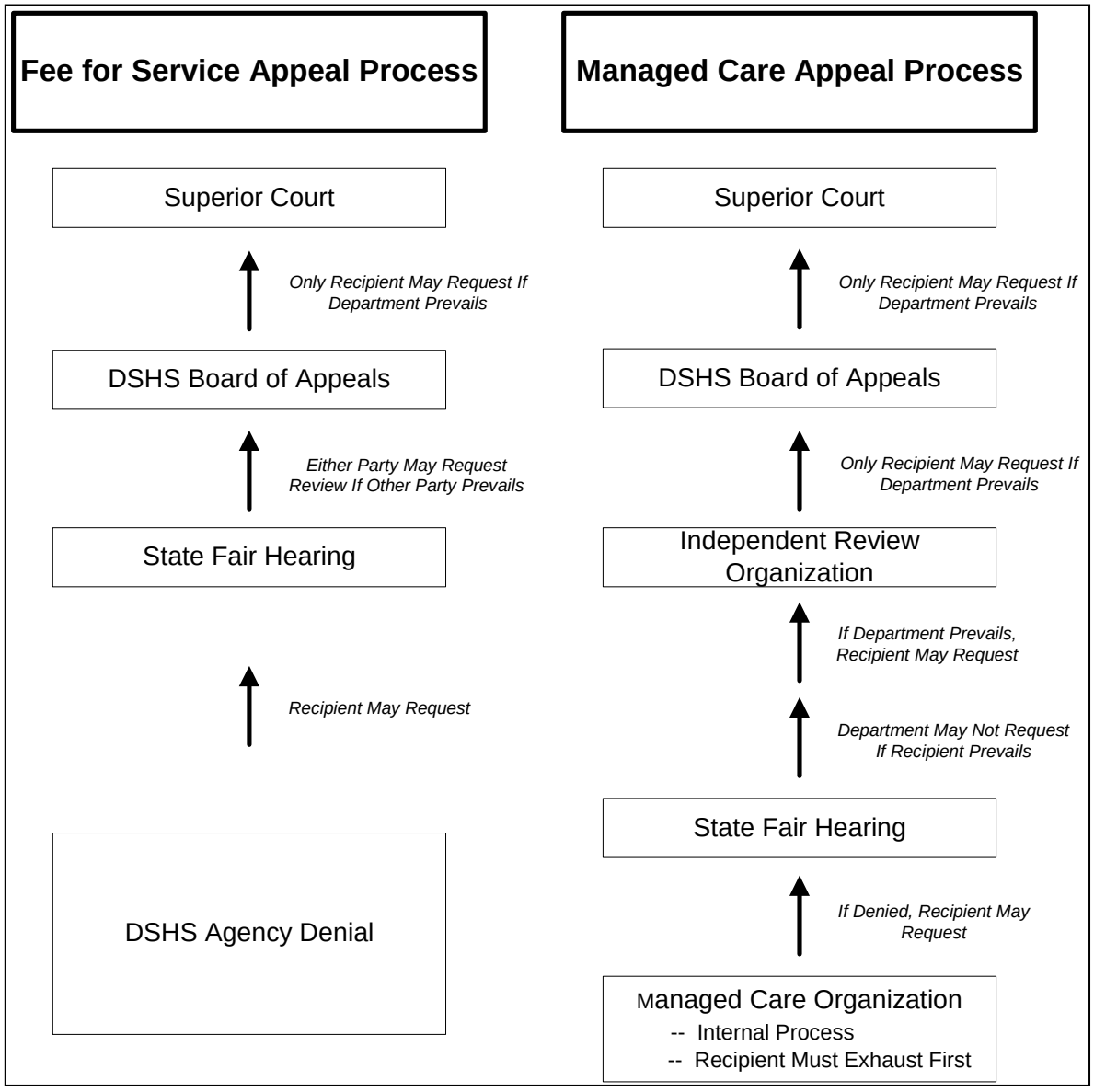
Federal statutes require states to provide all Medicaid beneficiaries, and those who apply for benefits, with the opportunity for a fair hearing.[83] Fair hearings provide clients with an opportunity to contest DSHS decisions before an impartial party over matters ranging from eligibility determinations, to the loss of previously provided drugs or services as the result of a Legislative decision. Fair hearings are **decentralized** across DSHS: each administration has fair hearings coordinators who are responsible for assuring that clients receiving services from their administration have access to hearings. If a client is not successful in resolving a dispute with the agency, the client is able to request a hearing with an Administrative Law Judge (ALJ) from the independent Office of Administrative Hearings.

Clients' circumstances determine the rights they receive to appeal the fair hearings process. A DSHS rule change, effective November 2002, limited the rights of client appeal in certain instances to achieve cost savings.[84] The Department estimates that it saves $550,000 annually by limiting certain clients' appeal rights to request reviews by the DSHS Board of Appeals; however, it also recognized that this decision had potentially adverse implications. The independent Office of Administrative Hearings and DSHS are tracking the results of this rule change. As a result of the change, however, clients—whose circumstances include TANF and mental health eligibility disputes—can appeal a decision with the local Fair Hearings Coordinator, but are only allowed a single hearing before an ALJ, without the opportunity for further administrative review. This is potentially confusing to clients receiving multiple services from DSHS. For example, a client who receives both TANF and Medicaid has several opportunities to appeal an adverse decision through the Medicaid fair hearings process (see Figure 16); however, the same client is allowed a single appeal before the same ALJ who initially ruled against them for their TANF benefits.

It is also worth highlighting that clients with the same need must navigate different hearings processes. As Figure 16 on the next page illustrates, hearings are different for Medicaid clients under fee-for-service providers and managed care organizations.

[83] 1902(a)(3) and 42 USC 1396a(a)(3).
[84] WAC 388-02-0215.

Figure 16 – Medical Assistance Fair Hearings



Source: DSHS.

QUALITY ASSURANCE

Quality assurance is **decentralized** among Medicaid-funded entities, and directed by specific guidelines for managed care organizations and nursing homes. For other services using the fee-for-service methodology, guidance is less prescriptive, and handled by each DSHS entity.

Quality Assurance: Managed Care

Federal requirements for quality assurance are specifically defined for managed care organizations. The Medical Assistance Administration ensures that the state meets key federal requirements:

- *Access Standards*: States must maintain standards for access to care so that covered services are available in a reasonable time.[85]
- *Quality of Care*: States must monitor other aspects, specifically related to the improvement of the quality of care, including grievance procedures, marketing, and information standards. Additionally, an external quality review organization must conduct an annual, independent review of each managed care organization under the Healthy Choice contract.[86]
- *Monitoring Procedures*: States must evaluate and provide quality assurance data about the quality and appropriateness of care that reflects the full spectrum of populations covered through the contract.[87]

Quality Assurance: Nursing Homes

Federal guidelines are quite specific about quality assurance procedures for nursing homes. Guidelines define the frequency of facility inspection, as well as the services and patients to be evaluated in the inspection. These responsibilities are **centralized**, and performed through the Aging and Disabilities Services Administration, which also monitors adult family homes and boarding homes. These quality surveys cover 246 nursing homes every six to 15 months, with an average interval between surveys of 12 months.

Prior to the establishment of federal guidelines for nursing home inspection, Washington defined its own enforcement and inspection standards. Surveys include:

- Overview of the quality of care—federal statute prescribes that nursing faculties are subject to unannounced inspections. State inspectors review a stratified, case-mix sample of residents,
- Review of the written plan of care, and
- Review of compliance with residents' rights.

The federal CMS audits DSHS records to ensure that DSHS staff conduct audits correctly and in a timely manner. If DSHS staff determine that there are problems with a nursing home, CMS is responsible for reprimanding the facility appropriately.[88]

Quality Assurance: Adult Family Homes and Boarding Homes

States have the primary responsibility for surveying adult family homes and boarding homes. Washington's 2,132 adult family homes provide room, board, laundry, supervision (as needed) and assistance with the activities of daily living in a residential setting. The state also surveys 531 boarding homes which provide services in a residential setting. Some specialize in nursing services, while others specialize in serving individuals with mental health problems,

[85] 1932(c)(2) and 42 USC 1396u-2(c)(2).
[86] 1932(c)(1) and 42 USC 1396u-2(c)(1); 1932(c)(2)(A)(iii) and 42 USC 1396u-2(c)(2)(A)(iii).
[87] 1932(c)(1) and 42 USC 1396u-2(c)(1).
[88] 1919(h)(3) and 42 USC 1396r(h)(3).

developmental disabilities, or dementia.[89] The unit in the Aging and Disabilities Services Administration handles these facilities as well.

Quality Assurance: In Home Providers

While there are not prescriptive federal guidelines for home health inspections, there are guidelines in place for the certification of agency and individual providers of home health care. Agency providers of home health care are licensed by the Washington State Department of Health and contract with local Area Agencies on Aging. Washington meets federal requirements for certifying individual providers of in-home health care for Medicaid clients. Providers must pass a Washington-criminal background check, sign a contract before beginning work, and complete an orientation and required training, all handled in the Home and Community Services Division in the Aging Administration. Additionally, Initiative 775, enacted by Washington's voters in 2002, established a Home Health Care Quality Authority to regulate and improve the quality of long-term in-home care services.

Quality Assurance: Resident Abuse

A key component of quality assurance is ensuring the health and safety of Medicaid residents in supported living arrangements. Federal statute requires the investigation and prosecution of cases of patient abuse and neglect in nursing homes and other institutions receiving Medicaid funds.[90] This function is **centralized**: suspected abuse of vulnerable adults and the disabled is primarily reported to the Aging Administration by calls from the client or their family or from staff from the facilities themselves.[91] DSHS staff determine whether the facility receives Medicaid funding, and whether the allegation of abuse or neglect is criminal. If a DSHS staff investigation confirms either case, the compliant is referred to Medicaid Fraud Control Unit which works with local law enforcement agencies and city attorneys to ensure that the criminal abuse of residents is investigated and prosecuted, if appropriate.

Quality Assurance: Other Measures of Performance

In its FY 2002 Annual Performance Plan and Report, CMS established Medicaid performance measures.[92] However, it does not appear that these measures are intended to provide states with performance targets. When JLARC staff interviewed CMS Region X officials, they indicated that they were unaware of these goals or any targets that Washington must meet.

Through amendments to the Budgeting and Accounting Act in 1996, the Washington Legislature requires all agencies to develop strategic plans, objectives for each major program in its budget, and performance measures to evaluate whether a program is successfully achieving its goals.[93] In its OFM budget requests, DSHS does not describe Medicaid as a major program; consequently, the Department does not have accompanying objectives established specifically for Medicaid. Instead, performance measurement is a **mixed model**: each administration that

[89] Provides room and board, social and therapeutic activities, help with personal care tasks, and may provide help with medications. Clients may receive limited supervision. Additionally, clients may receive services from outside providers, for instance, home-health, adult day health, and hospice care.
[90] 1902(a)(61) and 42 USC 1396a(a)(61).
[91] ADSA reported that last FY, the facilities themselves provided 63% of the reported 23,000 reports of abuse. Not every call is investigated as some claims of abuse are not violations of regulations. However, federal law requires staff who suspect abuse to self-report.
[92] DHHS, Health Care Financing Administration FY 2002 Annual Performance Plan and Report.
[93] RCW 43.88.090.

provides Medicaid-funded services has objectives and accompanying performance measures for its programs, which are coordinated through the Deputy Secretary.

Legislative direction for Medicaid-funded services is not as clear as it is for a program such as WorkFirst, where program targets are clearly stated in RCW. The Washington WorkFirst Act of 1997 amended existing public assistance statutes, and provided new directives, which include specific measures and objectives for the program.[94] In contrast, legislative direction to Medicaid is less specific: the Legislature requires DSHS to comply with the requirements necessary to receive federal funding.[95]

Measuring Satisfaction

A final means of measuring program quality that we considered is measuring customer satisfaction. Provider and beneficiary satisfaction is primarily **decentralized** across Medicaid-funded entities: each organization conducts assessments of its service with both groups. However, the Department conducts an annual, agency-wide survey of provider satisfaction. Additionally, the Office of Research and Data Analysis surveyed beneficiaries on issues such as satisfaction with the coordination of care, respect for client dignity, and ease of accessing services. This study provided DSHS with data used by programs such as the Washington Medicaid Integration Project (see Chapter Six).

DATA COLLECTION, ANALYSIS AND REPORTING

Washington Medicaid is required by federal statute to "make reports, in such form and containing such information, as the Secretary may from time to time require."[96] Some key reports of program-wide information submitted to CMS include:

- Quarterly projected expenditures,
- Quarterly actual expenditures, and
- Quarterly data on beneficiaries and paid claims.

Information Technology

Information technology (IT) at DSHS is managed primarily in a **decentralized** manner. The Chief Information Officer (CIO) for DSHS directly supervises the central IT shop, which provides security, user support, telephone, Wide Area Network, and Web services. This shop delineates and ensures compliance with statewide Department of Information Services (DIS) policies. The CIO acts in an advisory capacity to the Secretary regarding system development, but funding and supervision for planning, development, acquisition or operations of the major or minor systems supporting Washington Medicaid management is not centralized.

Each DSHS administration seeks approval, separately, from the State Information Services Board for proposed information systems within their individual sphere of responsibility. Each of these administrations has its own IT shop, and some have multiple shops. Each regional Community Services Office also has its own support staff for information technology operations.

