PRELIMINARY REPORT:

Review of the Health Care Authority's Budget Structure

LEGISLATIVE AUDITOR'S CONCLUSION:

The complexity of HCA's accounting structure reflects service delivery and helps to fulfill reporting requirements. The expenditure forecast work group that includes HCA, OFM, and legislative staff lacks a formal structure that could improve the utility of and confidence in the forecast.

September 2021

Executive Summary

The 2020 Legislature directed the Joint Legislative Audit and Review Committee (JLARC) to review the Health Care Authority (HCA) budget and accounting structures. The HCA budget includes Medicaid, health benefits for state and school district employees, and the health benefit exchange. The largest component is Medicaid, which is the focus of this study.

Medicaid[1] provides health coverage to eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Coverage includes medical assistance (physical health) and behavioral health services. Medicaid is funded by the state, with a match from the federal government.

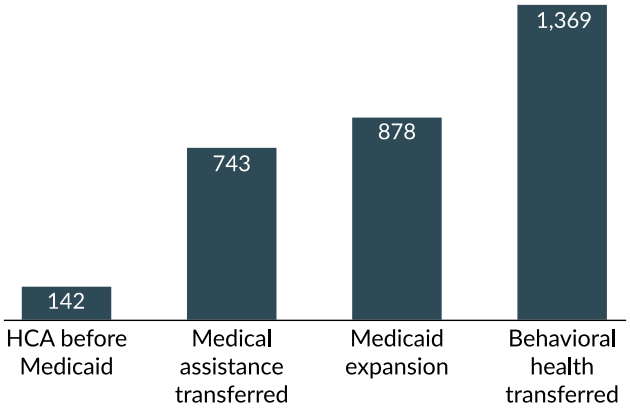
[1]Medicaid is called Apple Health in Washington.

Complexity of HCA's accounting structure reflects changes in service delivery and helps the agency meet reporting requirements

In 2011, the Legislature transferred the Medicaid medical assistance program from the Department of Social and Health Services (DSHS) to HCA. Changes to the medical assistance program since then include expansion of the eligible population, introduction of the Medicaid Transformation Waiver,[2] and the transfer of Medicaid behavioral health services to HCA in 2018.

With each change, HCA added codes to its accounting structure to tie expenditures to information such as program, eligibility group[3], and federal match rate. HCA uses combinations of codes to compile data for budget monitoring and state and federal reporting.

Number of accounting codes increased to reflect service changes



Source: Figures represent counts of three types of codes that are key to reporting and budgeting.

Another change is increased enrollment in managed care plans instead of fee-for-service. Under managed care, HCA pays a flat per member per month rate to managed care organizations for all covered medical services, whereas fee-for-service involves direct payments to healthcare providers for each covered medical service. As a result, HCA's accounting structure[4] has little information about specific service or administrative costs for managed care. HCA's approach is consistent with national trends in managed care, which place greater emphasis on measuring quality of care and patient outcomes than on the cost of specific services. Other HCA systems collect available data about service use.

HCA's Medicaid medical assistance budget is based on actuarial rate setting and expenditure forecasting

This report focuses on HCA's Medicaid medical assistance budget. The budget for behavioral health is developed separately.

The Medicaid medical assistance budget has two major components: the rate the state pays to managed care organizations (MCOs) and an expenditure forecast.

[2]Pilot projects intended to test new ways to deliver and pay for health care.
[3]Examples include adults eligible through Affordable Care Act (ACA) Medicaid expansion and people who are blind/disabled.
[4]The chart of accounts used in the Agency Financial Reporting System (AFRS).

- Independent actuaries develop a per member per month (PMPM) rate for groups of eligible people enrolled in managed care. Federal rules govern rate development.
- The Office of Financial Management (OFM), with substantial input from HCA, develops an expenditure forecast based on historical managed care and fee-for-service costs and expected enrollment. Legislative fiscal staff participate in an expenditure forecast work group and translate the forecast into the medical assistance budget. This process takes place at the staff level. Legislators may also introduce policy proposals that change the medical assistance appropriation.

Washington legislative staff have more opportunities for involvement in Medicaid medical assistance budgeting than their counterparts in some other states

Legislative staff in Washington are involved in PMPM rate setting, expenditure forecasting, and budget development. This level of involvement is uncommon in the six other states[5] that JLARC staff reviewed, where state Medicaid agencies have greater responsibility and control over the rate and budget development processes. In two of the states JLARC staff reviewed (Oregon and Virginia), legislative staff are involved in forecasting and the process is more formally defined.

The expenditure forecast work group lacks a formal structure, which could improve the utility of and confidence in the forecast

An expenditure forecast work group reviews OFM's development of the medical assistance expenditure forecast. The work group includes HCA, OFM, and legislative staff. The work group is not defined in statute and does not have formal by-laws. Other forecasting entities in Washington have more formal structures. Literature suggests that a structured process can build confidence in the forecast among decision makers. Substantial variations between the forecast and actual costs led to calls to evaluate or change the work group process. For example, a significant variation in 2016 led to the Legislature transferring responsibility for the forecast from HCA to OFM.

[5]Arizona, Indiana, Louisiana, Minnesota, Oregon, and Virginia

Legislative Auditor Recommendations

OFM should lead the medical assistance forecast work group in developing a charter that specifies its purposes, structure, and decision-making protocols.

You can find additional information in Recommendations.

REPORT DETAILS

1. Accounting structure meets reporting requirements

Complexity of HCA's accounting structure for Medicaid reflects changes in service delivery and helps the agency meet reporting requirements

The 2020 Legislature directed the Joint Legislative Audit and Review Committee (JLARC) to review the Health Care Authority's (HCA) budget and accounting structures. The largest component of HCA's budget is Medicaid.

- Medicaid[6] provides health coverage to eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities.
- Medicaid is funded by the state[7], with a match from the federal government. HCA administers Medicaid in Washington.

This section explains the effect of changes to HCA's accounting structure for Medicaid.

Washington State made significant changes to Medicaid service delivery since transferring medical assistance to HCA

In 2011, the Legislature transferred the Medicaid medical assistance program from the Department of Social and Health Services (DSHS) to HCA. Since then, the state has made significant changes to Medicaid service delivery. For example:

- **Affordable Care Act (ACA) Medicaid expansion (2014):** The ACA allowed states to expand Medicaid to most adults with incomes up to 133% of the federal poverty level. When the Legislature funded the expansion, it phased out seven programs that served populations who became eligible under the ACA.
- **Medicaid Transformation Waiver (2017):** HCA proposed Washington's Transformation Waiver to test new ways to deliver and pay for health care. It includes initiatives to address regional

[6]Medicaid is called Apple Health in WA.
[7]State funds include the general fund, local funds, and other dedicated accounts.

health issues (e.g., opioid use), behavioral health, and care options for older people and vulnerable adults. The federal Centers for Medicare and Medicaid Services (CMS) approves waivers.

