2017-19 Biennium Budget
Decision Package

Agency:
Health Care Authority on Behalf of the Health Benefit Exchange

Decision Package Code/Title:
HBE Cost Allocation Update

Budget Period:
Biennial Budget

Budget Level:
Maintenance Level

Agency Recommendation Summary Text:
The Health Benefit Exchange requests net-zero adjustments in funding sources to reflect the beneficiaries of services provided. This request reflects the updated Advanced Planning Document which was submitted to the Centers for Medicaid and Medicare Services and is consistent with recommendations of the 2016 State Auditor Performance Audit of the Exchange.

Fiscal Summary: Decision package total dollar and FTE cost/savings by year, by fund, for 4 years. Additional fiscal details are required below.

Operating Expenditures	FY 2018	FY 2019	FY 2020	FY 2021
Fund 001-1	-	-	-	-
Fund 17-T	$3,631,000	$3,719,000	$3,719,000	$3,719,000
Fund 001-2	($712,000)	($705,000)	($705,000)	($705,000)
Fund 001-C	($2,919,000)	($3,014,000)	($3,014,000)	($3,014,000)
Total Cost	**$0**	**$0**	**$0**	**$0**
Staffing	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
FTEs	0	0	0	0
Revenue	**FY 2018**	**2019**	**2020**	**2021**
Fund 001-1	-	-	-	-
Fund 17-T	$3,631,000	$3,719,000	$3,719,000	$3,719,000
Fund 001-2	($712,000)	($705,000)	($705,000)	($705,000)
Fund 001-C	($2,919,000)	($3,014,000)	($3,014,000)	($3,014,000)
Object of Expenditure	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Obj.	$0	$0	$0	$0

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Package Description

In 2014, the state implemented the Affordable Care Act, which introduced modified adjusted gross income (MAGI)-based rules for Medicaid eligibility determinations through the Exchange Healthplanfinder (HPF) website. Currently, over 1.6 million Medicaid and CHIP clients[1] have their eligibility records maintained through the HPF website. Approximately 160,000 Qualified Health Plan (QHP)[2] clients are also served.

In addition to being the portal for eligibility determination, current clients continue to access the HPF to update their client records when needed, receive HPF-generated notices and other required correspondence, and access customer support services provided by the Exchange operated Call Center and Navigator program.

The ratio of Medicaid clients to Qualified Health Plan (QHP) clients is approximately 91 percent. The Exchange incurs expenses for operational activities for which a portion is the responsibility of the Medicaid program. These costs have been allocated in the past using a methodology that reflects the proportion of Medicaid and CHIP clients using the HPF system and other services relative to usage by QHP applicants and enrollees. The 2016 State Auditor Office (SAO) Performance Audit of the Exchange identified that the Exchange was not being fully reimbursed for the Medicaid services it provides. The SAO audit recommended that the Exchange submit a revised cost allocation plan that ensured the Exchange include all costs for Medicaid services provided by the Exchange.

In August 2016, the Exchange submitted a revised cost allocation plan to the Centers for Medicare and Medicaid Services that simplified the cost allocation methodology and expanded the base of expenditures to accurately reflect the services provided on behalf of Medicaid, including the administrative costs of the Exchange. Previously the only costs attributed to Medicaid were HPF Operations and maintenance, call center costs, print and imaging services and in-person assistor/navigator cost. The recently submitted plan proposes recovering Medicaid reimbursement for the administrative costs of the Exchange, including staff supporting Exchange activities, such as policy, finance, operations staff and facilities. The SAO's report found that the Exchange would be more self-sustainable by receiving full reimbursement for the Medicaid services it provides. This funding request is intended to help achieve this goal.

Base Budget: If the proposal is an expansion or alteration of a current program or service, provide information on the resources now devoted to the program or service.
This request is a technical correction to align funding sources to reflect a modification in cost allocation for Medicaid services.

Decision Package expenditure, FTE and revenue assumptions, calculations and details: This decision package changes the source of funding for Medicaid services as follows:

Carry Forward Level assumptions for the 2017-19 Biennium are based on an average Federal Financial Participation (FFP) rate of 90 percent. The first part of the decision package corrects the funding split to reflect those activities that either get no Medicaid funding (QHP activities) or which receive a 50% (operations) or 75% (maintenance and operations) match rate. This step corrects the base fund split to reflect the currently approved Advanced Planning Document (APD).

[1] Washington State Caseload Forecast Council, June 2016 Medicaid Forecast
[2] Wakely May 2016 Enrollment Forecast

The second part of the decision package is based on an updated APD that was submitted August 1, 2016. This step reflects the recommendation of the SAO report that the Exchange more fully capture Medicaid funding for its activities that support Medicaid enrollees. Medicaid enrollees are approximately 91% of all enrollees processed through the Healthplanfinder system.