[94] EHB 3901, Chapter 58, Laws of 1997.
[95] RCW 74.09.500.
[96] 1902(a)(6); 42 USC 1396a(a)(6); 42 CFR 431.16.

Data Collection & Analysis

Washington Medicaid data collection is **decentralized** in four primary systems, managed by four different DSHS administrations. ACES (managed by the Economic Services Administration) supports the eligibility determination process and captures beneficiary information, while SSPS (managed by the Management Services Administration) and MMIS (managed by the Medical Assistance Administration) capture claims payment data and make payments to providers. The accounting system (managed by the Financial Services Administration) records expenditures. In addition to these major systems, beneficiary data is collected through a myriad of smaller systems, located throughout the various Medicaid-managing administrations and, often, through even smaller systems maintained and operated through local offices.[97]

The proliferation and use of multiple data systems significantly complicates efforts to get a databased grasp of the operations of the total Medicaid program. Medicaid data analysis is **decentralized** throughout DSHS; the Research and Data Analysis section undertakes specialized and comprehensive data analysis for the agency. While lots of data is collected in the many data systems, information that would support comprehensive decision-making is not readily available. Resources are expended to simply compile this data so that it can be analyzed and transformed into information, for each management information request about the entirety of Washington Medicaid.

These management information, analytical and, ultimately, management control shortcomings, difficulties and impediments were highlighted in JLARC's 2002 and 2003 DD performance audits.[98] Since DD is essentially, and predominantly a Medicaid program, this JLARC review, focusing on overall Medicaid management, suggests that such information system problems are only compounded throughout DSHS.

Medicaid Management Information System (MMIS)

MMIS is the backbone of Washington's Medicaid data collection and reporting, but its reach is largely confined to the services administered and paid for through the Medical Assistance Administration.[99] Federal requirements for MMIS are extensive, including the following critical system capabilities:

- Must be compatible with Medicare intermediaries and carriers;
- Must be capable of transmitting in the Medicaid Statistical Information System (MSIS) format;
- Must be HIPAA compliant (national standards for electronic claims payment), [100] and

[97] The agency's Technology Portfolio lists 121 separate applications. Medicaid systems are not specifically denoted.
[98] "Performance Audit of the Division of Developmental Disabilities", JLARC 02-13, December 2002 and "Division of Developmental Disabilities Performance Audit," JLARC 03-6, June 2003.
[99] MMIS also pays nursing facilities, which are overseen by the Aging and Disability Services Administration.
[100] The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the Department of Health and Human Services (DHHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. CMS is an arm of DHHS.

- Must be able to exchange data with other states on providers sanctioned for fraud or abuse in Medicaid or Medicare, and be capable of providing information to the Medicaid Fraud Control Unit.[101]

Recognizing the importance of this information system, the federal government funds 90 percent of system development and 75 percent of ongoing operations.[102] CMS must approve contracts related to the acquisition of an MMIS.

The Washington Medicaid Management Information System (MMIS) pays providers of non-waiver services approximately $175 million each month in response to two million claims submitted.[103] The MMIS was purchased in 1982, and is operated by a contractor. The computer code for the system was written in COBOL for the Iowa Medicaid system in 1979.[104]

Designed to be a health care claims payment system, MMIS has limited capability and limited capacity for modern management information, reporting and decision support. Further, the system does not encompass all Medicaid transactions, and therefore does not support reporting, analysis, and decision-making for the entire Medicaid program. The system also does not integrate information from other state agencies with key management, service delivery, and coordination roles in health care, such as the Department of Health, the Health Care Authority, and Department of Labor and Industries.[105]

MMIS Reprocurement: An Opportunity That Could be Missed

Many states have aging Medicaid claims payment systems that do not support the management of a large, complex health care organization in the current public accountability environment. A recent survey of state MMIS management staff revealed that 18 states have re-procured or are actively engaged in reprocurement, and five are planning to re-procure in the next five years. In CMS Region X, Alaska has re-procured; Oregon is completing its reprocurement RFP; and, Idaho has extended the contract with the current vendor to allow for MMIS reprocurement in 2007.[106]

DSHS is proceeding with a reprocurement of the MMIS. The agency received approval from the Information Services Board in April 2003, to extend the current contract with the system operator, ACS, through 2007 *"to allow sufficient time for a careful reprocurement process."*[107] Proposed phases and completion dates in the reprocurement process are:

1. Feasibility study and requirements analysis (February 2004),
2. Development of the federally required Advance Planning Document and the Request for Proposal, vendor selection, and contract approval (December 2004), and
3. Implementation of first module in planned 10 year roll out (December 2006).

[101] 1903(r)(1)(B) and (F) and (D); 42 USC 1396b(r)(1)(B) and (F) and (D).
[102] Social Security Act, 1902(a)(4)(A); 42 USC 1396a(a)(4)(A).
[103] DSHS Information Technology Portfolio, Infrastructure Applications Summary, 2/24/2003. SSPS pays waiver service providers.
[104] MMIS Reprocurement Strategy Executive Summary.
[105] MMIS Reprocurement Strategy Summary.
[106] Washington MMIS staff interviewed states about their MMIS efforts at a national conference for MMIS managers in 2002.
[107] MMIS Reprocurement Strategy Executive Summary.

Phase 1 is progressing and a consultant has begun work on the feasibility study and business requirements analyses. Based on the experience of other states, the annual cost is expected to be $20 – 30 million, with the federal government picking up 90 percent of the system design, development and implementation costs. Thereafter, CMS will fund 75 percent of ongoing operational costs.

CMS and the states have been working to develop a new blueprint for the 21st century MMIS. That model is not yet finalized, but emphasizes the concepts of flexibility and modularity, reporting and decision support, compliance with the Health Insurance Portability and Accountability Act (HIPAA), on-line services, integrated data (within the Medicaid program and **across related state agencies** such as Department of Health and the Health Care Authority), single payment system and encounter data.[108]

Conclusion and Findings

DSHS accomplishes legal, quality assurance, and data support activities through each of the six Medicaid managing administrations. Our primary concern in this area is that multiple, aging data systems do not support or promote a comprehensive approach to legislative policy making or DSHS management of Washington Medicaid. DSHS is charged with the responsibility for managing a large, complex 21st century health care organization, and is trying to do it with major data systems that are over 20 years old.

DSHS has the opportunity to address some of the data collection, analysis and reporting issues discussed throughout this report in its pursuit of a new MMIS. A unified MMIS, with a robust capacity to support decisions, could allow for a comprehensive approach to Medicaid management, and support the Legislature's policy making process.

[108] ACS, "Minimum Functional Standards in the 21st c MMIS," 2003.

CHAPTER SIX – COORDINATED MODELS OF SERVICE

JLARC has highlighted problems resulting from a lack of coordination among the six administrations within the Washington Department of Social and Health Services that provide Medicaid-funded services. However, within DSHS, several notable examples of coordination could be models for future efforts: the Department-wide **No Wrong Door** initiative, the **WorkFirst** program, children's programs that resulted from legislative direction in the 1999-2001 biennium, and a program for nursing home-eligible clients. These existing models of coordination within DSHS could fulfill the goals of the Washington Medicaid Integration Program, an effort intended to better service Medicaid clients receiving services from multiple DSHS administrations to achieve fiscal efficiencies.

DSHS Integration Effort

DSHS recognizes the lack of coordination among programs. The agency cites several barriers to coordination on its website: a lack of shared vision, a lack of staff unity, difficulty hiring and retaining skilled employees, a lack of communication between employees, and separate funding sources with specific statutory and contractual requirements.[109] However, coordinating services to clients is critical; in FY 1999, 24,913 clients received services from at least two of the following DSHS program areas: aging and disability services, mental health, and alcohol and substance abuse.[110] Research by DSHS reveals that these shared clients are some of the highest cost clients.[111]

To improve service, the DSHS Secretary initiated an effort to integrate delivery from multiple providers, and improve client access to services. This approach is exemplified by "No Wrong Door," a web-based resource that allows clients and front-line staff access to information about services specific to their needs, such as abuse and neglect, child support, disabilities, food assistance, homelessness, and medical care. As described in the Beneficiary Enrollment section of Chapter Three, clients can apply for many services over the internet using this service. Operationally, there are examples of DSHS programs successfully coordinating client services; specifically, the Secretary cites WorkFirst, Washington's welfare program, as such a model.[112]

WorkFirst: Coordinated Services Initiative

WorkFirst coordinates services from four state agencies: DSHS, the Employment Security Department, the State Board for Community and Technical Colleges, and the Department of Community, Trade and Economic Development. A specific practice that appeared promising to JLARC staff in a 2003 study of WorkFirst is the Coordinated Services Initiative, which was implemented statewide in October 2003 to provide holistic case management and prevent service duplication. Key to the initiative are case staffings that target clients with at least 36

[109] "Integrating Services at DSHS," http://www.dshs.wa.gov/geninfo/integrate.html.
[110] DSHS, "No Wrong Door," p.34, August 2001.
[111] "Expenditures and Use of DSHS Services: Aged, Blind, and Disabled Clients for FY 2001," http://www1.dshs.wa.gov/rda/research/9/65.pdf.
[112] "No Wrong Door Website Will Guide DSHS Clients, Staff And Partners To Resources Quickly And Easily," http://www.dshs.wa.gov/mediareleases/2002/pr02318.shtml.

months' use of cash assistance, who also receive services from multiple DSHS administrations. In a typical case staffing, the WorkFirst case manager assembles appropriate DSHS specialists and community partners to collectively assist the client. For example, a case staffing could involve a child support enforcement officer, a mental health evaluator, an employment services specialist, a social worker, and the WorkFirst case manager. This team of providers works with the client to help overcome barriers to employment, and move the client towards self-sufficiency. DSHS research found that the collaboration between the different providers improved client service, and was successful in identifying client issues which would not have been otherwise addressed.[113]

Family Policy Council

The Legislature established the Family Policy Council in 1992 through RCW 70.190 to encourage coordination in services for at risk children by providing the means to collaborate in planning and program administration. The Family Policy Council includes the directors of five state agencies (including the DSHS Secretary), four legislators, and a representative from the Governor's Office. Service coordination occurs through 53 community public health and safety networks across the state, which work to address local concerns. Currently, the networks are assessing local strategies to assist children and identify policy changes that may be necessary to improve coordination in communities.

Children's Blended Funding Projects

DSHS efforts to coordinate services are consistent with the Legislature's direction. RCW 74.14A.020 directed the agency to blend program funds to better serve children receiving services from multiple providers, including child welfare services, mental health, and juvenile rehabilitation. Previously, this had proven difficult, as most funds are specifically dedicated to only pay for a particular category of services. As a result of the ability to blend funds from disparate sources, the Department has initiated various projects emphasizing coordinated care for children.

For example, in a blended funding project in King County, children who had been served by multiple providers may receive services through a case management model that promotes team-based decisions. The team includes the child's family, an advocate from a local parent's organization, and a blended-funding care manager. This team helps the family identify community members who can direct the child to community resources and support services, such as mental health, educational services, basic needs (clothes, food, and dental services), recreational activities, such as summer camp, and community mentors.[114] The Children's Administration reports that children served in the program stay out of foster care longer, and rejoin their families sooner.[115]

Another program that successfully blends funds from multiple sources is the Comprehensive Program Evaluation Project, also known as "Safe, Babies, Safe Moms." It is operational in Snohomish, Whatcom, and Benton-Franklin counties. The project identifies pregnant substance abusers, and improves their access to health care and chemical dependency treatment. $4.6

[113] "Expenditures and Use of DSHS Services: Aged, Blind, and Disabled Clients for FY 2001," http://www1.dshs.wa.gov/rda/research/9/65.pdf.
[114] Report to the Legislature "Blending Funding Projects," Chapter 219, Laws of 2000, Section 2, December 1, 2000; p. 4.
[115] Ibid, p. 6.

million in combined annual funding from five DSHS programs and the Department of Health provide chemical dependency assistance through community-based treatment centers, in addition to housing support services. Since January 2001, the program has served 381 women.

PACE: Coordinated Services, Blended Funding

An example of a blended funding project that serves Medicaid clients is the Program of All-Inclusive Care for the Elderly (PACE). PACE has used Medicaid and Medicare funding since 1998 in King County to serve frail, elderly clients who would otherwise be served in a nursing home.[116] Enrollment is voluntary, but once a client is enrolled, PACE becomes the sole source of services for clients. PACE receives a capitated, monthly rate for each client, and serves them in an adult day center which provides clinical services, therapies, and opportunities for social interaction. The multidisciplinary team that serves clients includes physicians, nurses, social workers, van drivers (PACE clients receive transportation), and client aides. Team members assess participant's needs, develop a care plan, and "provide services for total care," including nursing home services, if necessary. Currently, PACE serves fewer than 200 beneficiaries with an average age of 78. No information is available on client outcomes or cost savings, although the Aging and Disability Services Administration is working on a study to evaluate changes in client health.

Washington Medicaid Integration Project

In April 2002, DSHS initiated the Washington Medicaid Integration Project (WMIP) to coordinate client care and achieve fiscal efficiencies for aged and disabled Medicaid clients, and clients eligible for both Medicaid and Medicare (dual-eligibles).

The Legislature authorized DSHS to combine and transfer funds for Medicaid clients from the separate budget categories for the Aging and Disability Services Administration, Alcohol and Substance Abuse, Mental Health, and Medical Assistance program budgets in the 2003-05 biennium. Specifically, the budget directs DSHS to "develop an integrated health care program designed to slow the progression of illness and disability and better manage Medicaid expenditures for the aged and disabled population." The proviso limits daily program enrollment to 6,000 clients, and requires an evaluation of changes in cost, utilization, and client outcomes.