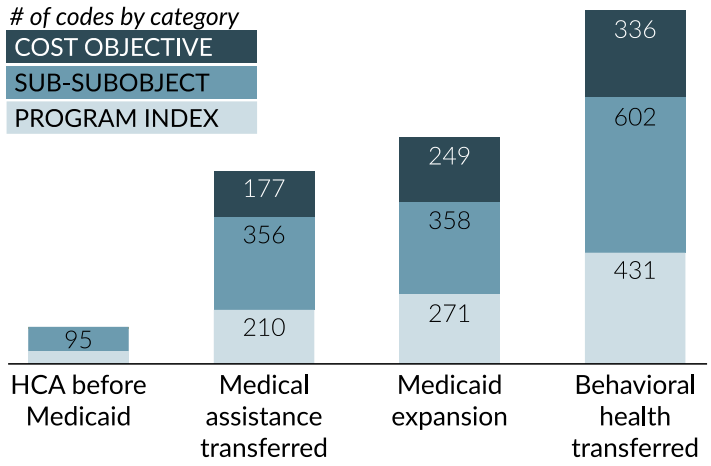
- **Behavioral health administration transfer (2018):** The Legislature transferred responsibility for behavioral health services from DSHS to HCA.

Other changes include additional federal waivers, adjustments to dental coverage, introduction of a preferred prescription drug list, quality improvement incentives, and changes to the hospital payment structure. Some changes have been at the Legislature's direction while others have been shifts in agency practice or policy.

HCA's accounting structure has grown and become more complex to reflect changes

The accounting structure is a system of codes that track expenditures and provide information such as fund source, legislative appropriation, enrollee group, payment purpose, and federal match rate. The Office of Financial Management (OFM) defines some code types for statewide consistency (e.g., fund) and allows agencies to define others.

Exhibit 1.1: Significant changes to Medicaid added new codes in HCA's accounting structure over time



Source: JLARC staff analysis of HCA's accounting structure.

Over time, program changes triggered the need for new codes and increased the complexity of HCA's accounting structure. While there are thousands of codes in HCA's accounting structure, for simplicity this report focuses on three types: program index, sub-subobject, and cost objective (described below). They provide information about the program, eligibility group[8], and federal match rate and are among the codes that are critical for federal reporting and budgeting.

- Before the transfer of medical assistance from DSHS, HCA had 142[9] of these codes.

[8]Examples include adults eligible through ACA Medicaid expansion and people who are blind/disabled.
[9]46 program indices, 95 sub-subobjects, and one cost objective.

- HCA adopted the DSHS accounting structure for medical assistance so that after the transfer of medical assistance, the number of these codes increased to 743[10].
- After Medicaid expansion and the transfer of behavioral health, the total for these three codes increased to 1,369.

The accounting structure must be updated at least annually to reflect ongoing changes (e.g., the federal match rate changes by year and eligibility group). These changes can add, change, or remove codes.

Combinations of accounting codes provide detail for federal reporting

The federal Centers for Medicare & Medicaid Services (CMS) requires HCA to report estimated and actual costs each quarter. HCA must separately report its administrative and service costs to CMS. It also must identify costs by federal fiscal year, eligibility group, type of service, and other factors. HCA assigns the relevant codes when it records expenditures in the accounting system. As demonstrated in Exhibit 1.2, HCA combines codes to provide the information needed for federal reporting.

Exhibit 1.2: Examples of how HCA uses combinations of codes for federal reporting

These code combinations			Identify these expenditures
SUB-SUBOBJECT	PROGRAM INDEX	COST OBJECTIVE	
M641	H12N1	T0NEN	PMPM payment for adults eligible through Medicaid Expansion 93% federal match rate, Q1, federal fiscal year 2020
M672	H1211	T0AA0	Managed care labor and delivery payment for adults eligible for Medicaid based on income 50% federal match rate, all quarters, federal fiscal year 2020
MS04	H1HSN	A0000	Certified public expenditure grant related to hospital safety net supplemental distribution state only (no federal match)

Source: JLARC staff analysis of HCA documents.

[10]210 program indices, 356 sub-subobjects, and 177 cost objectives.

Accounting structure also supports HCA budget development and monitoring

In addition to federal reporting needs, the codes in HCA's accounting structure also provide information for the state's medical assistance budget development and ongoing budget monitoring.

Budget development: HCA and the Office of Financial Management (OFM) use actual expenditures as the basis for a budget forecast (see next section to learn more). Combinations of codes in the accounting structure tie expenditures to the eligibility group and service codes used in the forecast. The coding combinations for forecasting differ from those used for federal reporting.

Budget provisos: When the Legislature adopts the budget, it may include provisos that limit an agency's spending for a program or activity. OFM designates an additional accounting code for each proviso. HCA uses the codes to monitor its spending and demonstrate how it implements legislative direction (see box to right). The Legislature included 152 provisos related to Medicaid in the 2019-21 biennial budget (including supplemental budgets).

Expenditure Authority codes track spending on legislative provisos

For example, in the 2019-21 biennium the Legislature directed HCA to spend $180,000 in federal funds for a toll-free hotline. HCA attached the OFM-designated expenditure authority code to each related expenditure. HCA, OFM, and legislative staff can use this code to identify expenditures.

Budget monitoring: The accounting structure also provides data needed for HCA's budget monitoring. Each month, HCA creates a report that compares actual and forecasted expenditures to the spending plan approved by OFM[11]. The report also projects the year-end balance. HCA uses the codes in the accounting structure to compile administrative and service costs into categories such as technology, managed care, specific fee-for-service costs (e.g., hospital inpatient care), and Medicaid Transformation Waiver.

Upcoming One Washington project will require HCA to replace its accounting structure and codes

OFM is leading a project called One Washington that will replace the state agency accounting system. Replacing the system means that the accounting codes will be replaced. It's unclear how this will affect HCA's accounting structure and its ability to support reporting and budget functions. HCA reports that it is working with OFM to minimize disruption.

[11]The spending plan is called an allotment.