As the Exchange is still awaiting final approval its proposed cost allocation methodology, the numbers reflected below are a placeholder to demonstrate the fund adjustments that will be needed once the APD is approved.

Approved Carry Forward Levels	**2018**	**2019**	**2020**	**2021**
001-1 General Fund - Basic Account-State	$5,184	$5,184	$5,184	$5,184
001-2 General Fund - Basic Account-Federal	$1,418	$1,421	$1,421	$1,421
001-C General Fund - Basic Account-Medicaid	$23,508	$23,883	$23,883	$23,883
17T-1 Health Benefit Exchange Account-State	$23,370	$23,708	$23,708	$23,708
Total	$53,480	$54,196	$54,196	$54,196
Technical Adjustment to Reflect FFY2016 Cost Allocation Methodology	**2018**	**2019**	**2020**	**2021**
001-1 General Fund - Basic Account-State	$5,184	$5,184	$5,184	$5,184
001-2 General Fund - Basic Account-Federal	$317	$321	$321	$321
001-C General Fund - Basic Account-Medicaid	$16,391	$16,611	$16,611	$16,611
17T-1 Health Benefit Exchange Account-State	$31,588	$32,080	$32,080	$32,080
Total	$53,480	$54,196	$54,196	$54,196
Proposed Cost Allocation Methodology Beginning FFY2017	**2018**	**2019**	**2020**	**2021**
001-1 General Fund - Basic Account-State	$5,184	$5,184	$5,184	$5,184
001-2 General Fund - Basic Account-Federal	$706	$716	$716	$716
001-C General Fund - Basic Account-Medicaid	$20,589	$20,869	$20,869	$20,869
17T-1 Health Benefit Exchange Account-State	$27,001	$27,427	$27,427	$27,427
Total	$53,480	$54,196	$54,196	$54,196
Fund Source Adjustment to Reflect FFY17 Allocation Methodology	**2018**	**2019**	**2020**	**2021**
001-1 General Fund - Basic Account-State	$0	$0	$0	$0
001-2 General Fund - Basic Account-Federal	-$712	-$705	-$705	-$705
001-C General Fund - Basic Account-Medicaid	-$2,919	-$3,014	-$3,014	-$3,014
17T-1 Health Benefit Exchange Account-State	$3,631	$3,719	$3,719	$3,719
Total	**$0**	**$0**	**$0**	**$0**
Calculations shown in thousands				

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Decision Package Justification and Impacts

What specific performance outcomes does the agency expect?

Improved fiscal accountability for using fund sources that reflect the beneficiaries of services. Enhanced sustainability through flat or reduced carrier assessment rates.

Performance Measure detail:
Improved sustainability for the Exchange.

Fully describe and quantify expected impacts on state residents and specific populations served.
The Exchange is seeking additional cost reimbursement for services provided on behalf of Medicaid enrollees, which represent about 91% of total enrollees. The following tables identifies the effect of each step by fund source.

What are other important connections or impacts related to this proposal? Please complete the following table and provide detailed explanations or information below:

Impact(s) To:		Identify / Explanation
Regional/County impacts?	No	Identify:
Other local gov't impacts?	No	Identify:
Tribal gov't impacts?	No	Identify:
Other state agency impacts?	Yes	Identify: Health Care Authority must submit the APD to CMS in their role as the State Medicaid Agency
Responds to specific task force, report, mandate or exec order?	Yes	Identify: 2016 SAO Performance Report of Washington Health Benefit Exchange
Does request contain a compensation change?	No	Identify:
Does request require a change to a collective bargaining agreement?	No	Identify:
Facility/workplace needs or impacts?	No	Identify:
Capital Budget Impacts?	No	Identify:
Is change required to existing statutes, rules or contracts?	Yes	Identify: Reflects change to Advanced Planning Document with CMS
Is the request related to or a result of litigation?	No	Identify lawsuit (please consult with Attorney General's Office):
Is the request related to Puget Sound recovery?	No	If yes, see budget instructions Section 14.4 for additional instructions

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Identify other important connections		

Please provide a detailed discussion of connections/impacts identified above.
The Health Care Authority submitted a revised Advanced Planning Document to CMS as the state Medicaid agency.

What alternatives were explored by the agency and why was this option chosen?
None. It is necessary to align revenue sources to expenditures

What are the consequences of not funding this request?
The Exchange will need to reduce expenditures that would negatively impact service delivery.

How has or can the agency address the issue or need in its current appropriation level?
The appropriation level is not changing, this only corrects the funding source to reflect expected revenues.

Other supporting materials:

Information technology: Does this Decision Package include funding for any IT-related costs, including hardware, software, services (including cloud-based services), contracts or IT staff?

☒ No

☐ Yes Continue to IT Addendum below and follow the directions on the bottom of the addendum to meet requirements for OCIO review.)

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