DSHS is designing a means for evaluating program outcomes, and plans to seek external assistance to complete the evaluation. Beneficiaries—the aged, blind, and disabled population—may voluntarily enroll in WMIP and will continue to have access to the same range of services they previously received. However, these services are planned to be provided in a coordinated, integrated manner. For example, a client receiving both aging community-based services, such as communication therapy and nursing services, and alcohol and substance abuse services, would continue to receive these services; in the integrated system, however, they would be provided through a coordinated team of providers.

Concurrent to DSHS' Medicaid integration efforts, the federal CMS announced a demonstration waiver specifically targeting clients who would benefit from coordinated health care services. Three organizations applied to participate in the CMS waiver to serve Washington clients; these responses targeted clients in King, Pierce, and Snohomish counties for implementation of the waiver. Although a CMS decision was expected by September 2003, the decision has yet to be announced. As a result of CMS' delay, DSHS initiated a contingency plan to serve clients

[116] Clients must be 55 and older, certified as eligible for nursing home care by DSHS, and live within King County.

consistent with the Legislature's proviso. In November 2003, DSHS announced a RFP for providers in Snohomish County to provide integrated managed care services, including medical, mental health and chemical dependency services, for Medicaid-only clients. The agency plans to begin enrolling clients in July 2004.

National Models and Outcomes of Medicaid Integration

Integrating funding and services to better serve Medicaid clients is an idea that has been pursued nationally since the early 1990s. Researchers, led by the Robert Wood Johnson Foundation (RWJF), a private philanthropic organization, believe that providing effective care for dual-eligibles requires health plans to coordinate the preventive services of Medicare and long-term services available through Medicaid. Minnesota was the first state to implement an integration project, and has worked with CMS to sustain funding since 1995. At least 14 states have integration efforts in place, including Washington. States have not always targeted integrated service delivery identically. In some instances, integrated services are limited to individuals receiving both Medicare and Medicaid, while in others, it is also available to Medicaid-only clients.

Service coordination appears promising, and has yielded a range of results in other states. Few studies have evaluated the outcomes of client health served through integrated services. Results of those studies have yielded inconsistent results: a study in Minnesota indicated no improvement in client health outcomes, while a recent study of integration in Texas concluded that services appear to have a positive impact on reducing client hospital stays, as well as save the state $123 million over a two-year program from 2000 to 2002 by providing coordinated care in a managed care setting.[117] More frequently examined is client satisfaction. Programs in Minnesota, Texas, and Wisconsin all report increased client satisfaction with the care they receive through integrated services.[118]

Although outcomes remain mixed in states' Medicaid Integration projects, it is an area that provides the opportunity for DSHS administrations to coordinate resources and services to better serve clients. DSHS is successfully operating coordinated programs that have improved service delivery. The Medicaid Integration project has the opportunity to build upon these successes, and improve service delivery to clients and achieve cost savings in the process.

[117] "Medicaid Managed Care Waiver Study," http://www.hhsc.state.tx.us/starplus/reports /06_2002MC Waiver Study.pdf; http://www.hsr.umn.edu/coa/Research/chair%20projects/Dual%20Eligible%20Publications% 20and%20 Abstracts.html.

[118] University of Maryland Center on Aging: Medicare / Medicaid Integration Project, http://www.hhp.umd.edu /AGING/MMIP/index.html.

CHAPTER SEVEN – CONCLUSIONS AND RECOMMENDATIONS

JLARC's changed conceptual approach to reviewing Washington Medicaid has revealed a number of opportunities for improvement across DSHS. These opportunities have been highlighted throughout the report, and are illustrated through examples in this chapter.

Conclusion – Oversight Issues in Decentralized Medicaid Management Structure (Chapters Three, Four, and Five)

Washington Medicaid management consists of a number of functions that are largely **decentralized** throughout the agency (and sometimes, across state agencies). This study found wide variance in expertise and capacity to address Medicaid management functions among the Washington Medicaid managing entities. Chapters Three, Four, and Five provided a full discussion of these issues.

JLARC does not mean to suggest that any one management model is preferred. Each model, **centralized, decentralized, or mixed**, has advantages and disadvantages, and each can work when sufficient communication and collaboration is employed. We did not, however, find that DSHS has a mechanism in place to comprehensively guide or review the performance of these mostly **decentralized** management functions and activities, or to review the resources and capacities applied to them in each of the Medicaid managing administrations. Such a mechanism could identify opportunities for improved coordination, and recognize and propagate best practices developed within each Administration.

Recommendation for Improving Oversight of Decentralized Medicaid Management

The largely decentralized approach to Medicaid management currently used by DSHS could be improved by employing an oversight mechanism.

Recommendation 1

DSHS should build on the work of the JLARC Washington Medicaid study and regularly review management functions for efficiency and effectiveness to determine if the total program is coherent and cohesive. These reviews could increase the possibility that the expertise and capacity that has been developed in certain Medicaid managing administrations is available to all Medicaid managing administrations.

Legislation Required:	None
Fiscal Impact:	None
Reporting Date:	April 2004

Conclusion – Improvements Needed in Managing Medicaid Costs and Predicting Caseloads (Chapter Four)

Cost containment activities for Medicaid programs managed by the Medical Assistance Administration, 60 percent or $7 billion biennially, have been subjected to extensive scrutiny by an outside consultant to the Legislature. However, the other $5 billion in biennial expenditures has not undergone such rigorous review, as discussed below. A review of this type could improve legislative understanding of available options for cost containment.

DSHS manages **forecasting** activities centrally, in collaboration with the Caseload Forecast

Council (CFC). The CFC formally adopts caseloads that are statutorily required to be the basis for the Governor's budget request, and for the Legislature's biennial operating budget. Medicaid programs managed by the Medical Assistance Administration, 60 percent or $7 billion biennially, are forecast by the CFC. Within the $5 billion or 40 percent in biennial Medicaid expenditures managed by other DSHS entities, some programs are addressed in the formal forecasting process (i.e., nursing facilities) while others are not (home and community based services for the developmentally disabled). An examination of the program elements, data sources and forecast methodologies for those services currently formally forecast, as well as an examination of the program elements, data sources and projection methodologies for those services that are **not** currently formally forecast, could assist policy makers in determining which services should be subject to the formal forecasting process.

Past JLARC reports have highlighted the inconsistency in client assessment for DD services, which is a key component in **setting rates** for these services. The newly merged Aging and Disability Services Administration has standardized techniques and procedures for rate setting and negotiations for services for the elderly and physically disabled, as highlighted in Chapter Four. This Administration is working with a consultant to assess which DD services can use these techniques. This effort may provide greater consistency and logic for rates for similar services and clients.

Now, What about Cost Containment?

About 40 percent, or **$5 billion**, of Washington Medicaid expenditures are managed **outside** of the Medical Assistance Administration. Primary drivers of this portion of the Medicaid budget are nursing home care, home and community-based services for the elderly or disabled and community based care for people with mental illness and developmental disabilities.

The **Lewin Group**, Inc., in a three-report series under contract to the Legislature, extensively evaluated recent efforts at cost containment in Medicaid programs managed through the Medical Assistance Administration. Legislative committees heard findings from these reports during the 2003 session. During one appearance, the Lewin representative observed: *"MAA has been tasked by the Legislature to be rigorous in ways that led to [various cost containment initiatives]*. ***I do think that asking other parts of DSHS to undergo that same sort of process would be a good thing."***

Lewin's representative went on to give an example of the **untested assumption** in the COPES program, for example, that subsidizing personal care in a person's own home prevents costly nursing home admissions. He pointed out, that in the absence of rigorous data measuring the effect of these policies, an equally credible assertion could be made that a low threshold for personal care services doesn't prevent nursing home admissions. Rather, the "supply" of such state-provided care may merely supplant informal care that would have been otherwise provided by family and neighbors anyway.

Various "cost containment" measures are applied to those Medicaid programs (the **other 40 percent**) not covered by the Lewin report in nearly every budget cycle. At times, these incremental measures are supported by data; at other times the decisions are made based on best professional judgment, conventional wisdom or, occasionally, information from the providers of these supposedly less-costly services. Legislators are regularly presented with conflicting information from interested parties purporting to show that one service alternative or another will offset and substitute for more intensive services costing much more. However, in the absence of evidence and independent verification, policy makers have difficulty choosing those options, among the various alternatives presented, that will incur the least cost to the public. The Legislature may wish to pursue the recommendation of its consultant and subject some of the cost-savings assumptions of these programs outside the Medical Assistance Administration to greater scrutiny.

Recommendations for Managing Medicaid Costs and Improving Forecasts

Implementation of these recommendations could identify options for cost containment, clarify the forecast process for Medicaid funded programs, and improve consistency and predictability of home and community-based services costs.

Recommendation 2

The Legislature should consider engaging a consultant to examine the 40 percent, or $5 billion biennially, in Medicaid programs managed outside the Medical Assistance Administration and evaluate opportunities for cost containment. The consultant also should examine the program elements, data sources and forecast and projection methodologies for these programs, and recommend to the Legislature the best techniques for understanding future caseload patterns.

Legislation Required:	None
Fiscal Impact:	$300,000
Reporting Date:	Initial report, November 2004 Final report, April 2005

Recommendation 3

DSHS should continue the effort underway in the Aging and Disability Services Administration to assure consistency in DD client assessment and rate setting, and include information about this effort and plans for implementation in the required reporting related to the JLARC Performance Audit of the Division of Developmental Disabilities. Reporting should discuss how the Administration assures that the variance in rates paid for similar services by different programs is supported by data.

Legislation Required:	None
Fiscal Impact:	None
Reporting Date:	June 2004

Conclusion – Data Improvements Needed (Chapter Five)

Multiple, aging data systems do not support a comprehensive approach to Legislative policy making or DSHS management of Washington Medicaid. JLARC has cited several instances of these data limitations. DSHS has the opportunity to address some of the data collection, analysis, and reporting issues discussed throughout this report with a new Medicaid Management Information System (MMIS). A unified MMIS, with a robust capacity for management decision support, could allow for a comprehensive approach to Medicaid management, and support the Legislature's policy making process. The case study below illustrates the limitations of the current approach.

Case Study of Federal Reporting: What Happens When Everyone Is Responsible?

Since 1999, states have been required to electronically report quarterly detailed encounter data about beneficiaries in the Medicaid Statistical Information System (MSIS) format to CMS. This data would provide far more detail about utilization of services at a national level than is currently available, and is intended to inform the rate setting process at the state level. [119]

Requiring quarterly *electronic*, rather than annual *paper*, submission of this data was a stumbling block for many states, as was the 2000 change to requiring expenditure reporting to reflect the month of *payment*, rather than the month of *service*. Implementation of the MSIS requirement is ongoing, but 42 states have managed to meet the federal requirements for 2001.

Washington has not submitted this required quarterly report since the close of federal fiscal year 2000. The report is now 12 quarters in arrears. When DSHS officials were queried about the cause for the late reports, JLARC staff was informed that the data needed from the MMIS system was ready to be submitted, but the data needed from waiver programs, supported not by MMIS but by SSPS and many small data systems within each Medicaid managing administration, was not ready.

It became apparent that no manager "owned" the problem, because of the decentralized nature of Medicaid management in DSHS. Medical Assistance Administration staff, whose data was ready (and has since been submitted), felt limited responsibility to get the remainder of the report completed. Staff from the other administrations similarly felt little pressure to get the report submitted, because it was a Medicaid requirement.` The situation is further complicated by a common view, shared by many states' Medicaid managers, of this particular report as a "compliance exercise" that provides little value to states.

JLARC staff raised this issue with DSHS staff while conducting our interviews for the study. Few senior managers in any Administration that we spoke with were aware of the problem. Research and Data Analysis staff reported that they had been approached by waiver managers and requested to compile the data from the many systems involved. RDA estimated that it would require funding from each of the administrations involved equivalent to one FTE month to support the effort. Without the involvement of senior managers, decisions on funding and completing the reports stalled.

Recommendations for Improved Medicaid Data

Implementation of these recommendations could improve the comprehensiveness and quality of data to support Medicaid policymaking and management.

Recommendation 4

DSHS should become current on federally required Medicaid Statistical Information System (MSIS) reporting.

Legislation Required:	None
Fiscal Impact:	None
Reporting Date:	April 2004

[119] Balanced Budget Act of 1997. A discussion of the implementation of this requirement can be found on the CMS web site: cms.hhs.gov/medicaid/msis/mstats.asp.

Recommendation 5

DSHS should assure that the proposed new MMIS unifies Medicaid expenditure and beneficiary data to support comprehensive legislative policy making and DSHS management.

Legislation Required:	None
Fiscal Impact:	DSHS estimates $20-30 million annually
Reporting Date:	February 2004

Agency Responses

We have shared the report with the Department of Social and Health Services (DSHS) and the Office of Financial Management (OFM) and provided them an opportunity to submit written comments. Their written responses are included as Appendix 2. JLARC's comments on these agency responses follow as Appendix 2A.

Acknowledgements

We appreciate the assistance provided by DSHS staff in conducting this study.

Thomas M. Sykes
Legislative Auditor

This report was provided to members of the Joint Legislative Audit and Review Committee in January 2004, and was presented to the Committee at its January 7, 2004, meeting. Because the Committee did not have a quorum at the January 7th meeting, however, a formal vote to approve the report for distribution was delayed until the Committee's April 2004 meeting. On April 21, 2004, this report was approved for distribution by the Joint Legislative Audit and Review Committee.