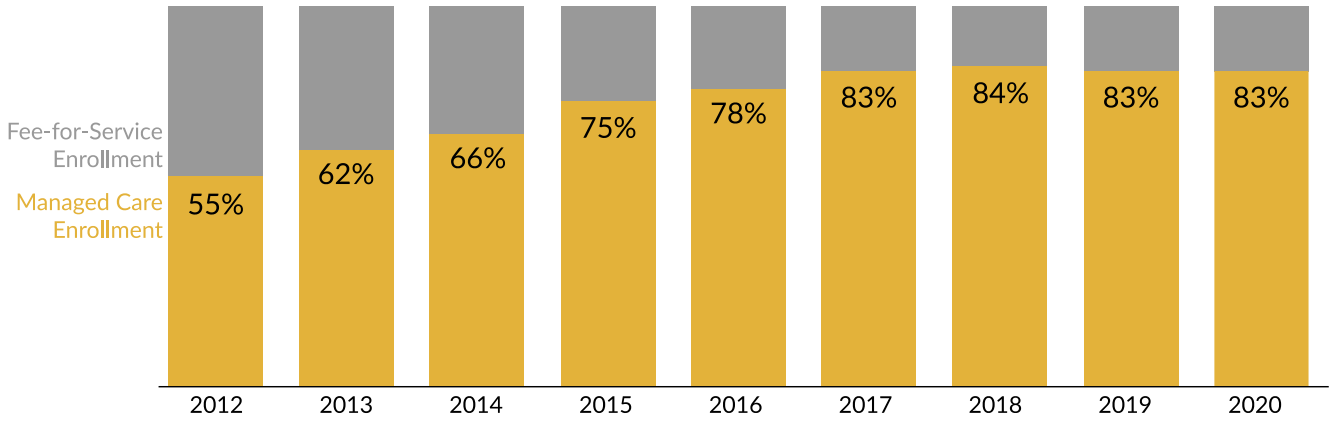
In interviews, HCA noted that it has not changed the accounting structure for behavioral health, pending the transition to One Washington. HCA stated that it intends to use the opportunity to better align its accounting and budgeting processes.

Enrollment in managed care has grown faster than total enrollment

Medicaid services are paid for in two ways: fee-for-service and managed care. Under fee-for-service, HCA pays a healthcare provider directly for each service. Under managed care, HCA pays a managed care organization (MCO) a flat per member per month rate for all healthcare services, and the MCO pays the healthcare providers. HCA contracts with five MCOs.

Between fiscal years 2012 and 2020, total enrollment in Medicaid grew from 1.2 million to 1.8 million people, a 50% increase. At the same time, the portion of enrollment in managed care grew from 671,000 to 1.5 million, a 128% increase. Managed care now accounts for 83% of all Medicaid enrollees. Much of the growth is due to the ACA Medicaid expansion, which broadened the adult population that is eligible for Medicaid.

Exhibit 1.3: Managed care enrollment increased from 55% to 83% of total Medicaid enrollees between FY 2012 and 2020



Source: JLARC staff analysis of HCA data.

HCA's accounting structure has less information about specific service costs for managed care than it does for fee-for-service

The accounting structure records HCA's expenditures. Since HCA pays managed care organizations a flat rate to provide all covered services, its accounting structure has little information about specific service or administrative costs for managed care. The codes that represent most managed care expenses are for the flat per member per month rate paid to MCOs for all covered services. In contrast, codes for fee-for-service reflect specific services such as hospital stays or physician visits. This is a typical feature

of managed care systems in all states. Other HCA systems, including ProviderOne, collect available data about services provided under both managed care and fee-for-service.

HCA uses financial incentives and penalties to encourage MCOs to use alternative payment models for paying providers (e.g., rewards for meeting quality targets, paying a flat rate for all services). Encouraging alternative payment models is consistent with national trends. However, the alternative models can reduce the information available about costs of specific services.

Managed care emphasizes measurement of quality and outcomes

Nationally, the expansion of Medicaid managed care is accompanied by greater attention to measuring quality of care and patient outcomes. HCA uses multiple approaches to review quality and outcomes, including the following:

- HCA reviews managed care costs and utilization on a monthly basis. In addition, MCOs must submit multiple reports to HCA about enrollment, costs, quality, incentives, subcontracts, medical loss ratios, and encounters. These data are essential for understanding costs, measuring plan quality, and evaluating compliance with contract requirements.
- HCA reviews the costs and performance of other partners that receive funds to improve health care quality and delivery. For example, Accountable Communities of Health (ACHs) are independent organizations that work with providers to address specific health care issues (e.g., opioid use). If an ACH meets performance targets, it earns incentive funds. HCA publishes a quarterly report of administrative costs and the incentives that ACHs earn and distribute.

2. Budget based on actuarial rate setting and forecasting

HCA's Medicaid budget development is based on actuarial rate setting and expenditure forecasting

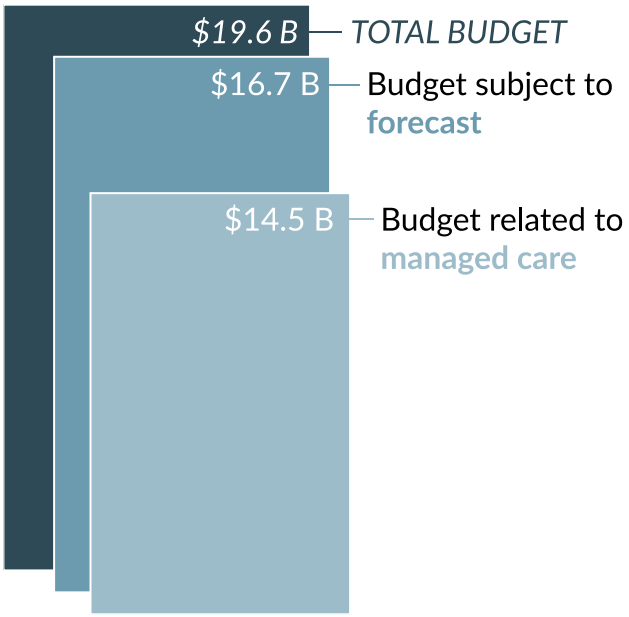
The 2020 Legislature directed JLARC to review the Health Care Authority's (HCA) budget structure. Medicaid medical assistance is the largest component of HCA's budget and is the focus of this section.

