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 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.