Senator Jim Horn
Chair

APPENDIX 1 – SCOPE AND OBJECTIVES

Washington Medicaid

SCOPE AND OBJECTIVES

MAY 2003

STATE OF WASHINGTON
JOINT LEGISLATIVE AUDIT
AND REVIEW COMMITTEE

STUDY TEAM

Deborah Frazier

LEGISLATIVE AUDITOR

TOM SYKES

Joint Legislative Audit & Review Committee
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BACKGROUND

Washington Medicaid captures over 30 percent of the state's biennial operating budget and over 75 percent of the biennial operating budget of the Department of Social and Health Services (DSHS). These calculations consider both the federal funds and required state match.

Medicaid is usually thought of as a primary health care insurance program for low-income people, and much of the policy discussion and legislative focus has been directed toward that segment of the Medicaid budget.

However, the primary health care portion of Washington Medicaid represents 60 percent of the $11.6 billion committed biennially. The remaining 40 percent of Medicaid expenditures provides:

- Long term care services for the elderly and disabled;
- Therapies and other support services for persons with developmental disabilities, persons with mental illness, children in foster care, persons receiving substance abuse services, juvenile offenders and at-risk youth; and,
- Administration for all Medicaid services, including funding for local school districts.

The federal Department of Health and Human Services (DHHS) administers the Medicaid program through the Centers for Medicare and Medicaid Services (CMS). CMS delegates some of this administrative authority to a single state agency in each state.

The agreement between the federal government and the single state agency, reflecting the administrative activities and programmatic elements for which federal funds will be provided, is called the "state Medicaid plan". In Washington, DSHS is designated as the single state agency for administration of the state Medicaid plan.

Medicaid, with its administrative and programmatic complexity, pervades the human services segment of the state budget, presenting both challenges and opportunities to policymakers and managers.

MANDATE

The Committee initiated and authorized this study at the October 2002 meeting in response to the need to gain a more thorough understanding of Washington Medicaid.

PROPOSED SCOPE AND OBJECTIVES

The study will enhance the Legislature's decision-making capacity by providing a comprehensive view of Washington Medicaid.

The report will place Washington Medicaid in perspective by providing:

- A descriptive overview of Washington Medicaid;
- A description of the management of Washington Medicaid;
- An inventory and description of the various activities, programs, and services that are Medicaid funded; and,
- A discussion of initiatives to improve the coordination of services and resources to persons receiving Medicaid funded services.

Consistent with previous JLARC human services studies that have pointed to the need for improved coordination among DSHS programs, some of the questions the report will examine are:

- What is required by the federal government?
- What flexibility is given to the state, and what choices have been made?
- Are there opportunities to realize efficiencies by standardizing, consolidating, or simplifying administrative activities or services?
- Which decisions are made from an agency perspective?
- Which decisions are made from an individual program perspective?
- How is information technology used to support management?
- What is the Medicaid Integration Project? What are its fiscal and policy goals?

Where appropriate, this report will make recommendations for change and improvements in the policy framework and management of Washington Medicaid.

The Washington Medicaid project also anticipates following the implementation of services and resources coordination initiatives in future updates to evaluate whether coordination improves customer outcomes and uses state financial resources more effectively and efficiently.

OVERVIEW OF STUDY APPROACH

JLARC staff will conduct the study through research, data analysis, and field work. Consultants will be used as appropriate to provide specialized expertise.

TIMEFRAME FOR THE STUDY

Staff will present the preliminary and final reports at the JLARC meetings in October and December.

JLARC STAFF TO CONTACT FOR THE STUDY

Deborah Frazier (360) 786-5186 frazier_de@leg.wa.gov

APPENDIX 2 – AGENCY RESPONSES

- Department of Social and Health Services
- Office of Financial Management

JLARC's comments on agency responses follow as Appendix 2A.

Note: JLARC provided the Department of Social and Health Services and Office of Financial Management with the opportunity to respond to the Preliminary Report. Their responses to this report (pages 57-64) reflect the recommendations of that version of the report, which proposed six recommendations. However, based on discussions with other legislative staff and with OFM, JLARC combined, modified and broadened two of the recommendations in the Medicaid Preliminary Report. Both DSHS and OFM were provided with an opportunity to comment on the combined recommendation. Neither opted to do so.

RECEIVED
DEC 11 2003
JLARC

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Olympia, WA 98504-5000

December 8, 2003

Tom Sykes, Legislative Auditor
Joint Legislative Audit and Review Committee
506 – 16th Avenue, Southeast
P O Box 40910
Olympia, Washington 98501-2323

Dear Mr. Sykes:

Thank you for the opportunity to respond to the recommendations made in the Washington Medicaid Study Preliminary Report.

DSHS concurs or partially concurs with all of the recommendations made in the report. A chart indicating our response to each recommendation along with our comments is enclosed.

We look forward to presenting our responses to the Committee in January 2004.

Sincerely,

DENNIS BRADDOCK
Secretary

Enclosure

cc: Liz Dunbar, Deputy Secretary
Douglas Porter, MAA, Assistant Secretary
Stan Marshburn, Chief Financial Officer
Kathy Brockman, Chief Administrative Officer
Christy Ridout, Chief Information Officer
Susan Lucas, Director

JLARC Washington Medicaid Study Recommendations
DSHS Response
December 11, 2003

RECOMMENDATION	AGENCY POSITION	COMMENTS
1. DSHS should build on the work of the JLARC Washington Medicaid study and regularly review management functions for efficiency and effectiveness to determine if the total program is coherent and cohesive. These reviews could increase the possibility that the expertise and capacity that has been developed in certain Medicaid managing administrations is available to all Medicaid managing administrations.	Partially Concur	DSHS concurs with the JLARC finding that Medicaid plays an essential role in financing the agency's services. As discussed in the report, over three-quarters of DSHS' expenditures are Medicaid financed. It has been a long-standing state policy to optimize Medicaid financing in order to leverage state funds to provide essential services for low-income residents. However, the linkage to Medicaid financing should not necessarily drive service delivery or agency organization. Service delivery should be developed in a manner that optimizes service coordination for clients and yields cost-effective service delivery design; it should not be based on sources of funding. Service delivery also needs to reflect the relative ability of providers to effectively manage complex delivery systems. The agency organization needs to mirror the categorical populations that DSHS is charged with serving. It also needs to recognize that most of DSHS administrative operations are at a regional and local community level. DSHS has been engaging in across-administration Medicaid initiatives. As noted in the JLARC report, DSHS is embarking on a Medicaid Integration Project that will model the combining of medical, behavioral health and long-term care services through a single contracting entity with the goal of having more integrated care coordination to achieve better health status for clients and to better manage Medicaid expenditures. DSHS already has some experience in this area through its PACE (Program of All-Inclusive Care for the Elderly) pilot project.

		DSHS also has been engaging in cross-administrative effort to improve the financial management of its program. The Payment Review Program (PRP) utilized detailed algorithms to evaluate Medicaid expenditures across the department to assess whether there is fraud, abuse or other inappropriate billing practices. The agency has embarked on an extensive evaluation of administrations' fiscal and management requirements to develop a proposal for a new Medicaid Management Information System (MMIS) to support the entire Medicaid program, and possibly other DSHS administrated programs. DSHS concurs with the JLARC finding that there are opportunities to strengthen its Medicaid financed programs through enhanced coordination across administrations. Secretary Braddock has tasked his Assistant Secretaries with developing a mechanism to enhance program coordination. The department can report on progress with this effort in April 2004.
2. The Caseload Forecast Council should create and adopt forecasts for the biennial $500 million in community-based services to persons with developmental disabilities funded under the Community Alternatives Program (CAP) waiver, as is already accomplished for the Community Options Program Entry System (COPES) waiver for older and physically disabled people.	Concur	If the agency is successful in securing approval from CMS for four waivers, this recommendation should be revised to recommend forecasting for all four waivers.
3. The Legislature should consider engaging a consultant to examine the 40 percent or $5 billion biennially, in Medicaid programs managed outside the Medical	Partially Concur	The department concurs that there is a need to evaluate opportunities for cost containment within mental health, alcohol and substance abuse, long-term care programs and those for people with developmental disabilities. The department's Aging and Disability Services Administration is already conducting an extensive analysis of DDD programs for the purpose of identifying cost containment

Assistance Administration and evaluate opportunities for cost containment.		opportunities. This analysis included discussions with a wide variety of knowledgeable individuals including stakeholder groups and staff from the Legislature, the Governor's Office, ADSA program and field, and other DSHS functional areas. The DD cost containment project has identified more than 30 projects to be investigated during the 03-05 biennium. Projects range from the very technical to broad management activities. Some of the identified projects will result in no quantifiable savings, some may result in large savings. But all are areas that have been identified as having potential for improving credibility and accountability in DD programs and/or making expenditures more efficient in the programs. We anticipate that this project will generate savings or cost avoidance totaling $1.5 million during FY04. Additionally, the ADSA Home and Community Services Division established a Quality Assurance Unit in 2002. This unit reviews activities in all of the HCS and Area Agency on Aging field offices to ensure that policies are consistently followed. Through its 2002 monitoring efforts, the unit identified $389,000 in cost savings and $12.2 million in cost avoidance. A similar unit has recently been established to monitor activities in DDD offices. For mental health and substance abuse services, cost containment may not yield significant results due to the capped nature of these programs and to the under-capitalization of substance abuse services.
4. DSHS should continue the effort underway in the Aging and Disability Services Administration to assure consistency in DD client assessment and rate setting, and include information about this effort and plans for implementation in the required reporting related to the JLARC Performance Audit of	Concur	

the Division of Developmental Disabilities. Reporting should discuss how the Administration assures that the variance in rates paid for similar services by different programs is supported by data.		
5. DSHS should become current on federally required Medicaid Statistical Information System (MSIS) reporting.	Concur	
6. DSHS should assure that the proposed new MMIS unifies Medicaid expenditure and beneficiary data to support comprehensive legislative policy making and DSHS management.	Concur in Principle	Until the feasibility study and system requirements work are complete, we cannot assure that the new MMIS will unify all data for all Medicaid services.

STATE OF WASHINGTON
OFFICE OF FINANCIAL MANAGEMENT
Insurance Building, PO Box 43113 • Olympia, Washington 98504-3113 • (360) 902-0555

December 16, 2003

RECEIVED
DEC 16 2003
JLARC

TO: Tom Sykes, Legislative Auditor
Joint Legislative Audit and Review Committee

FROM: Marty Brown, Director MS

SUBJECT: JLARC PRELIMINARY REPORT (MEDICAID)

Thank you for the opportunity to review and respond to the Joint Legislative Audit and Review Committee's preliminary report entitled, "Washington Medicaid Study."

The Office of Financial Management agrees with many of your recommendations relating to efficient and effective coordination of programs, the role of forecasting, and data improvement needs.

RECOMMENDATION	OFM POSITION	COMMENTS
Recommendation 1: DSHS should build on the work of the JLARC Washington Medicaid study and regularly review management functions for efficiency and effectiveness to determine if the total program is coherent and cohesive. These reviews could increase the possibility that the expertise and capacity that have been developed in certain Medicaid managing administrations is available to all Medicaid managing administrations.	Partially concur	The recommendation is consistent with efforts currently underway to better integrate Medicaid services across programs. Further, it is always desirable to remain vigilant about and to share experiences of best practices among managers. It is important to design and manage programs based on client and provider needs rather than on the funding source of the programs.
Recommendation 2: The Caseload Forecast Council (CFC) should create and adopt forecasts for the biennial $500 million in community-based services to persons with developmental disabilities funded under the Community Alternatives Program (CAP) waiver, as is already accomplished for the Community Options Program Entry System (COPES) waiver for older and physically disabled people.	Partially concur	A forecast of potentially eligible persons not presently being served under CAP is of value as a needs assessment, but the Caseload Forecast Council (CFC) might not be the appropriate venue for such a forecast. Further discussion with the CFC is needed before a decision is made on this forecast.

Recommendation 3: The Legislature should consider engaging a consultant to examine the 40 percent, or $5 billion biennially, in Medicaid programs managed outside the Medical Assistance Administration and evaluate opportunities for cost containment.	Concur	The Lewin report, which assessed and summarized promising cost containment activities in Medical Assistance Administration, provided valuable guidance for policy makers. Given the fiscal outlook for the 2005-07 biennium, and the likelihood that future program constraints will be necessary, a consultant review of further cost-containment opportunities should be considered.
Recommendation 4: DSHS should continue the effort underway in the Aging and Disability Services Administration to ensure consistency in DD client assessment and rate setting, and include information about this effort and plans for implementation in the required reporting related to the JLARC Performance Audit of the Division of Developmental Disabilities. Reporting should discuss how the Administration ensures that the variance in rates paid for similar services by different programs is supported by data.	Concur	
Recommendation 5: DSHS should become current on federally required Medicaid Statistical Information System (MSIS) reporting.	Concur	
Recommendation 6: DSHS should ensure that the proposed new MMIS unifies Medicaid expenditure and beneficiary data to support comprehensive legislative policy making and DSHS management.	Concur	The replacement of the existing information system provides an exceptional opportunity to improve capturing, reporting, and consolidating data to support many users' needs as well as enhance program management.