The 2019-21 medical assistance budget[12] totaled $19.6 billion. According to HCA:

- $16.7 billion (85% of the total appropriation) was subject to the expenditure forecast process. Expenditures that are not part of the forecast include program administration and hospital payments that are based on federal formulas.
- $14.5 billion (74% of the total appropriation) was related to managed care, most of which is based on the rates set by actuaries.

These figures do not include the behavioral health budget.

Exhibit 2.1: The medical assistance budget is based on managed care rates and the expenditure forecast



Source: HCA calculation of 2019-21 appropriated and non-appropriated funds, and February 2020 and February 2021 medical assistance forecasts.

Note: Total budget includes administration costs.

Rate setting and forecasting are inputs for budget process

Per member per month (PMPM) rates and the medical assistance forecast are integral to HCA's medical assistance budget. HCA, the Office of Financial Management (OFM), legislative staff, and actuaries begin the rate setting and forecasting months before budget proposals are due.

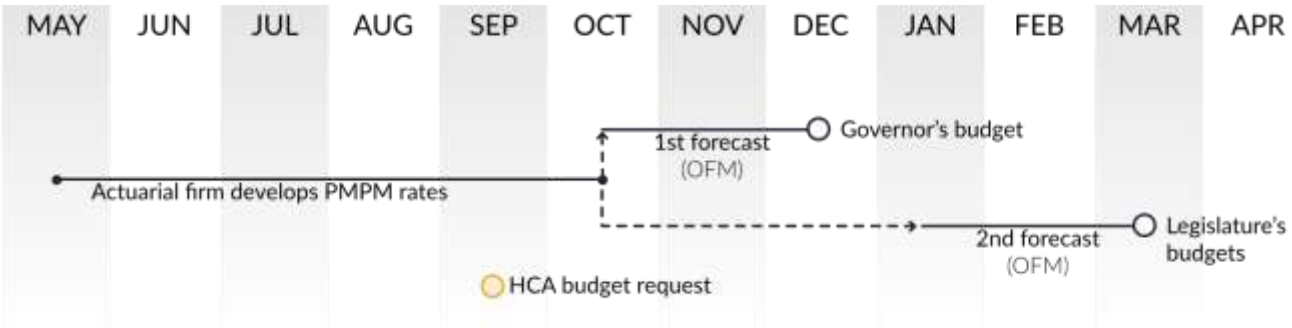
- The development of PMPM rates starts in May and concludes in October, when rates are submitted to the Centers for Medicare & Medicaid Services (CMS) for approval. PMPM rates

[12] Including the FY20 and FY21 supplemental budgets.

take effect on January 1 of the following year (e.g., rates for calendar year 2021 were set in 2020).

- The forecast is completed twice a year: in November to support the Governor's budget proposal, and in February to support the Legislature's. The PMPM rates are incorporated into the forecast as an adjustment.
- Due to timing, neither process informs HCA's budget request to the Governor in September. HCA uses placeholders in its request for the parts of the budget subject to the forecast.

Exhibit 2.2: The forecast is completed twice a year

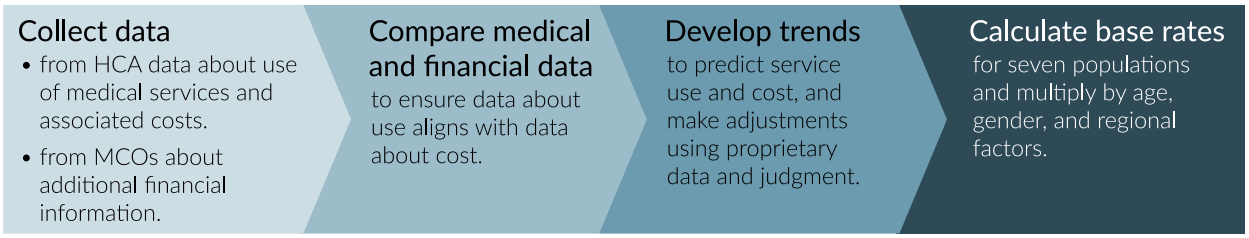


Source: JLARC staff analysis of OFM Operating Budget Instructions and interviews with OFM forecasting staff.

Independent actuarial firm develops managed care rates that meet CMS requirements

Under federal law, an independent actuary must certify that managed care rates are sufficient to cover all "reasonable, appropriate, and attainable costs" under the terms of the managed care contracts. HCA contracts with Milliman, an actuarial firm, to develop Medicaid medical assistance PMPM managed care rates.

Exhibit 2.3: Actuaries take four main steps to develop PMPM rates



Source: JLARC staff analysis of Milliman rate setting documentation.

Each month, HCA calculates managed care organization (MCO) payments by multiplying the PMPM rate by the number of enrollees. Rates vary based on a patient's age, eligibility group, and region. There are 240 unique rates for medical assistance. For example, the PMPM rate for a 2-year-old girl in the

blind/disabled group in King County is $1,181.90. The PMPM for a 30-year-old man in the ACA Medicaid expansion group in Chelan County is $164.36. MCOs may also receive additional payments for specific services. For example, MCOs may receive a special payment for labor and delivery expenses.

HCA, OFM, and legislative staff are involved with Washington's rate development process

During the rate-setting process, Milliman meets regularly with HCA, OFM, and legislative staff to discuss the assumptions in the actuarial models. The assumptions include prospective trends, adjustments based on program changes, and non-benefit expenses (e.g., MCO administrative costs and risk/profit margin). At times, Milliman may ask the group for input, but the actuaries have the ultimate authority to set all assumptions for the rate development.

OFM leads the forecast development, which affects 85% of the state Medicaid medical assistance budget

OFM, with significant HCA and legislative staff participation, develops the expenditure forecast that informs the Governor's and Legislature's Medicaid medical assistance budgets.

OFM, HCA, and legislative staff participate in a multi-agency expenditure forecast work group

An expenditure forecast work group composed of staff from OFM, HCA, and legislative staff meets regularly to develop the Medicaid medical assistance expenditure forecast. Although many of the same staff are present, these meetings are separate from the actuarial rate development process described above. OFM produces a series of draft forecast summaries for all services and caseloads. The work group reviews and discusses each one, and provides feedback to OFM.

For more information about the work group, see Section 4.