Again, thank you for the opportunity to provide comment on this report.

cc: Wayne Kawakami, Office of Financial Management

APPENDIX 2A – JLARC'S COMMENTS ON AGENCY RESPONSES

We are pleased that OFM and DSHS concur or partially concur with the study's six recommendations. However, JLARC would like to clarify Recommendation 1, Oversight of a Decentralized Management Structure. The report does not recommend a reorganization or change in the service delivery of DSHS programs. As noted in the report, any management model can be effective with sufficient collaboration and communication. However, as exemplified by the delay in the required MSIS reporting, Medicaid is not viewed as a cohesive program. Certain DSHS entities have the capacity to meet these federal requirements, while others do not. The inability to meet federal reporting requirements is detrimental to the program as a whole. Currently, a group of managerial peers is responsible for meeting requirements such as MSIS, without a mechanism to ensure compliance. We also noted management functions where DSHS organizations had "best practices" that could be shared with other entities, but were either not shared, or were slow to be implemented due to the lack of a centralized oversight mechanism. Regular reviews of the management functions for efficiency and effectiveness of the program as a whole—not solely opportunities to collaborate—could improve communication within DSHS, and ultimately improve service delivery to DSHS clients.

APPENDIX 3 – RATES INVENTORY

Chapter Four describes rate setting for Washington Medicaid-funded services. This appendix provides an inventory of Medical Assistance services and the services provided by the three waivers. The first page is an inventory of Medical Assistance's largest expenditures, based on fee-for-service provider data. All data is based on CY 2002 monthly averages, with the exception of physician services, which are based on FY 2002 data. Information provided includes the total number of claims by service, as well as the total expenditures for each service. Also included are the average monthly premiums for Healthy Options clients, as well as child delivery rates, and average monthly deliveries; annually, Washington Medicaid pays for 40 percent of births in this state.

Rate setting and negotiations for services provided under three waivers are handled in the newly merged Aging and Disabilities Services Administration:

- Community Alternative Program (CAP) waiver, which serves clients with developmental disabilities;
- Community Options Program Entry System (COPES) waiver, which serves elderly and disabled clients; and
- Medically Needy Residential (MNR) waiver, which serves clients with similar characteristics to those in COPES, with the distinction that these clients qualify based upon their medical need, and participate at a higher financial rate than COPES clients.

The recently-merged Administration plans to apply the techniques and rate structures developed for services to the elderly and disabled to DD services. Currently, the Administration is working with a consultant to analyze DD services that can use evaluation tools and rate setting techniques used by Aging. This may result in greater consistency and logic in the rates for similar services.

As highlighted in Chapter Four, DD regional offices have considerable discretion in setting rates. Rates for several services are negotiated regionally, and are not formula driven. While case managers and local resource managers consider a uniform set of factors when determining administrative costs and assessing clients, each of these components is non-standard, as reflected by the large number of services in the inventory without standardized bands of rates. In contrast, rates for COPES services for individual clients are guided by a standardized assessment tool that is intended to provide a means of paying consistent rates for clients with similar needs. It is also worth noting the large array of payment options available in the CAP waiver for similar services. Although COPES services are also tailored to the needs of individual clients, case managers have less discretion, assuring greater congruity in rates paid for services to these clients.

Basic Medicaid Services Inventory

	Average Rate/Claim	Total Number of Claims	Total Reimbursed
Drugs	$51	10,758,836	$545,048,134
Inpatient Hospital Claims	$4,838	88,742	$429,294,593
Outpatient claims	$234	949,141	$222,546,430
Dental Services	$34	3,161,527	$108,925,790
Physician Services			
Anesthesia	$699	56,317	$39,337,683
Children Screens	$51	562,254	$28,689,685
Maternity	$276	103,116	$28,484,024
Adult Office Visits	$32	690,224	$21,948,854
Lab	$9	1,372,494	$12,031,416
All Other	$24	8,578,354	$203,860,300
	Managed Care Premium Rates (Per Member, Per Month)	**Average Number of Clients**	**Newborn and Monthly Premiums**
Healthy Options	$118.16	449,298	$53,090,021
	Child Delivery Case Rate: Average Premiums	**Monthly Premium Count**	**Child Delivery Case Rate: Premium Payments**
Child Delivery Case Rate	$4,200	1,432	$6,012,650

Home and Community Basic Services Waiver Inventory

SERVICE NAME	Total FY03 Expenditure	# Unduplicated Clients	Unit	Published Rate	Average Rate Paid Per Unit of Utilization	Waiver
Community Residential						
Supported Living - Daily: Payment for training and support assistance to enable a DDD client to live in an independent setting. Services include: providing assistance to clients in performing necessary functions or performing necessary functions.	$160,803,004	3,359	day	Vendor Unique	$142.99	CAP
COPES Assisted Living: Placement of COPES eligible client in an assisted living facility.	$84,352,501	6,103	day	Varies by Geographic Region and Level of Client Care	$62.90	COPES
COPES Adult Family Home Services: Placement of COPES eligible client in an adult family home.	$59,517,853	4,207	day	"	$68.08	COPES
COPES Enhanced Adult Residential Care (EARC) Services: Placement of a COPES eligible client in a boarding home.	$15,581,517	1,462	day	"	$55.03	COPES
DDD Group Home - Adult: Services and payment for an adult entering and living in a contracted DDD group home.	$15,454,262	473	day	Vendor Unique	$124.29	CAP

SERVICE NAME	Total FY03 Expenditure	# Unduplicated Clients	Unit	Published Rate	Average Rate Paid Per Unit of Utilization	Waiver
PACE/Elder Place-Seattle	$6,253,984	224	day	$110.33	$113.44	COPES
Licensed Staff Residential Home: Payment for a child (under 18) with specialized needs, who is in voluntary out-of-home placement, and living in a licensed staffed residential home. Payment for provider time and expertise when service is exceptionally demanding and includes supervision, physical care and emotional support related to the developmental needs and optimum care of the child.	$5,667,906	78	month	Non-Std	$284.98	CAP
Other Supported Living/Full Day: Payment to a DDD training and support provider (contracted) working to help client live in an independent setting. Includes assisting client in performing essential functions.	$5,194,624	82	day	Vendor Unique	$178.92	CAP
Family Foster Care, Specialized Support: Payment for additional maintenance costs for children with exceptionally and highly individualized needs. Payment for foster provider time and expertise necessary to perform exceptionally demanding supervision, habilitation, physical care & emotional support.	$4,199,072	294	month	Non-Std	$1,357.60	CAP
DDD Community Support Attendant Care Adult (Own Home): Payment for additional care and/or training for a DDD client not in a division-funded residential program. Services are more intense than those provided by the generic program serving the client.	$2,908,137	267	each	Non-Std	$314.24	CAP
DDD Community Support Attendant Care (Adult Family Home): Payment for additional care and/or training for a DDD client residing in an adult family home. The services are more intense or different than those provided through the regular adult family home program serving the client.	$1,974,651	138	each	Non-Std	$830.47	CAP
Cost of Care Adjustment - Supported Living: Payment to a contracted provider for the cost of care of supporting clients in Supported Living Services when the program/residence is temporarily at less than full strength.	$1,912,170	251	day	up to $325	$150.92	CAP

SERVICE NAME	Total FY03 Expenditure	# Unduplicated Clients	Unit	Published Rate	Average Rate Paid Per Unit of Utilization	Waiver
DDD Staff Add-On: Payment for client specific staffing adjustments.	$1,594,094	200	hour	$13.81 or $14.08 or $14.35	$14.76	CAP
Alternative Living - Individual Provider: Payment for a client with a contracted individual provider of intensive services on a one-to-one basis for training in skills improving community survival (home maintenance, transportation, socialization, etc).	$1,508,768	579	hour	up to $13.50	$13.47	CAP
Foster Group Care Specialized Support - Monthly: Payment for a child with specialized needs, who is in out-of-home voluntary group care. Includes: purchase of foster group provider time, exceptionally demanding supervision, habilitation, physical care and emotional support related to the developmental needs of the child.	$1,485,456	44	month	Non-Std	$3,888.69	CAP
Attendant Care/Staff Add-On by Agency Provider: Payment to contracted provider for additional care and/or training for DDD children or youth in voluntary out-of-home foster care or supported living. Services are more intense than those provided by the generic program serving the client.	$954,615	43	hour	up to $36.26	$17.61	CAP
DDD Community Support Agency Attendant Care (Adult, Own Home): Payment to an agency for additional care and/or training for a DDD client not in a division-funded residential program.	$607,472	38	each	Non-Std	$576.66	CAP
Companion Home-Monthly Rate: Payment for intensive individual supportive living services, also known as "difficulty-of-care." Also pays or services to ensure client safety and well-being for a qualified adult living in a one person foster-family-home residence.	$517,778	13	month	Non-Std	$3,973.98	CAP
DDD Community Support Attendant Care (Parent Provider): Authorization of payment to a parent provider for the additional care and training of their own adult child.	$451,425	49	each	Non-Std	$342.76	CAP
Intensive In-Home Support (Agency, In Home): Payment to a contracted agency provider for intensive supervision and/or personal care of a child to prevent out- of-home placement.	$441,699	17	month	Non-Std	$3,332.01	CAP

SERVICE NAME	Total FY03 Expenditure	# Unduplicated Clients	Unit	Published Rate	Average Rate Paid Per Unit of Utilization	Waiver
In-Home Specialized Support (Agency, In Home): Payment to a contracted agency provider for intensive supervision and/or personal care of a child to prevent out-of-home placement.	$237,537	14	hour	Non-Std	$15.48	CAP
MNR Assisted Living: Client is placed in an assisted living facility.	$190,516	43	day	Varies by Geographic Region and Level of Client Care	$64.23	MNRW
Family Foster Care Specialized Support - Agency Provider: Payment for additional maintenance costs for children with exceptionally and highly individualized needs. Includes: agency provider assistance performing exceptionally demanding supervision, habilitation, physical care and emotional support related to the developmental needs of the child.	$160,183	18	month	Non-Std	$133.04	CAP
COPES CARE Assisted Living: Placement of COPES client in an assisted living facility.	$112,691	54	day	Varies by Geographic Region and Level of Client Care	60.25	COPES
MNR Adult Family Home Services: Client is placed in an adult family home.	$110,783	29	day	"	$65.37	MNRW
In - Home Specialized Support-Individual Provider-Hourly: Payment to a contracted individual provider for intensive supervision and/or personal care of a child to prevent out-of-home placement.	$108,445	11	hour	Non-Std	$10.09	CAP
Intensive In-Home Support (Individual Provider, In Home): Payment to a contracted individual provider for intensive supervision and/or personal care of a child to prevent out- of-home placement.	$87,171	5	month	Non-Std	$1,662.85	CAP
COPES CARE Adult Family Home: Placement of a COPES client in an adult family home.	$63,036	39	day	Varies by Geographic Region and Level of Client Care	$63.94	COPES
Companion Home - Daily Rate: Payment for intensive individual supportive living services, also known as "difficulty-of-care." Also pays or services to ensure client safety and well-being for a qualified adult living in a one person foster-family-home residence.	$53,204	2	day	Non-Std	$167.67	CAP

SERVICE NAME	Total FY03 Expenditure	# Unduplicated Clients	Unit	Published Rate	Average Rate Paid Per Unit of Utilization	Waiver
COPES CARE EARC Services: Placement of a COPES client in a boarding home.	$28,480	16	day	Varies by Geographic Region and Level of Client Care	$54.70	COPES
Cost of Care Adjustment: Payment to a provider for serving clients in Supported Living Services when the program or residence is temporarily at less than full strength.	$19,345	5	day	up to $325	$220.85	CAP
Supported Living Client Evaluation: Reimbursement to a Supported Living contractor to assess whether to accept a referred client.	$12,560	24	hour	$20.00	$20.00	CAP
MNR CARE Adult Family Home: Client is placed in an adult family home.	$4,777	1	day	Varies by Geographic Region and Level of Client Care	$78.31	MNRW
MNR CARE Assisted Living: Placement of client in a licensed and contracted assisted living facility.	$4,413	3	day	"	$59.59	MNRW
MNR EARC Services: Placement of a client in a contracted boarding home with a COPES contract.	$3,571	2	day	"	$59.51	MNRW
Personal Care Services						
COPES Personal Care- Individual Hourly: Personal care services in accordance with the comprehensive assessment and service plan; plan requires one through 184 hours service per month.	$84,620,007	11,107	hour	$7.68	$7.82	COPES
COPES Personal Care: Payment to a COPES agency personal care provider.	$63,943,057	8,999	hour	$13.44	$13.70	COPES
COPES Personal Care — Individual — Monthly: Personal care services for plan requiring 185 hours of service or more per month. Payment is at the COPES monthly rate.	$25,329,191	2,190	month	$1,420.80	$1,367.54	COPES
COPES Personal Care — Individual — day: Implementing personal care services in accordance with the comprehensive assessment and service plan. The plan requires at least six hours service per day or more than 184 hours service per month.	$5,961,914	579	day	$46.08	$64.69	COPES