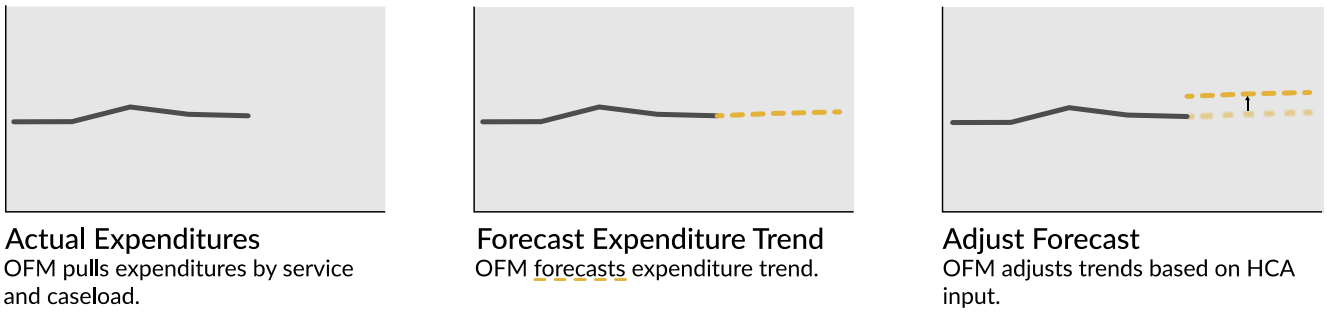
OFM collects and analyzes expenditure and caseload data for the forecast

Expenditure forecasting is a complex process that involves hundreds of models and estimates. OFM informs and consults legislative staff throughout the process.

1. **OFM staff pull expenditure data from the state accounting system.** Using codes from the accounting system, OFM and HCA organize the data by service (e.g., payments to MCOs, outpatient care, drug rebates) and caseload. Caseload refers to the number of people in different eligibility groups such as low-income adults, children, pregnant women, elderly adults, and people with disabilities. These groups differ from those used by the actuaries for setting PMPM rates.

2. **OFM forecasts trends for the expenditures.** OFM associates the expenditure data with monthly caseload information from the Caseload Forecast Council (CFC)[13]. OFM then divides expenditures by the number of enrollees in each monthly caseload. The result is the historical amount spent per person for each service or managed care payment each month. OFM uses the historical amounts to forecast expenditure trends. See Section 4 for more information about the CFC.
    - In this step, OFM forecasts managed care costs per person based on actual expenditures, instead of the current PMPM rate. This is because actual expenditures account for adjustments and special payments such as the labor and delivery payments noted above.
3. **OFM adjusts the forecasted trends for previously authorized program and benefit changes.** Some expenditures are not fully reflected in the historical data, but will affect future expenditures. Examples include new actuarial managed care PMPM rates, updates in fee-for-service payment schedules for existing benefits, or changes in how often fee-for-service medical services are used. HCA is responsible for proposing and documenting any changes, and OFM is responsible for adjusting the forecast. Adjustments may be positive or negative.

Exhibit 2.4: OFM forecasts per person medical assistance expenditures and adjusts for program and policy changes



Source: JLARC staff analysis.

Following the forecast, OFM reports periodically to the work group about how much actual expenditures vary from the forecast.

OFM and legislative staff convert the expenditure forecast to the legislative budget format

Once the expenditure forecast work group agrees on a final draft of the forecast, OFM budget analysts and legislative fiscal staff translate it into the legislative budget format. This format shows how next biennium's costs would increase or decrease from the current appropriation if there were no new

[13]The Caseload Forecast Council forecasts the number of people expected to need services from state programs.

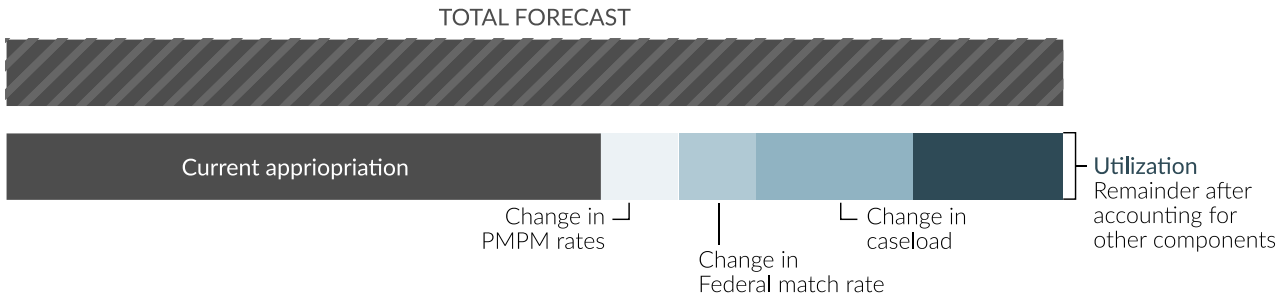
healthcare policy proposals. The Legislature's medical assistance appropriation generally reflects the amount from the forecast, adjusted up or down for any new healthcare policy proposals.

To develop the budget into the legislative format, OFM budget analysts and legislative fiscal staff:

1. Subtract the current appropriation level from the total forecast amount and then
2. Split the amount of the change into separate components.
    - The largest component is caseload, which is the cost or savings associated with the Caseload Forecast Council's enrollee forecast.
    - Other components include change in the federal match rate and managed care PMPM rates.
    - Utilization is a catch-all component that accounts for the difference between the current appropriation and the forecast once all other components are accounted for. Despite its name, it does not reflect changes due to service utilization.

The resulting budget shows the maintenance level[14], before accounting for any policy proposals.

Exhibit 2.5: OFM and legislative fiscal staff convert the expenditure forecast to the budget format



Source: JLARC staff analysis.

Note: This is a hypothetical representation. The current appropriation and other components do not correspond to a specific legislative budget.

HCA uses a simpler process to forecast Medicaid behavioral health expenditures

HCA uses a separate process to forecast behavioral health expenditures. Though the budget is smaller[15], the behavioral health program is similar to medical assistance in terms of its accounting complexity and use of managed care. However, the behavioral health expenditure forecasting process is simpler.

[14]Reflects the cost of mandatory caseload, enrollment, inflation and other legally unavoidable costs not in the current budget.
[15]The 2019-21 behavioral health budget was $3.5 billion and the medical assistance budget was $18.9 billion.

An independent actuary sets PMPM rates for behavioral health and HCA multiplies those rates by the caseload provided by the CFC. The expenditure forecast work group is not involved, and HCA does not forecast individual service trends.

In addition to a simpler process, the behavioral health forecast more closely aligns components of the forecast with the managed care program. It uses regional caseloads, which align with the managed care rate groups used by contracted actuaries. The medical assistance forecast uses statewide eligibility groups that are different from the managed care rate groupings.

3. Legislative staff in WA more involved than in other states

Legislative staff in Washington have more opportunities for involvement in Medicaid budgeting than their counterparts in other states

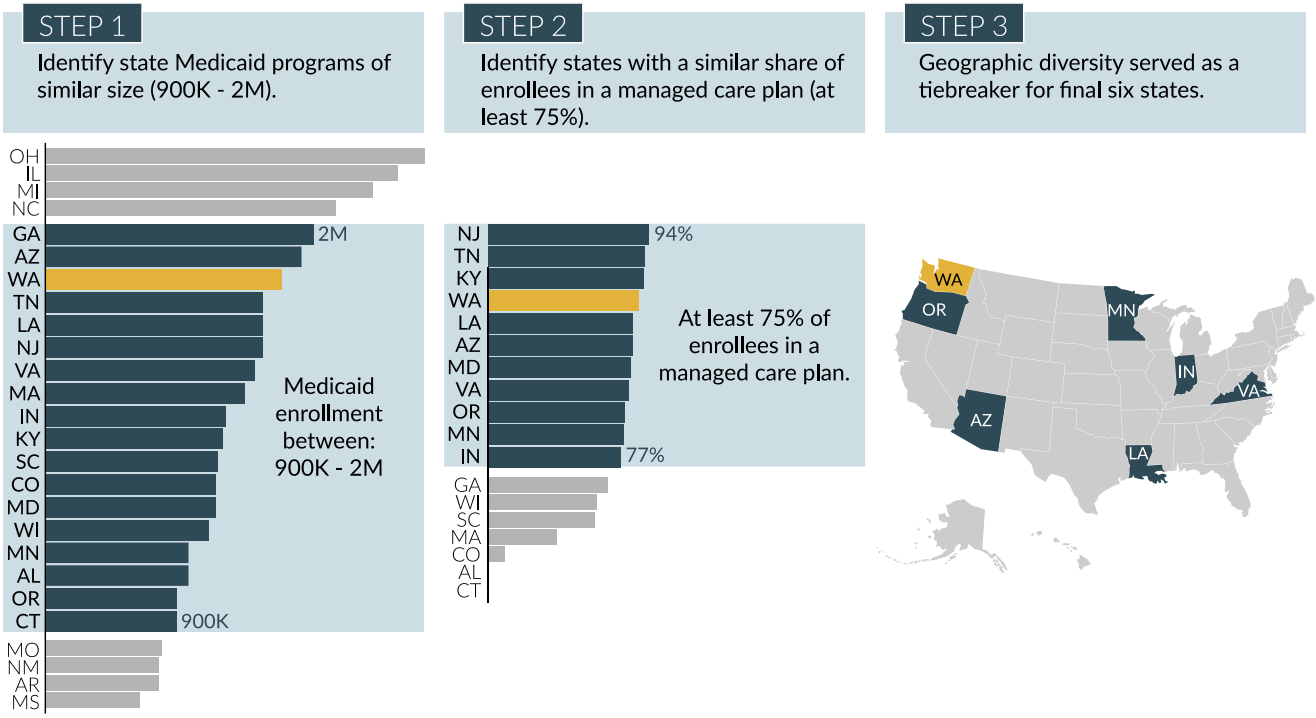
JLARC staff reviewed practices in states with similar Medicaid programs and populations

The Legislature directed JLARC staff to compare the Health Care Authority's (HCA) budget structure to those from other states of a similar size. After consulting with key stakeholders and outside experts, JLARC staff identified comparable state Medicaid programs using two primary metrics:

- Total Medicaid enrollment.
- The percentage of enrollees in a managed care plan.

Geographic diversity and stakeholder feedback narrowed the list to six states: Arizona, Indiana, Louisiana, Minnesota, Oregon, and Virginia (see Exhibit 3.1). JLARC staff interviewed agency and legislative staff in each state about their managed care rate and budget development processes.

Exhibit 3.1: JLARC staff identified comparable state Medicaid programs based on enrollment, percentage on managed care plans, geographic diversity, and stakeholder feedback



Source: Kaiser Family Foundation and JLARC staff analysis.

Milliman[16] provided additional information about legislative involvement in the rate development process through a separate survey of its actuaries working in 12 states, including Washington.

Legislative staff in Washington have opportunities to provide input during the actuary's rate development work. This is uncommon in other comparison states.

As explained in the previous section, an independent actuarial firm sets the per member per month (PMPM) rates paid to managed care organizations. HCA contracts with Milliman for this work, and legislative staff have opportunities to provide input on the assumptions used.

[16]Milliman is an actuarial services firm that develops Medicaid per member per month (PMPM) rates in Washington and other states.

Rate development is typically contracted out to third-party actuarial firms

PMPM rate development is a technical and regulated process. Federal regulations require managed care rates to be developed and certified by qualified actuaries. State Medicaid agencies typically contract with an independent actuarial firm for rate development. Of the six other states JLARC staff reviewed, only Arizona's rates are developed by actuaries employed by the state Medicaid agency.

Legislative involvement in the rate development process is uncommon in other comparison states

Milliman's survey found that legislative staff are not consulted during the rate development process in other states. Further, Washington is one of two states[17] that updates its legislature during the rate development process. According to the survey, other state legislatures were either informed after rates were finalized (6) or not informed at all (4). In contrast, legislative staff in Washington met with staff from Milliman, HCA, and OFM 15 times during the 2020 rate development process.

Separate from the Milliman survey, JLARC staff learned that Virginia's rate development process also includes legislative staff. The state Medicaid agency and its contracted actuary meet with legislative fiscal staff during the rate development process to discuss cost and utilization trends and the assumptions used in the actuarial models. Legislative staff are not consulted during the rate setting process in Arizona, Indiana, Louisiana, Minnesota, or Oregon.

In other states, the Medicaid agency is responsible for expenditure and caseload forecasting. In Washington, several entities share responsibility for the forecasts.

To develop the Medicaid budget, states forecast the number of enrollees and the cost of providing services. These two components form the basis of the Medicaid forecasts in the six states JLARC staff reviewed.

- In five of the six states, the state Medicaid agency produces a combined caseload-expenditure forecast. In Washington, the caseload and expenditure forecasts are produced through separate multi-stakeholder processes.
- In four of the six states, the Medicaid agency is solely responsible for producing the caseload-expenditure forecast.

Where legislative staff are involved in the forecast, the process is formally structured

[17]Mississippi's legislature was invited to a draft rate presentation for the first time in 2020.