SERVICE NAME	Total FY03 Expenditure	# Unduplicated Clients	Unit	Published Rate	Average Rate Paid Per Unit of Utilization	Waiver
COPES Individual Family Provider — Parent / Child Hourly: Authorization of personal care services; provider is either the parent of the client or the child of the client (18-21). Service plan requires one through 184 hours service per month.	$1,229,450	276	hour	$7.68	$7.69	COPES
COPES Individual Family Provider — Parent / Child Monthly (IRS): Complies with IRS regulations for child/parent providers for the authorization of personal care services. Provider is either the parent of the client or the child of the client (18-21); requires 185 hours service or more per month.	$665,052	96	month	$1,420.80	$1,393.65	COPES
COPES Individual Provider Fundamental Caregiver Training: Reimbursement to individual providers who complete the department's Fundamentals of Caregiver course.	$518,254	2,619	hour	$7.68	$7.68	COPES
COPES Individual Provider Continuing Education: Reimbursement to individual providers who complete DSHS's Continuing Education course (required annually for continuing employment as a personal care provider).	$412,654	4,508	hour	$7.68	$7.68	COPES
COPES Individual Family Provider, Parent / Child Continuing Education (IRS): Payment for child/parent providers for the authorization of modified caregiver training. Provider is either parent of the client or the child of the client (18-21 yrs.).	$40,784	11	day	$46.08	$62.30	COPES
COPES Individual Provider Modified Caregiver Self Study: Reimbursement to individual providers who complete the department's Modified Caregiver self study (required for employment as a personal care provider).	$12,403	187	hour	$7.68	$7.68	COPES
COPES Individual Family Provider — Parent / Child Individual Provider Fundamental Caregiver Training: Complies with IRS regulations for child/parent providers; provider is either the parent of the client or the child of the client (18- 21).	$4,101	20	hour	$7.68	$7.68	COPES

SERVICE NAME	Total FY03 Expenditure	# Unduplicated Clients	Unit	Published Rate	Average Rate Paid Per Unit of Utilization	Waiver
COPES Individual Family Provider — Hour: Parent / Child Continuing Education (IRS): Payment to comply with IRS regulations for child/parent providers for the authorization of modified caregiver training. The provider is either parent of the client or the child of the client (18- 21).	$2,796	38	hour	$7.68	7.68	COPES
COPES Individual Family Provider — Parent / Child Modified Caregiver Self Study (IRS): Complies with IRS regulations for child/parent providers; provider is either the parent of the client or the child of the client (18-21).	$146	3	hour	$7.68	$7.68	COPES
Respite Care						
Family Support Respite Care-Hourly: Arranging and making payment for services provided on an hourly basis to permit time limited respite from caregiver and household responsibilities and to enable the client to remain in the least restrictive setting.	$3,084,575	2,254	hour	$7.68	$7.68	CAP
Family Foster Care Respite-Hourly (In Foster Home): Payment for respite care in a licensed foster home for relief supervision and as support to the foster provider.	$867,321	143	hour	$7.68 - $21.56	$8.52	CAP
Family Support Respite Care-Agency: Arranging and making payment for In-home respite services provided by a contracted Home Care or Home Health agency on an hourly, daily or monthly basis to permit time limited respite from caregiver and household responsibilities.	$591,638	328	each	Non-Std	$76.63	CAP
COPES Adult Day Care - Day: Provides adult day care to COPES clients who meet the day care service eligibility.	$460,712	185	day	$36.48	$32.64	COPES
DDD Family Support Out-of Home Respite Care-Hourly: Arranging and making payment for services provided on an hourly basis to permit time limited respite from caregiver and household responsibilities and to enable the client to remain in the least restrictive setting.	$434,358	296	hour	$7.68	$7.68	CAP

SERVICE NAME	Total FY03 Expenditure	# Unduplicated Clients	Unit	Published Rate	Average Rate Paid Per Unit of Utilization	Waiver
Attendant Care Family Support Provides payment for longer, more intensive care than the family can receive through the respite care program.	$256,415	72	each	Non-Std	$46.50	CAP
Family Foster Care Respite-Hourly (Out of Foster Home): Payment for respite care where the service is provided out of a licensed foster home for relief supervision and support to the foster provider.	$251,186	39	hour	$7.68 - $21.56	$9.05	CAP
Family Support Respite Care-Daily: Arranging and making payment for services provided on a daily basis to permit temporary respite from caregiver and household responsibilities and to enable the client to remain in the least restrictive setting.	$239,184	200	day	$61.44	$61.44	CAP
Client Care - Attendant Care: Payment for additional care and/or training for DDD children or youth in voluntary out-of-home foster care. The services are more intense than those provided by the generic program serving the client.	$216,557	35	hour	$7.68	$7.68	CAP
DDD Family Support Out-of-Home Respite Care-Day: Arranging and making payment for services provided on a daily basis to permit temporary respite from caregiver and household responsibilities and to enable the client to remain in the least restrictive setting.	$178,471	104	day	$61.44	$61.44	CAP
In-Home Respite - Hourly: Payment for time-limited respite in the family home, helps to prevent institutionalization of the child or youth.	$159,814	24	hour	$7.68 - $21.56	$8.00	CAP
Intensive In-Home Support-(Out of Home): Payment for out-of-home respite care for VPP child served with in-home specialized support.	$99,798	7	month	Non-Std	$2,137.74	CAP
Family Foster Care Respite-Full Day-Out of Foster Home	$85,607	35	day	up to $61.44	$58.07	CAP
Family Foster Care Respite-Full Day (In Foster Home): Payment for respite care in a licensed foster home for relief supervision and as support to the foster provider.	$75,758	38	day	up to $61.44	$61.64	CAP

SERVICE NAME	Total FY03 Expenditure	# Unduplicated Clients	Unit	Published Rate	Average Rate Paid Per Unit of Utilization	Waiver
In Home Respite Care - Hourly	$58,498	11	hour	$10.50	$10.50	CAP
DDD MH Respite Bed Scheduled (out of home): Respite care for client in danger of losing their current residential setting as a result of their behavior; or to authorize services for client moving from Service Code 7261 (MH CRISIS) once the level of care need	$50,051	23	day	Non-Std	$112.20	CAP
Family Support Community Guide: Arranging and making payment for those services provided by a community guide following a plan developed by the case manager and the family of the client to increase access to informal community supports.	$37,214	227	each	up to $212	$24.04	CAP
COPES Adult Day Care - Hourly: Adult day care services to clients who meet COPES eligibility (not Adult Day Health Services).	$33,702	16	hour	$9.10	$7.82	COPES
In-Home Respite - Hourly (Out of Home): Payment to provider for services on an hourly basis to permit time limited respite for the care giver and to enable the child or youth to remain in the least restrictive environment. This service is provided outside the family home and helps to prevent institutionalization of the child or youth.	$16,037	7	hour	$7.68 - $21.56	$7.68	CAP
In-Home Respite - Full Day (Out of Home): Payment to permit time-limited respite to enable the child or youth to remain in the least restrictive environment. Provided outside the family home and helps to prevent institutionalization of the child or youth	$11,808	7	day	up to $61.44	$69.88	CAP
In-Home Respite - Full Day (In Home): Payment for services to permit time-limited respite to enable the child or youth to remain in the least restrictive environment. Provided in the family home and helps to prevent institutionalization of the child or youth.	$4,807	5	day	up to $61.44	$92.17	CAP
Out of Home Respite Care - Hourly	$830	1	hour	$10.50	$10.50	CAP
DDD Group Home - Respite/Preplacement: Provision of a respite stay or preplacement visit in a DDD Group Home when a bed is held vacant for that purpose.	$272	1	day	Vendor Unique	$90.72	CAP

SERVICE NAME	Total FY03 Expenditure	# Unduplicated Clients	Unit	Published Rate	Average Rate Paid Per Unit of Utilization	Waiver
Home Delivered Meals						
COPES Home Delivered Meals: One nutritionally balanced meal per day, delivered to the client's home (liquid meal supplements do not meet this federal requirement).	$3,385,229	3,147	each	up to $6.80	$5.42	COPES
Specialized Medical Equipment and Supplies						
Personal Emergency Response System Service: Monthly equipment rental and monitoring of a PERS.	$2,108,848	7,730	month	Non-Std	$32.47	COPES
COPES Specialized Medical Equipment and Supplies: Include devices, controls or appliances which enable COPES clients to improve their abilities to perform activities of daily living or to perceive, control or communicate with the environment in which they live.	$784,400	1,686	each	up to $646.91	$319.38	COPES
COPES Personal Emergency Response System Installation: Initial installation of COPES personal emergency response system (PERS) equipment. PERS is an electronic device, which enables certain high-risk clients to secure help in the event of an emergency.	$88,452	2,204	each	Non-Std	$39.11	COPES
Family Support Specialized Aids: Arranging for and making payment for specialized aids necessary to meet the client's needs. May include: the purchase, rental, loan or refurbishment of specialized aids or equipment.	$77,914	100	each	up to $1,200	$297.13	CAP
Professional Services - Special Aids: Payment for specialized aids deemed necessary to meet the needs of the child or youth and for which no other appropriate resource is available.	$3,991	3	each	up to $900	$96.00	CAP
DDD Community Support - Specialized Aids: Arranging and making payment for specialized aids deemed necessary to meet the client's needs and for which no other appropriate resource is available. Aids may include, but are not limited to, the purchase, rental, loan or refurbishment of specialized aids or equipment.	$2,245	2	each	up to $750	$1,112.50	CAP

SERVICE NAME	Total FY03 Expenditure	# Unduplicated Clients	Unit	Published Rate	Average Rate Paid Per Unit of Utilization	Waiver
MNR Specialized Medical Equipment & Supplies: Client is over income and not eligible for MPC or COPES services. Include devices, controls or appliances which enable clients to improve their abilities to perform activities of daily living or to perceive, control or communicate with the environment in which they live.	$628	1	each	up to $646.91	$628.19	MNRW
Medications: Prescription drugs not covered by the Medicaid state plan.	$138	1	each	Non-Std	$138.39	CAP
Behavior Therapy						
DDD Professional Services Payment for contracted professional services. Services may include but are not limited to: Consultation, evaluation, diagnosis, and treatment.	$2,068,092	1,024	hour	Non-Std	$54.25	CAP
Behavior Management/Counseling: Development and implementation of programs to help clients behave in ways that enhance their inclusion in the community, including direct interventions and may include work with other persons in the client's life.	$319,875	319	hour	Non-Std	$57.52	CAP
DDD Collaborative Work Plan: Professional Psychiatric services for DDD eligible clients.	$33,777	38	each	Non-Std	$213.78	CAP
Nursing Services						
COPES RN Delegation: Payment for Nurse Delegation services provided to a COPES client in an adult family home. Includes initial nursing assessment, reassessment, teaching or supervising a nursing assistant and related travel time and collateral contacts.	$712,718	1,478	per 15 minutes	$8.08	$8.07	COPES
Nurse Delegation/Nursing Services: Payment to a registered nurse or a nursing agency for nurse delegation services including the initial visit, additional teaching and supervisory visits.	$532,850	1,480	each	$8.08	$8.08	CAP
Professional Services - Nursing Services: Payment to a contracted registered nurse or nursing agency for private duty nursing services to a child or youth.	$383,678	13	hour	Non-Std	$23.22	CAP
COPES Skilled Nursing: Services within the scope of the state's Nurse Practice Act, provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse.	$310,532	153	per visit	up to $50.00	$49.20	COPES

SERVICE NAME	Total FY03 Expenditure	# Unduplicated Clients	Unit	Published Rate	Average Rate Paid Per Unit of Utilization	Waiver
Nursing Services provided by a licensed nurse to provide or teach skilled nursing tasks.	$198,084	32	each	Non-Std	$23.39	CAP
COPES Skilled Nursing Special Circumstances: Provision of COPES skilled nursing services to providers using a special rate due to extraordinary client circumstances (only used only when special rate has been approved for the AAA contracted provider).	$42,705	7	per visit	$50.01 - $85.15	$66.64	COPES
COPES Home Health Aide: Includes health-related assistance with hands-on personal care, ambulation and exercise, and self-administered medications.	$32,955	9	per visit	up to $18.07	$19.01	COPES
RN Delegation Services: Payment to a registered nurse or a nursing agency for nurse delegation services including the initial visit, additional teaching and supervisory visits (only for VPP clients, between 18 and 21).	$5,212	9	each	$8.08	$8.08	CAP
MNR RN Delegation: Payment for Nurse Delegation services as provided to a MN client residing in an adult family home. Includes: initial nursing assessment, reassessment, teaching or supervising a nursing assistant and related travel time and collateral.	$582	4	per 15 minutes	$8.08	$8.08	MNRW
Environmental Adaptations						
COPES Environmental Modification: Physical adaptations to the client's own home, required by the client's comprehensive assessment and service plan; prevents client's placement into a nursing facility.	$629,543	24	each	$1.08 - $431.27	$852.99	COPES
Environmental Modifications: Physical adaptations to client's home which enable the individual to function with greater independence. Includes the purchase of required materials.	$17,215	12	each	Non-Std	$796.63	CAP
Transportation						
DDD Community Support Transportation (Miles): Reimbursement to a provider for the use of a privately owned vehicle to transport a client to receive DDD services or for the provider to perform some client related function.	$261,165	653	mile	$0.31	$0.31	CAP