In two of the six states JLARC staff reviewed (Oregon and Virginia), legislative staff are involved in Medicaid forecasting. The forecast process is formally defined in both states. This approach is consistent with best practices (see Section 4).

In Oregon, legislative staff sit on two caseload forecast oversight committees. Governing charters establish the committees' authority, purpose, scope, and member responsibilities. In addition, a technical oversight committee charter establishes formal procedures for making changes to the forecast process. The procedures specify how committee members propose changes and the process by which the committee chair and the forecast office administrator review and adjudicate those proposals. The technical oversight committee was developed after a 2013 audit by the Oregon Secretary of State found that the caseload forecast process lacked sufficient oversight and transparency.

In Virginia, the Medicaid forecast process is established in a recurring legislative proviso that establishes the:

- Stakeholders involved in the forecast process.
- Specific components of the forecast.
- Forecast due dates.
- Ongoing reporting requirements.

A separate recurring Virginia proviso establishes the External Finance Review Council, a quarterly multi-stakeholder meeting to compare Medicaid expenditures to the most recent forecast. Additional meeting topics include changes to the managed care program, PMPM rate development, and utilization and cost trends. The quarterly meetings are open to the public and include staff from the state Medicaid agency, legislative fiscal committees, and other state agencies.

4. Expenditure forecast work group lacks formal structure

Contrary to best practice, Washington's expenditure forecast work group lacks a formal structure that could improve the utility of and confidence in the forecast

As noted in Section 2, the expenditure forecast is key to developing the Health Care Authority's (HCA) Medicaid medical assistance budget. The Office of Financial Management (OFM) has developed the forecast since 2016. However, HCA provides the data and modeling for adjustments to the forecasted trends, and an expenditure forecast work group reviews the work. Previous reviews of the work group have revealed problems due to different understandings of the work group's purposes and a lack of formal structure.

Expenditure Forecast Work Group Members

Health Care Authority (7)

Office of Financial Management (6)

House and Senate fiscal committee staff (2)

Milliman actuaries (consulting as needed)

The work group has organized processes but does not have agreed-upon purposes

The forecast is completed twice each year: once for the Governor's budget and once for the Legislature's budget. Work group members suggest that the volume of work that they review, along with the desire to use the most recent data available, means there is often a rush to complete the forecast.

At the beginning of each forecast process, OFM forecasting staff send a document to work group members to establish high-level responsibilities (e.g., review primary trends, review draft forecast) and ground rules (e.g., one speaker at a time, jointly design next steps). They also send a meeting schedule. While OFM has developed organized processes to produce the forecast, the work group is not defined in statute and does not have a formal charter.

Work group members have different understandings of the forecast's purposes and different priorities for its use. All three entities use the forecast to support the Governor's and Legislature's budgets. In addition:

- OFM budget analysts and legislative fiscal staff use the forecast process to understand cost drivers and trends and to monitor expenditures.

- Legislative fiscal staff also use the forecast process to identify issues with HCA's accounting and program management.

HCA staff stated that they do not use the forecast to understand cost drivers, monitor expenditures, or identify program issues. In the other states JLARC staff reviewed, the Medicaid forecast is not generally used for purposes beyond budget development.

Work group process reviewed multiple times

OFM staff familiar with the group's history stated that variations between the forecast and actual costs led to calls to evaluate and change the forecast work group process.

- **2003:** Work group members asked the Washington Institute for Public Policy (WSIPP) to evaluate the forecast process and make recommendations to improve it. WSIPP's recommendations included clearly defining roles to avoid ambiguity and identifying the appropriate tasks and duties of all parties, prioritizing inquiries and analyses to improve forecast timeliness, and formalizing quality assurance and review processes. Currently, these recommendations are not implemented.
- **2016:** The Legislature transferred responsibility for the forecast from HCA to OFM. Prior to the transfer, legislative staff expressed concerns about HCA's transparency and inability to fully answer questions about the forecast process.
- **2017:** At the Legislature's request, Willis Towers Watson (WTW) actuaries examined the forecast process. WTW's preliminary report included a list of questions about the forecast for further exploration. These questions, including how to avoid surprises and whether changes to the forecasting process are needed, were not resolved.

Other forecast entities have decision-making protocols defined in statute or charter, as suggested by best practice

WSIPP's 2003 report recommended that the medical assistance forecast work group adopt a formal structure and charter. A charter could include protocols for making decisions about what to analyze and workload priorities. WSIPP suggested that the charter allow the work group to establish subcommittees for specific tasks, such as monitoring actual expenditures against the forecast.

Other Washington State forecasting entities have more formal structures:

- The Caseload Forecast Council (CFC) was established by statute in 1997. The Legislature defined the CFC's purpose and created a tiered system where a technical work group reports to CFC principals. The director stated that a more structured process helps mitigate conflicts caused by organizational politics and increases the forecast's acceptance by decision makers.
- The Economic and Revenue Forecast Council (ERFC) was established by statute in 1984. The Legislature created a technical work group to produce the forecast, which ERFC principals consider and adopt.

Best practices in academic literature call for formalizing forecast processes. The literature suggests that a structured process builds confidence and acceptance in the forecast among decision makers.

Legislative Auditor makes one recommendation to improve the expenditure forecast work group

OFM should lead the medical assistance forecast work group in developing a charter that specifies its purposes, structure, and decision-making protocols.

The essential elements of the charter should include:

- The purposes of the forecast.
- The intended customers.
- Detailed roles and responsibilities of each member.
- Protocols such as the level of agreement necessary to finalize a decision.
- Rules for settling disagreements.
- How inquiries and requests for analysis are prioritized.
- How assumptions are documented and communicated to intended customers.
- How to compare prior forecasts against expenditures.
- Quality assurance mechanisms.

RECOMMENDATIONS & RESPONSES

Legislative Auditor Recommendation

The Legislative Auditor makes one recommendation regarding the medical assistance expenditure forecast work group

Recommendation #1: OFM should lead the medical assistance forecast work group in developing a charter that specifies its purposes, structure, and decision-making protocols.

The essential elements of the charter should include:

- The purposes of the forecast.
- The intended customers.
- Detailed roles and responsibilities of each member.
- Protocols such as the level of agreement necessary to finalize a decision.
- Rules for settling disagreements.
- How inquiries and requests for analysis are prioritized.
- How assumptions are documented and communicated to intended customers.
- How to compare prior forecasts against expenditures.
- Quality assurance mechanisms.

Legislation Required:	None
Fiscal Impact:	None. JLARC staff assume the recommended action can be implemented within existing agency resources.
Implementation Date:	December 31, 2022
Agency Response:	To be included with Proposed Final Report.

Agency Response

Agency response(s) will be included in the proposed final report, planned for December 1, 2021.

Current Recommendation Status

JLARC staff follow up with agencies on Legislative Auditor recommendations for 4 years. Responses from agencies on the latest status of implementing recommendations for this report will be available in 2022.

MORE ABOUT THIS REVIEW

Audit Authority

The Joint Legislative Audit and Review Committee (JLARC) works to make state government operations more efficient and effective. The Committee is comprised of an equal number of House members and Senators, Democrats and Republicans.

JLARC's nonpartisan staff auditors, under the direction of the Legislative Auditor, conduct performance audits, program evaluations, sunset reviews, and other analyses assigned by the Legislature and the Committee.

The statutory authority for JLARC, established in Chapter 44.28 RCW, requires the Legislative Auditor to ensure that JLARC studies are conducted in accordance with Generally Accepted Government Auditing Standards, as applicable to the scope of the audit. This study was conducted in accordance with those applicable standards. Those standards require auditors to plan and perform audits to obtain sufficient, appropriate evidence to provide a reasonable basis for findings and conclusions based on the audit objectives. The evidence obtained for this JLARC report provides a reasonable basis for the enclosed findings and conclusions, and any exceptions to the application of audit standards have been explicitly disclosed in the body of this report.

Study Questions

Click image to view PDF of proposed study questions.

Washington JLARC

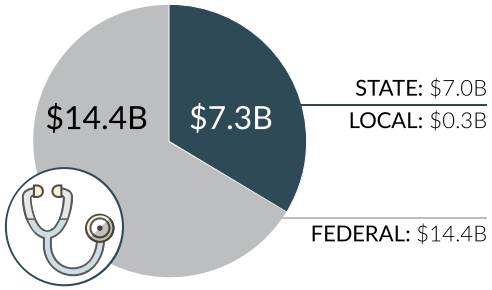
PROPOSED STUDY QUESTIONS
Review of Health Care Authority's Budget Structure

State of Washington Joint Legislative Audit and Review Committee — January 2021

2020 Legislature directed JLARC to review Health Care Authority's budget structure

The Legislature appropriated $21.7 billion in state, local, and federal funds to the Health Care Authority (HCA) for the 2019-21 biennium. It also directed JLARC to review HCA's budget structure and compare it to other states' Medicaid agency budget structures.

The largest component of HCA's budget is Medicaid, which serves about 2 million Washingtonians. It will be the focus of this study.



Medicaid changes include a shift to managed care and integration of behavioral and physical health care systems

Since 1987, a growing share of Washington's Medicaid beneficiaries have been served through managed care. Under managed care, HCA pays private organizations a set monthly rate to provide covered health care services to each person they enroll. The organizations pay the health care providers. About 85% of beneficiaries are enrolled in managed care and 15% are enrolled in fee-for-service plans, where the state pays the providers directly.

HCA also purchases behavioral health services, which include treatment for mental health and substance use disorders. Since 2016, Washington has worked to merge Medicaid behavioral and physical health care under an integrated managed care model. Behavioral health care administration was transferred to HCA from the Department of Social and Health Services in 2018. As of January 2020, all HCA managed care contracts include coverage for both behavioral and physical health care.

HCA is responsible for setting Medicaid rates, tracking expenditures, and reporting

Each year, HCA works with actuaries and legislative committees to set new Medicaid managed care rates that inform the Legislature's budget decisions. HCA also maintains a chart of accounts (a tool for recording and categorizing financial transactions) and health care data to support budget development and reporting.

This study will examine HCA's budget structure and address the following questions

1. How is the chart of accounts structured? Does it align with budget, accounting, and reporting requirements?
2. How have changes in systems and service delivery affected HCA's budgeting and accounting practices?
3. How does HCA inform the Legislature about its rate and budget development practices?
4. How do other states' Medicaid agencies structure their accounts and provide information to their legislatures?

Study Timeframe

Preliminary Report: September 2021 **Proposed Final Report:** December 2021

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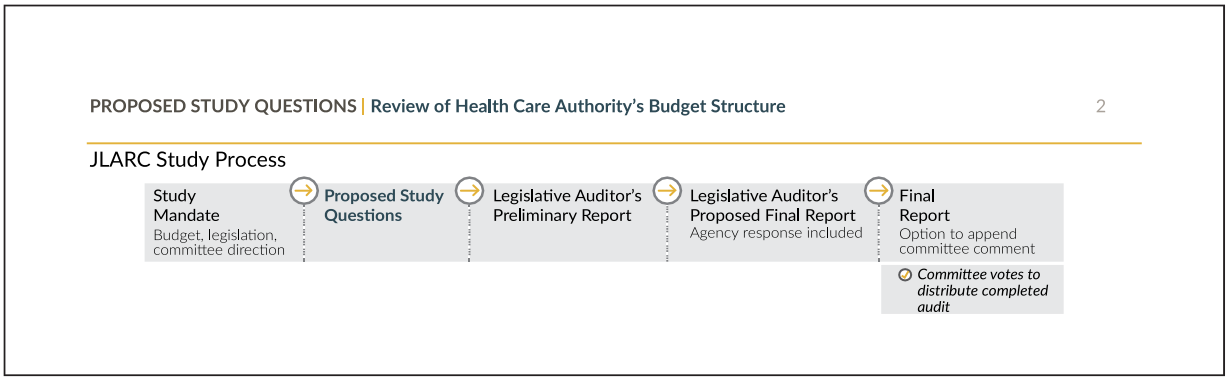

Methodology

The methodology JLARC staff use when conducting analyses is tailored to the scope of each study, but generally includes the following:

- **Interviews** with stakeholders, agency representatives, and other relevant organizations or individuals.
- **Site visits** to entities that are under review.
- **Document reviews**, including applicable laws and regulations, agency policies and procedures pertaining to study objectives, and published reports, audits or studies on relevant topics.
- **Data analysis**, which may include data collected by agencies and/or data compiled by JLARC staff. Data collection sometimes involves surveys or focus groups.
- **Consultation with experts** when warranted. JLARC staff consult with technical experts when necessary to plan our work, to obtain specialized analysis from experts in the field, and to verify results.

The methods used in this study were conducted in accordance with Generally Accepted Government Auditing Standards.

More details about specific methods related to individual study objectives are described in the body of the report under the report details tab or in technical appendices.

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