SERVICE NAME	Total FY03 Expenditure	# Unduplicated Clients	Unit	Published Rate	Average Rate Paid Per Unit of Utilization	Waiver
COPES Transportation: Provides the client with access to essential community services and resources (service is in addition to the brokered transportation to medical services available to the client; does not replace or substitute this service).	$84,311	228	mile	0.21 or Contract Price	$5.92	COPES
Client Care - Transportation: Payment for transportation incurred by or on behalf of a child in out-of-home foster care receiving DDD services. May include the cost of escort service or non-escort travel time when required.	$75,135	68	each	up to $800	$290.25	CAP
DDD VPP Transportation – Miles: Arranging and making payment for the cost of transportation incurred by or on behalf of a DDD client.	$68,913	61	mile	$0.31	$0.31	CAP
Transportation /Family Support: Arranging and making payment for the cost of public transportation incurred by or on behalf of a client receiving Family Support services.	$30,674	132	mile	$0.31	$0.31	CAP
DDD Community Support, Continuing Transportation/Escort: Payment for the cost of continuing public transportation incurred by or on behalf of a DDD client.	$25,585	18	each	up to $800	$125.23	CAP
Transportation - Family Support: Payment for the cost of public transportation incurred by or on behalf of a client. May include the cost of escort service of non-escort travel time when required.	$7,559	20	each	up to $200	$43.80	CAP
DDD Community Support, One-Time Transportation: Reimbursement to a provider for the use of public/private transportation to transport a DDD client.	$40	1	each	up to $800	$40.00	CAP
Extended State Plan Services						
Professional Services: Payment for therapeutic services. May include: counseling, physical, occupational therapies, communication and psychological therapies.	$151,106	59	each	Non-Std	$91.43	CAP
Communication Therapy: Services provided or supervised by a licensed therapist.	$74,382	73	each	Non-Std	$51.10	CAP
Occupational Therapy: Services provided or supervised by a licensed occupational therapist.	$23,999	27	each	Non-Std	$42.00	CAP

SERVICE NAME	Total FY03 Expenditure	# Unduplicated Clients	Unit	Published Rate	Average Rate Paid Per Unit of Utilization	Waiver
Physical Therapy Services: Services provided or supervised by a licensed physical therapist to alleviate the dysfunction of the client and to improve client's quality of life.	$21,027	19	each	Non-Std	$213.75	CAP
Professional Services - Evaluations: Payment to determine the eligibility and need for DDD services and other services needed in the areas of developmental, psychological, emotional and medical areas of deficit of the child or youth in voluntary out-of-home foster care placement.	$15,795	10	hour	Non-Std	$75.00	CAP
Client Training						
COPES Client Training: Service provides client training by licensed and certified provider types with expertise in the area of the client's training need.	$180,886	366	hour	$30.75	$52.43	COPES
Staff and Family Consultation and Training						
Family Consultation and Training: Family consultation and training may include 1:1 training related to the participant's needs; support groups, classes and attendance at authorized conferences and trainings.	$8,622	21	each	Non-Std	$90.00	CAP

APPENDIX 4 – ADDITIONAL DATA ON MANDATORY AND OPTIONAL SERVICES

States are required by federal law to serve certain populations and pay for certain services (mandatory). States have the option to serve other populations and pay for other services (optional). This topic is discussed in some detail in Chapter Two of this report.

This appendix provides:

- A table displaying mandatory and optional services, divided between acute care and long term care.
- A series of charts presenting additional information about mandatory and optional populations and services, comparing Washington with the nation.

A WORD ABOUT DATA

The accuracy, reliability, and timeliness of nationally reported Medicaid data have long been cause for concern among researchers and the General Accounting Office (GAO). A common observation among Medicaid managers, in Washington and elsewhere, is that the data and format required to comply with federal reporting is simply not useful to their daily operations.[120]

Submission of the required reports is viewed by the states as a compliance exercise; therefore, the submissions are not carefully scrutinized. Like most data sets, the numbers are most accurate in the aggregate, and become less accurate the farther one "drills down" into the detail. The GAO, and other research groups, have found that the best source for timely and accurate data about specific aspects of the national Medicaid program is to survey each state.[121]

It was not feasible for JLARC to conduct a nationwide survey to capture the data necessary to present both a comprehensive and detailed look at beneficiaries and expenditures for Washington Medicaid. This report has emphasized the difficulties in obtaining data about the total Washington Medicaid program. The data presented in these charts represent the best estimates for the comprehensive program that Medicaid managers could generate.

The report also highlighted that these difficulties carry through to national numbers. Despite these limitations, the data used to produce the national charts are the best that are readily available to researchers working with the Medicaid program. **Throughout this appendix, national data is for 1998, the last year for which this data is complete.** These national figures are compared to Washington data for 2001.

[120] One former Medicaid official documented this view: "States keep data for their own purposes that is different from what they report to CMS, because the CMS reports are not viewed as being particularly useful." Correspondence from T. Riley, National Academy of State Health Policy, 12/19/2000, in KFF p 148.

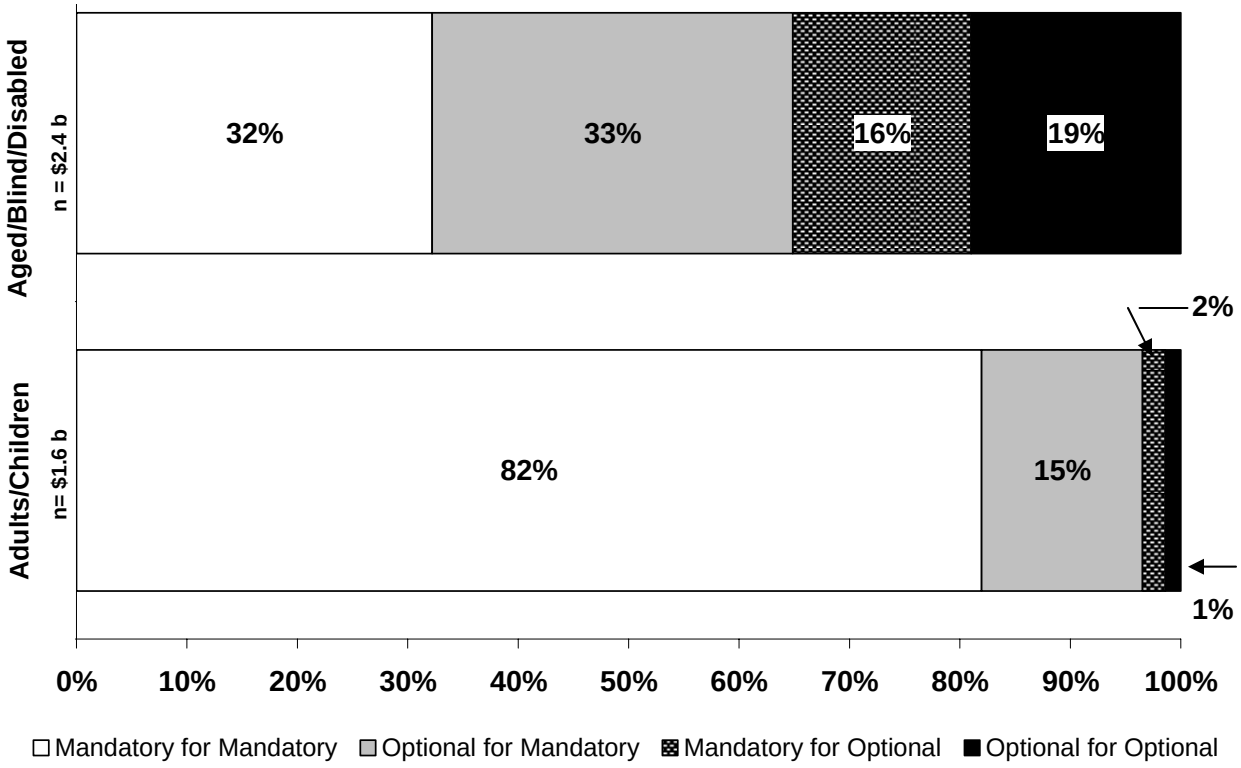
[121] "Medicaid Enrollment: Amid Declines, State Efforts to Ensure Coverage After Welfare Reform Vary," General Accounting Office, September 10, 1999 (GAO-HEHS-99-163).

Figure A – Medicaid Statutory Benefits Categories

"Mandatory" Items and Services Acute Care	**"Optional" Items and Services Acute Care**
• Physicians' Services • Laboratory and x-ray services • Inpatient hospital services • Outpatient hospital services • Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21 • Family planning services and supplies • Federally-qualified health center (FQHC) services • Rural health clinic (RHC) services • Nurse midwife services • Certified nurse practitioner services	• Prescribed drugs • Medical care or remedial care furnished by licensed practitioners under state law • Diagnostic, screening, preventive, and rehabilitative services • Clinic services • Dental services, Dentures • Physical therapy and related services • Other specified medical and remedial care
Long-term Care	**Long-term Care**
Institutional Services • Nursing Facility (NF) services for individuals 21 or over	• Intermediate care facility for individuals with mental retardation (ICF/MR) services • Inpatient and nursing facility services for individuals 65 or over in an institution for mental diseases (IMD) • Inpatient psychiatric hospital services for individuals under age 21
Home & Community-Based Services • Home health care services (for individuals entitled to NF care)	• Home health care services • Case management services • Respiratory care services for ventilator-dependent individuals • Personal care services • Private duty nursing services • Hospice care • Services furnished under a PACE program • Home-and community-based (HCBS) services waiver

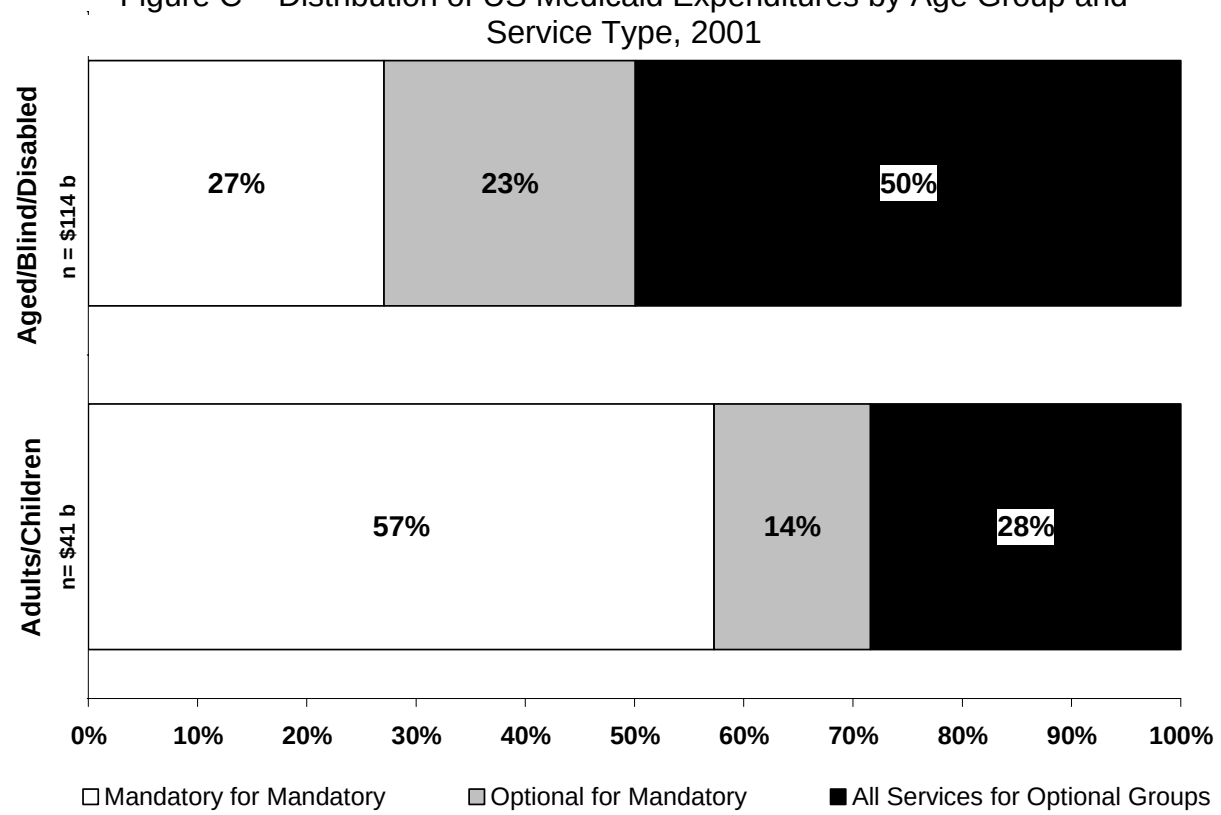
Source: The Kaiser Commission on Medicaid and the Uninsured.

Figure B – Distribution of Washington Medicaid Expenditures by Age Group and Service Type, 2001



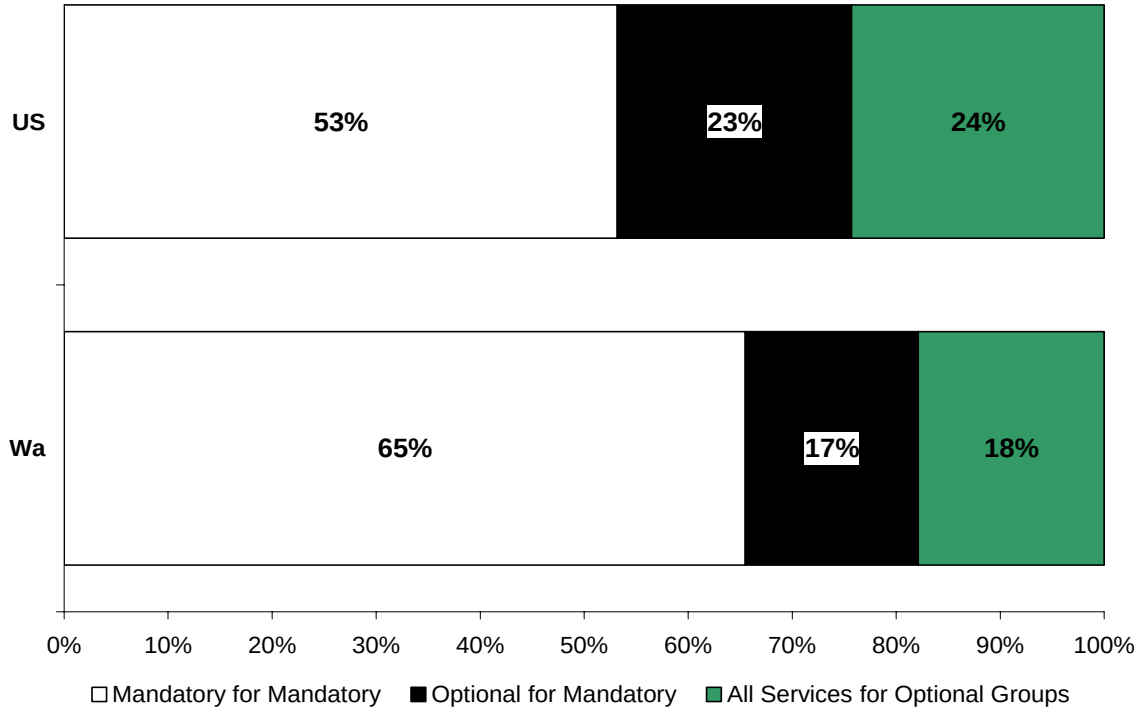
Source: DSHS.

Figure C – Distribution of US Medicaid Expenditures by Age Group and Service Type, 2001



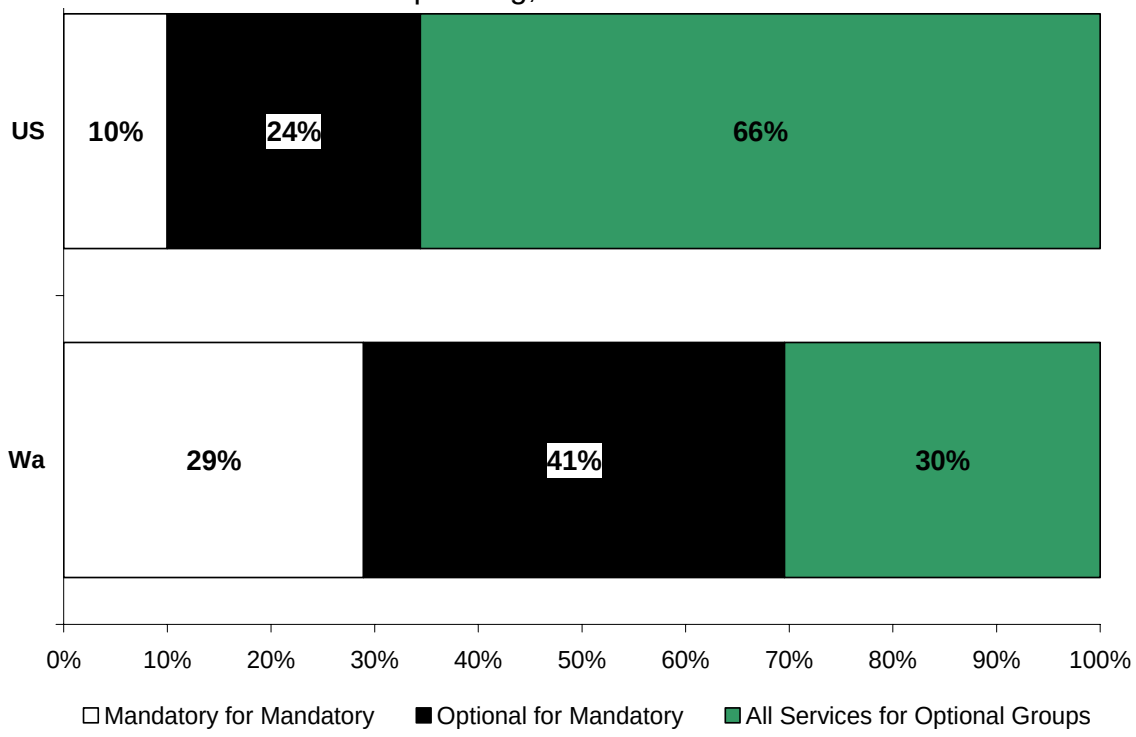
Source: Urban Institute.

Figure D – Acute Care - Mandatory and Optional Medicaid Spending, 1998 and 2001



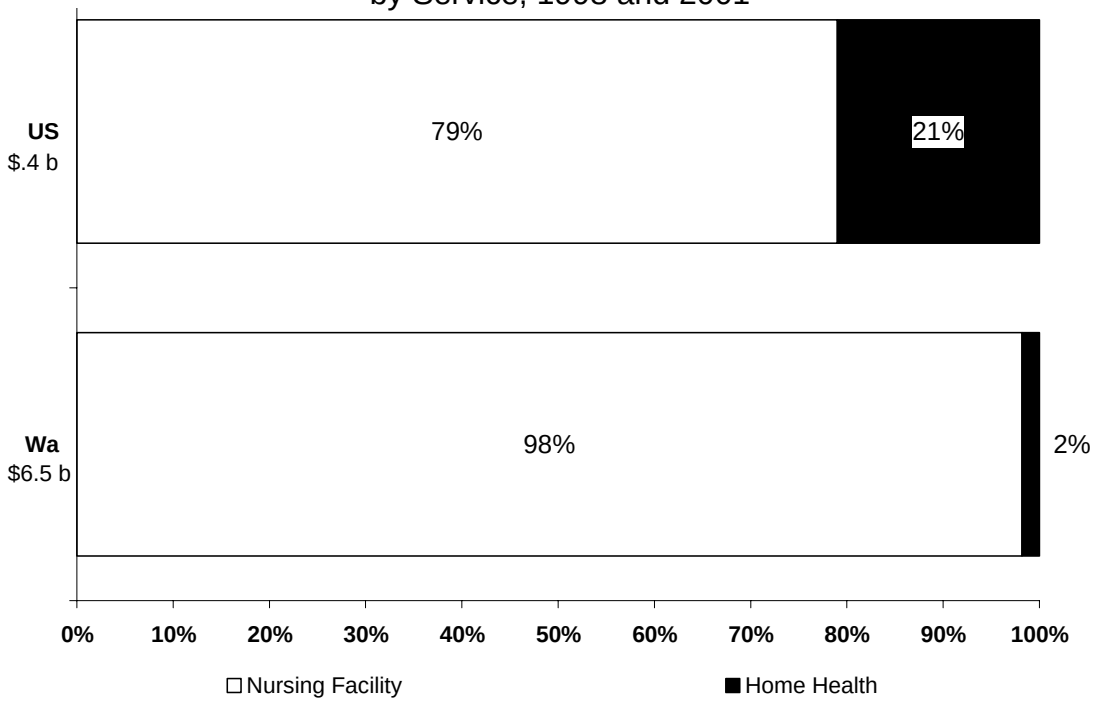
Source: Urban Institute, DSHS.

Figure E – Long Term Care - Mandatory and Optional Medicaid Spending, 1998 and 2001



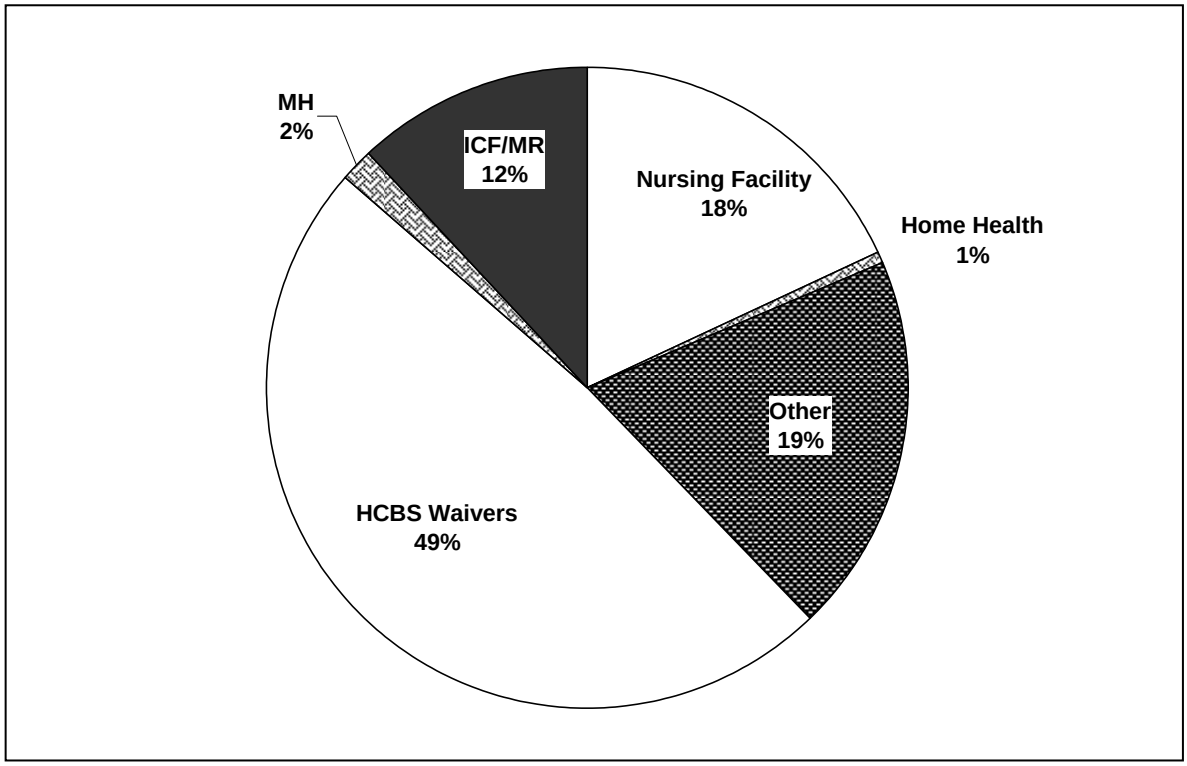
Source: Urban Institute, DSHS.

Figure F – Long Term Care - Medicaid Mandatory Spending by Service, 1998 and 2001



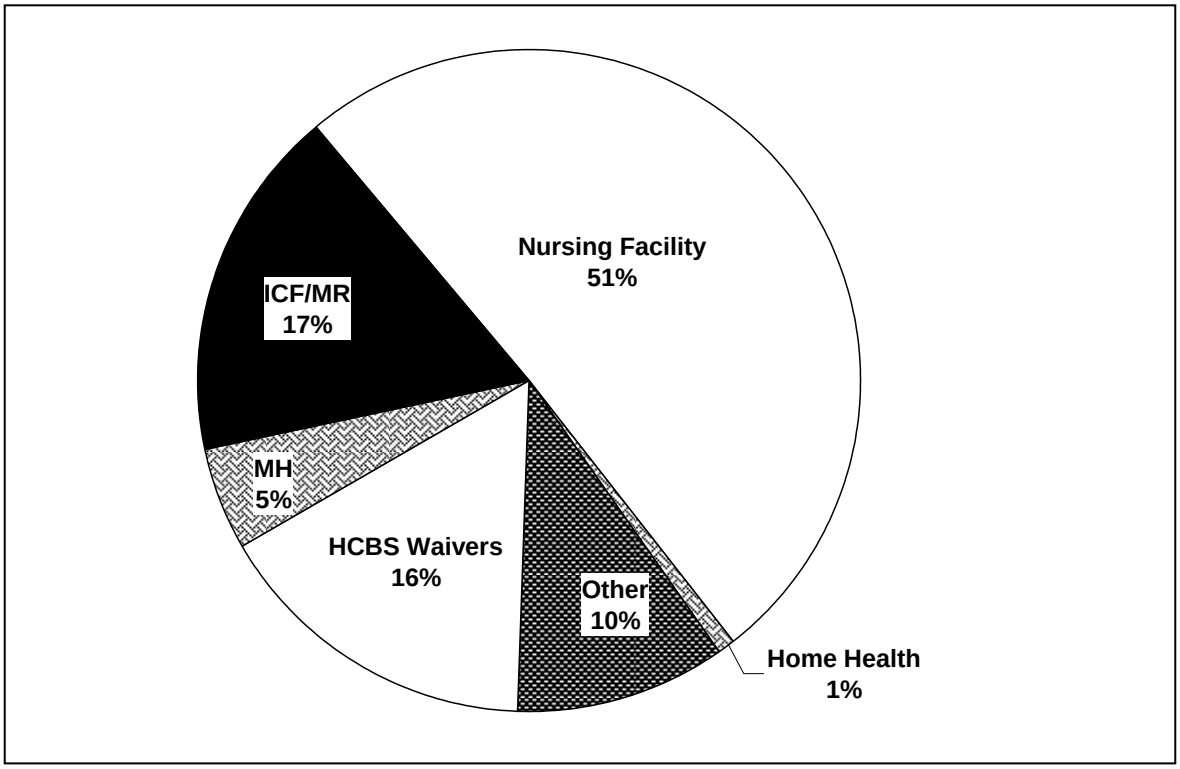
Source: Urban Institute, DSHS.

Figure G – Long Term Care - Washington Optional Medicaid Spending, 2001, n= $1.0 billion



Source: DSHS.

Figure H – Long Term Care - US Optional Medicaid Spending, 1998, n = $58.7 billion



Source: Urban Institute.